Emergency Department Payment Policy

Policy

The Plan will pay claims for services provided in an Emergency Department (ED) setting for all services meeting the prudent layperson standard definition as defined below.

Definitions

The prudent layperson standard is used as a basis for payment. The prudent layperson standard is defined as a "condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in serious jeopardy to the health of the member or another person or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

This definition is consistent with CMS, DOI, and NCQA requirements.

Reimbursement

Services must be coded to the appropriate, medically necessary level of intensity. The Plan recognizes the Current Procedural Terminologys (CPT's) definitions of services and follows the CMS 1995/1997 documentation guidelines for evaluation and management (E&M) services. Medical records must support the reported levels of service based on the CMS 1995/1997 documentation guidelines, and records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding.

The presence of documentation that meets the specific CMS 1995/1997 documentation guidelines is not the sole determinant of whether or not a level of service will be reimbursed. The reason for the visit must medically support the extent of the history, exam, and/or discussion time noted. Documentation should support the level of service reported, and the volume of documentation should not be the primary factor upon which a specific level of service is billed. It is expected that E&M levels billed will be consistent with the descriptions of level of severity of the presenting problem(s) which appear as part of CPT's descriptions of the corresponding levels of ED E&M service.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and this determination is binding on the Plan.

Routine and/or scheduled follow up visits to the Emergency Department are not eligible for facility or professional payment, except with prior authorization by the plan or PCP referral.

Member Copayments:

- Emergency Department copayments apply to the technical component of the Emergency Department visit.
- For Medicare Advantage plan members receiving treatment at out-of-network facilities, the Plan will pay the Medicare allowable charges minus applicable copayment.
- The Emergency Department copayment will not be applicable if the patient is admitted to observation, same-day surgery, or inpatient (unless otherwise stated in the member's *Evidence of Coverage/Schedule of Benefits*) as a consequence of the Emergency Department visit.

Charges for Emergency Department services resulting in or following an observation stay:

- The Emergency Department technical charge is considered part of the observation charge and will not be reimbursed separately when performed on the same day, day prior, or day after an observation stay.

- Unless specified separately in the contract, the Emergency Department professional component will be reimbursed separately.

Charges for Emergency Department services resulting in a same-day surgery:

- Charges for Emergency Department services resulting in a same-day surgery performed outside of the emergency room will not be reimbursed separately.

Charges for Emergency Department services resulting in an admission:

- If the Emergency Department services result in an admission, these charges should be considered under the inpatient stay. The Emergency Department technical charge is considered part of the inpatient stay and will not be reimbursed separately.
- Unless specified separately in the contract, the Emergency Department professional component will be reimbursed separately.

Charges for late-night services:

- Charges billed in addition to basic services provided in an Emergency Department because the services occurred after 10 p.m. will not be reimbursed separately.

Fast-track/urgent care:

- This Emergency Department policy would apply for hospitals that submit fast-track Emergency Department charges with a facility urgent care component.

Physician Charges for Infusion/Injection Services in the Emergency Department:

- Consistent with industry standard guidelines for Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusion services (96360-96379), the Plan will not reimburse practitioners for these services when provided in an emergency room setting. Modifiers 26 and TC cannot be used with these codes.

Trauma response team activation for Medicare Advantage, NaviCare and PACE plan members:

Effective October 1, 2021, Fallon Health will reimburse trauma response team activation for Medicare Advantage, NaviCare and PACE plan members when billed in accordance with Medicare guidance:

- When trauma activation occurs under the circumstances described by the National Uniform Billing Committee (NUBC) guidelines that would permit reporting a charge under 68x and the hospital (i.e., a designated tauma center) provides at least 30 minutes of critical care so that CPT code 99291 is appropriately reported, the hospital may also bill one unit of HCPCS code G0390, Trauma response team activation associated with hospital critical care service, reported with revenue code 68x on the same date of service as CPT code 99291, and the hospital will receive an additional APC payment.
- As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care when trauma activation occurs should bill for a visit, typically an emergency department visit, at a level consistent with CPT guidelines. Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 68x, may report a charge under 68x, but they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit that is reported.
- Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician or hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.
- In summary,
    - Trauma Centers must be licensed, designated or authorized by the state or local government authority and are assigned a trauma level (Trauma Response Level 1-IV).
    - In order to bill for trauma activation there must have been notification of key hospital personnel in advance of the patient's arrival in response to triage information from pre-

hospital caregivers (e.g., EMS). The activation fee cannot be used for trauma activations if there was not pre-arrival notification, for example, when a patient is dropped off at the emergency department by a friend or family member.

