

		<b>Reimbursement Policy</b>
<b>Subject: Reimbursement for Eligible Billed Charges</b>		
Effective Date: <b>10/01/17</b>	Committee Approval Obtained: <b>07/19/17</b>	Section: <b>Administration</b>
<p>***** The most current version of our 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 <a href="https://providers.amerigroup.com/DC">https://providers.amerigroup.com/DC</a>. *****</p>		
<p>These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Amerigroup District of Columbia, Inc. 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 District 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.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:</p> <ul style="list-style-type: none"> <li>• Reject or deny the claim.</li> <li>• Recover and/or recoup claim payment.</li> </ul> <p>Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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.</p> <p>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.</p>		
<b>Policy</b>	<p>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, District, 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:</p> <ul style="list-style-type: none"> <li>• Member program eligibility</li> </ul>	

	<ul style="list-style-type: none"> <li>• Provider program eligibility</li> <li>• Benefit coverage</li> <li>• Authorization requirements</li> <li>• Provider manual guidelines</li> <li>• Amerigroup administrative policies</li> <li>• Amerigroup clinical policies</li> <li>• Amerigroup reimbursement policies</li> <li>• Code editing logic</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• Items the provider receives free of charge.</li> <li>• Items the provider provides to the member free of charge.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• Billed charges</li> <li>• Covered charges</li> <li>• Billed charges for covered services</li> <li>• Allowed charges</li> <li>• Percent of charge</li> </ul>
<b>History</b>	<ul style="list-style-type: none"> <li>• Initial review approved <b>07/19/17</b> and effective <b>10/01/17</b></li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• DC Department of Health Care Finance policies</li> <li>• Amerigroup contract with the DC Department of Health Care Finance</li> <li>• National Association of Insurance Commissioners (NAIC) Model Regulation, 2013</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>• Claims Submission— Required Information for Professional Providers</li> </ul>
<b>Related Materials</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>