Reimbursement Policy

Subject: Emergency Services: Nonparticipating Providers and Facilities

Effective Date: **05/01/17**	Committee Approval Obtained: **09/30/19**	Section: **Administration**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage allows reimbursement for emergency services provided by nonparticipating professional providers and facilities unless provider, state, federal or CMS contracts

	and/or requirements indicate otherwise. Unless otherwise required by federal regulation and/or contract, reimbursement is based on no more than the amount that would have been reimbursed to the provider if the beneficiary were enrolled in original Medicare. Amerigroup Medicare Advantage adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA). Amerigroup Medicare Advantage will not limit consideration of reimbursement for emergency services on the basis of lists of diagnoses or symptoms; however, additional medical record documentation may be required in order to clearly identify and determine appropriate reimbursement of emergency services. Claims for emergency services are subject to the Medicare Advantage Eligible Billed Charges, Code and Clinical Editing Guidelines, and Claims Requiring Additional Documentation reimbursement policies of Amerigroup Medicare Advantage.
History	• Biennial review approved **09/30/19**: Policy template updated • Biennial review approved and effective **05/01/17**: Policy template updated; Exhibit B removed • Biennial review approved and effective **11/09/15**: Policy template updated • Initial policy approval and effective date **01/01/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract • DRA of 2005 (Pub. L. No. 109-171) • EMTALA
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submissions — Required Information for Facilities • Claims Submissions — Required Information for Professional Providers • Code and Clinical Editing Guidelines • Eligible Billed Charges • Sanctioned and Opt-Out Providers
Related Materials	• None