MEDICAL PAYMENT POLICY	
Policy Name:	Facility Emergency Department Policy
Policy Number:	
Approved By:	Medical Management
Provider Notice Date:	July 1, 2016
Original Effective Date:	July 1, 2015
Annual Approval Date:	
Revision Date:	August 1, 2016
Products:	Pennsylvania Medicaid and Pennsylvania Medicare Advantage Plans
Application:	All participating and non-participating facilities
Page Number(s):	1 of 3

Disclaimer

Gateway Health's (Gateway) medical payment policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical decisions.

POLICY STATEMENT:

The scope of this policy is to define payment methodologies for emergent and non-emergent services performed in an Emergency department and provided to Pennsylvania Medicaid and Pennsylvania Medicare Advantage members. This policy identifies the method of reimbursement for Emergency Department (ED) claims with emergent and non-emergent primary diagnosis beginning with dates of services August 1, 2016 and to outline the reimbursement for the screening fee when the emergency department visit is deemed a non-emergent service.

DEFINITIONS:

Emergency Medical Condition [EMC] is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Emergency Department Services include but are not limited to treatment, supplies, facility charges, and diagnostic tests.

Screening for an Emergency Medical Condition [EMC] is required and covered even in the event the emergency department visit is determined to be non-emergent. All members presenting to the emergency department must be provided a medical screening examination appropriate to the individuals' presenting signs and symptoms. Once the individual is screened and it is determined the individual has only presented to the ED for a non-emergency purpose and does not require stabilization, the hospital's Emergency Medical Treatment and Labor Act (EMTALA) (reference 1 below) obligation ends for that individual at the completion of the medical screening examination. Payment will be made to clinics or emergency rooms for the screening only for the non-emergency use of the emergency room.

PROCEDURES:

Authorizations are not required for emergency services.

A. Emergent Criteria – ED criteria requires the billing of the defined ICD-10 (or current version) emergent diagnosis codes in specific claim form fields for Gateway members who seek services in the Emergency Room. Services that do not meet the definition of Emergency Medical Condition (EMC) are not reimbursable on an emergent basis. In order for treatment of a condition to be payable on an emergency basis, the following must occur:

1. Symptoms must be sufficiently severe: Medical emergency care symptoms must be sufficiently severe to cause the patient to seek immediate medical aid.

2. UB04 claim form/CMS-1450 [or its successor] must identify a defined emergent diagnosis code in the Principal DX field 67 and the Patient Reason for Visit Code field 70 A-C. Failure to follow these guidelines may result in rejection of the claim or incorrect adjudication of your claim.

B. Reimbursement

The following guidelines apply when determining emergency and non-emergency reimbursement methodology for facility providers.

1. Emergency services do not require prior authorization or PCP referral and are provided for emergency services. If the emergency facility bills with Rev Code 0450 and the appropriate level of care (e.g. 99281-99285 or 99291-99292), and an emergent diagnosis code(s) is billed in Box 67 and/or Box 70A-C, the claim will be reimbursed in accordance with the participating provider's Gateway contract. Non-participating providers will be reimbursed in accordance with Gateway's non-participating provider policy.

2. If the facility bills with Rev Code 0450 and the appropriate level of care, and a non-emergent diagnosis code(s) is billed in **both** Box 67 and Box 70A-C, the claim will be reimbursed a screening fee equal to the lesser of billed charges or the participating provider's contracted rate for a 99281 in their Gateway contract. If a participating provider does not have specific contracted rate for a 99281 the screening fee will be reimbursed the lesser of the billed charges or $25. The screening fee is all-inclusive of facility Emergency Department services. No additional ancillary services will be paid.

Prospective Review Process is available for claims for emergency services. Facilities may bill their initial claims with medical records to have their claims reviewed pre-payment to determine medical emergency prior to the claim being processed. The facility may attach the complete emergency medical record to the claim and the claim

and records will be pended for clinical review to determine if the services provided are a valid emergency medical condition. If the claim is determined to not meet emergency medical criteria after medical record review, the respective explanation of payment will provide an appropriate denial.

Policy Source(s)
Emergency Medical Treatment and Labor Act (EMTALA), codified at 42 CFR 489.24