Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Reimbursement for Eligible Billed Charges		
Effective Date: **04/01/10**	Committee Approval Obtained: **07/14/16**	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 > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state. *****

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 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 both participating and nonparticipating providers and facilities.

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

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements.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 strives to minimize these variations.

Amerigroup 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	Eligible Charges means charges billed by the provider subject to conditions and requirements which make the service eligible for reimbursement. Amerigroup allows reimbursement of Eligible Charges unless provider, state, federal or CMS contracts and/or requirements

	indicate otherwise. Eligibility for reimbursement of the billed service is dependent upon application of the following conditions and requirements: • Member program eligibility • Provider program eligibility • Benefit coverage • Authorization requirements • Provider manual guidelines • Amerigroup administrative policies • Amerigroup clinical policies • Amerigroup reimbursement policies • Code editing logic The allowed amount reimbursed for the Eligible Charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, copayments, deductibles, and coordination of benefits. Amerigroup will not reimburse providers for: • Items the provider receives free of charge • Items the provider provides to the member free of charge In absence of clear language or specific reference to Eligible Charges in provider contracts, the use of the following terms will default to Eligible Charges as stated within this policy: • "Billed charges" • "Covered charges" • "Billed charges for covered services" • "Allowed charges" • "Percent of charge"
Exemptions	There are no exemptions to this policy.
History	• Biennial review approved 07/14/16 • Effective 12/31/15: Exited Florida Medicare • Biennial review approved 08/24/15: Policy language updated; Policy title updated

	• Effective 06/01/14: Exited Ohio • Biennial review approved 05/20/13: Policy template updated • Review approved 04/09/12: Background section updated; policy template updated • Review approved 04/11/11: Background section updated; policy template updated • Review approved 11/02/09 and effective 04/01/10: Policy language updated; policy template updated • Review approved and effective 02/27/07: Policy template updated • Initial committee approval and effective date: 03/02/06
References and Research Materials	This policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status, in addition to the following: • CMS • State Medicaid • Amerigroup state contracts • National Association of Insurance Commissioners (NAIC) Model Regulation, 2013
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Submission – Required Information for Professional Providers
Related Materials	• None