Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Claims Submission - Required Information for Professional Providers		
Effective Date: **04/30/19**	Committee Approval Obtained: **04/30/19**	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 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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	Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original CMS-1500 Health Insurance Claim Form to Amerigroup Medicare Advantage for payment of health care services.

	Providers must submit a properly completed *CMS-1500* for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup Medicare Advantage will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include the following information, if applicable:
	• Patient information (name, address including ZIP code, date of birth, gender, relationship to insured, and medical condition as related to employment or an accident)
	• Insured's information (member ID number, name, address including ZIP code, policy, group or Federal Employees' Compensation Act number, name of insurance plan or program, and name of other health benefit plan)
	• Coordination of benefits/other insured's information (name, policy or group number, and name of insurance plan or program)
	• Name of referring physician or source
	• Indication of outside laboratory
	• ICD-9 diagnosis code(s), including fourth and fifth digit when required or ICD-10 diagnosis code(s) depending upon the dates of service
	
	Note: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM, on either the old or revised version of the CMS-1500 claim form.
	• Clinical Laboratory Improvement Act certification number
	• Date(s) of service(s) rendered
	• Place of service
	• Procedures, services or supplies (description of services rendered using CPT-4 codes/HCPCS codes and appropriate modifiers)
	• Charge(s) for service(s) rendered
	• Day(s) or unit(s) related to service(s) rendered
	• Total charges and amount paid by patient
	• Federal TIN
	• Name and address of facility where services were rendered and the NPI of the service facility, if applicable
	• NPI:
	  ○ Individual servicing provider's NPI must be reported as the rendering provider ID, if applicable
	  ○ When billing is from a group, the group's NPI must be reported as the billing provider, if applicable
	• Other non-NPI ID number of the referring, ordering or supervising provider
	• Billing provider information (name, address including ZIP code, telephone number)

	• Indication of signature on file — a handwritten or computer generated signature for the provider of service or his/her representative — and date the form was signed • National Drug Code(s) (NDC) to include the NDC number, unit price, quantity and composite measure per drug Amerigroup Medicare Advantage cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return. Although Amerigroup Medicare Advantage prefers the submission of claims electronically through the electronic data interchange (EDI), Amerigroup Medicare Advantage will accept paper claims. A paper claim must be submitted on an original claim form with drop out red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.
History	• Biennial review approved and effective 04/30/19: Policy template updated • Biennial review approved and effective 07/13/15: Policy language updated; Related policies updated • Amerigroup Medicare Advantage review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submission — Required Information for Facilities • Corrected Claims • Drugs and Injectable Limits • Modifier Usage • Other Provider Preventable Conditions • Unlisted, Unspecified or Miscellaneous Codes
Related Materials	• Acceptance of Altered Claim Forms • Electronic Data Interchange Manual