Reimbursement Policy

Subject: Reimbursement of Sanctioned and Opt-Out Providers

Effective Date: **12/09/12**	Committee Approval Obtained: **10/03/16**	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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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	Amerigroup does not allow reimbursement to providers who are excluded or debarred from participation in state and federal health care programs. We also do not allow reimbursement to providers who have rendered services to members enrolled in any Medicare program if such provider has opted out from participation in Medicare. Services

	that are rendered by such a provider that is sanctioned or has opted out of participation in Medicare may only be reimbursed in urgent or emergent situations. Claims received for services other than emergency services submitted by sanctioned or opt-out providers as provided herein will be denied. Amerigroup will allow reimbursement to a sanctioned or opt-out provider for emergency items or services **only** if the claim is accompanied by a sworn statement of the person furnishing the items or services specifying: • The nature of the emergency • Why the items or services could not have been furnished by a provider eligible to furnish or order such items or services **Note:** Payment may not be made for services furnished by an opt-out physician or practitioner who has signed a private contract with a Medicare beneficiary for emergency or urgent care items. Amerigroup screens providers through all applicable state and federal exclusion lists.
Exemptions	• Amerigroup Community Care in Tennessee does not allow reimbursement to any provider who is excluded from participation in the state and federal health care programs. • Modifier GJ is required on Medicare claims for emergency or urgent care services when rendered by an opt out provider.
History	• Biennial review approved 10/03/16: Policy template updated • Effective 12/31/15: Exited Florida Medicare • Review approved 11/09/15: Tennessee exemption added • Biennial review approved 08/18/14: Policy language updated; Texas exemption removed • Effective 04/07/14: Medicare Advantage exemption updated 08/01/14 • Effective 07/01/13: Ohio Exited • Biennial review approved 05/21/12 and effective 12/09/12: Opt-out language added; Texas exemption added; Medicare exemption added; Policy template updated • Initial approval and effective date: 10/11/10
References and Research Materials	This policy has been developed through consideration of the following: • CMS

	• State Medicaid • Amerigroup state contracts • Code of Federal Regulations • Social Security Act
Definitions	• **Reimbursement Policy Definitions**
Related Policies/Procedures	• Claims Requiring Additional Documentation • Emergency Services: Non-Participating Providers and Facilities
Related Materials	• None