Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Reimbursement of Services with Obsolete Codes		
Effective Date: **07/13/18**	Committee Approval Obtained: **07/13/18**	Section: **Coding**

*****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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 does not allow reimbursement for services billed with obsolete codes, in compliance with industry standard coding practices according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Billing with obsolete codes is not HIPAA-compliant.

	Claims submitted for services using obsolete codes will be denied. Providers must resubmit claims with applicable new or replacement codes to have services considered for reimbursement. Resubmitted claims are subject to claims timely filing guidelines.
History	• Biennial review approved 10/19/17 • Biennial review approved 03/19/15: Background, references and research materials and 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 contract • Federal Register Vol. 65, No. 160 45 CFR Parts 160 and 162 Health Insurance Reform: Standards for Electronic Transactions • National Correct Coding Initiative • HIPAA Compliance Guidelines
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Timely Filing • Code and Clinical Editing Guidelines
Related Materials	• None