

Reimbursement Policy

April 2016

Reimbursement policy language may have changed. These policies will serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by the Amerigroup Iowa, Inc. benefit plans. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Effective **April 1, 2016**, Reimbursement Policies will transition to the Amerigroup provider website. For policy specific information:

1. Go to providers.amerigroup.com/ia.
2. Under the **Provider Resources & Documents** menu, select **Quick Tools**
3. Click on **Reimbursement Policies**

Code and clinical editing

Amerigroup applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. We utilize sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to the Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative, Medical Policies and Clinical Utilization Management Guidelines. Amerigroup is committed to working with you to ensure timely processing and payment of claims.

Provider Updates

Inpatient Facility Transfers

(Policy 13-002, effective 04/01/2016)

Amerigroup allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for the same episode of care, in compliance with federal and/or state guidelines regarding facility transfers payment.

Amerigroup will use the following criteria:

- Transferring facility will receive a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting
- Receiving facility will receive full diagnosis related group (DRG) payment

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

Inpatient Readmissions

(Policy 13-001, effective 04/01/2016)

Amerigroup will implement Inpatient Readmission rules effective **April 1, 2016**, following state and CMS guidelines.

Claims identified as a readmission are subject to the following:

- Readmissions occurring up to thirty (30) days from discharge for the same diagnosis or condition, or for evaluation and management of, the prior stay's medical condition are considered part of the original admission and should be combined.

Inpatient Readmission rules only affect facilities reimbursed for inpatient services by a DRG methodology.

Amerigroup reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission.

To view specific criteria for each reimbursement policy, refer to the list of reimbursement policies online:

1. Go to **providers.amerigroup.com/ia**.
2. Under the **Provider Resources & Documents** menu, select **Quick Tools**
3. Click on **Reimbursement Policies**

For additional information, please reference your Provider Manual and/or your Provider Agreement as a guide for reimbursement criteria. Your continued feedback is critical to our success. For more information on this topic or questions about this provider bulletin, please call Provider Services at 1-800-454-3730.