Amerigroup An Anthem Company	**Reimbursement Policy**	
Subject: Scope of Practice		
Effective Date: **01/01/15**	Committee Approval Obtained: **07/13/18**	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 non-contracting 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 services that are within the provider's scope of practice under state law in accordance with CMS guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	The provider shall be licensed in or hold a license recognized in the jurisdiction where the patient encounter occurs. Amerigroup Medicare Advantage allows reimbursement for telemedicine performed within the provider's scope of practice as regulated by state law. Scope of practice is determined by: • Advanced practice education in a role and specialty. • Legal implications. • Scope of practice statements as published by national professional specialty and advanced organizations. • State medical licensure requirements. • Federal regulations. Services provided outside of a practitioner's scope of practice are not covered or reimbursable. Amerigroup Medicare Advantage allows reimbursement for providers with nonresidency but who have advanced training performing services in a medically underserved area as allowed by state law. Amerigroup Medicare Advantage allows reimbursement for providers when no board-certified physicians are available to meet local requirements as allowed by state law. Nonparticipating Medicare providers will be reimbursed according to CMS guidelines.
History	• Biennial review approved 07/13/18: Policy template updated • Biennial review approved 08/01/16: Policy template updated • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • 42 CFR §440.2 — Federal Regulations on Scope of Practice

Definitions	• **Scope of Practice** refers to:
	  ○ The extent to which providers may render health care services and the extent they may do so independently
	  ○ The type of diseases, ailments, and injuries a health care provider may address. (American Medical Association Glossary of Terms)
	• **General Reimbursement Policy Definitions**

Related Policies	• Locum Tenens Physicians/Fee-for-Time Compensation

	• Professional Anesthesia Services • Reimbursement of Sanctioned and Opt-Out Providers
Related Materials	• None