- Revenue code series 68x can be used only by trauma hospitals designated by the state or local government. Different subcategory revenue codes (068x) are reported by designated Level 1-4 trauma centers. Designated trauma centers should not bill a trauma response activation level higher than their designated trauma center level. For example, a designated trauma level II center cannot bill a level I trauma response regardless if a trauma response level I was activated.
- Trauma activation code G0390 may be submitted separately under revenue code 68x when provided on the same date of service as critical care service CPT 99291.

See Medicare Claims Processing Manual, Chapter Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 160.1 Critical Care Services, for additional information.

Trauma response team activation (HCPCS code G0390) will deny vendor liable for commercial and MassHealth ACO lines of business.

Referral/notification/prior authorization requirements

Prior authorization is not required for Emergency Department services. The Plan shall determine coverage based on the Reimbursement criteria outlined above.

Billing/coding guidelines

Services must be coded to the appropriate, medically necessary level of intensity. The Plan recognizes CPT's definitions of services and follows the CMS 1995/1997 documentation guidelines for E&M services. Medical records must support the reported levels of service based on the CMS 1995/1997 documentation guidelines, and records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding.

The presence of documentation that meet the specific CMS 1995/1997 documentation guidelines is not the sole determinant of whether or not a level of service will be reimbursed. The reason for the visit must medically support the extent of the history, exam, and/or discussion time noted. Documentation should support the level of service reported, and the volume of documentation should not be the primary factor upon which a specific level of service is billed. It is expected that E&M levels billed will be consistent with the descriptions of level of severity of the presenting problem(s) which appear as part of CPT's descriptions of the corresponding levels of ED E&M service.

The Plan requires all professional charges to be submitted on a CMS-1500 claims form and hospital charges to be submitted on a UB04 claims form, or in HIPAA-standard electronic formats, per industry standard guidelines.

In any case in which a radiologist or cardiologist furnishes the interpretation (a written interpretation or a verbal interpretation that will be written later) of x-ray and/or EKG, the emergency room physician should not bill for the interpretation. The Plan will pay for the claim submitted by the radiologist or cardiologist.

Naloxone nasal spray
Effective April 1, 2020, nasal naloxone spray is covered for MassHealth ACO, NaviCare and Summit ElderCare plan members when dispensed by an Emergency Department. Nasal naloxone spray is covered for commercial plan members when dispensed by an Emergency Department effective December 1, 2020.

Claims for naloxone nasal spray dispensed by an Emergency Department must be submitted as follows in order to ensure separate reimbursement:

- Revenue Code 0636

- HCPCS Code J3490 and NDC*
- Modifier HG

* The NDC is required when billing for naloxone nasal spray (see **Drugs and Biologicals Payment Policy** for additional information).

Naloxone nasal spray comes in a package containing two (2) 4-mg doses of naloxone. Emergency Departments may dispense more than one package to a plan member when the member's treating practitioner determines it is clinically appropriate and medically necessary.

Place of service

This policy applies to professional and facility services that are submitted with a place of service 23 indicating an Emergency Department.

Excluded products

This policy does not apply to Fallon Health Weinberg MLTC as Emergency Department Services are not covered under this plan.

Policy history

Origination date:	07/14/2000
Previous revision date(s):	03/05/03, 03/03/04, 03/16/05, 11/09/05, 10/25/06, and 10/24/07, 03/01/09, 07/01/09 07/01/09 – Updated Reimbursement explanation of Emergency Department services resulting in or following observation and resulting in admission. 05/01/2010 - Removed language about case review and ambulance from the Reimbursement section; added language to the Reimbursement and Billing/coding guidelines sections about FCHP's use of CMS 1995/1997 documentation guidelines and record review to monitor reported level of service. 07/01/2012 – Reviewed, no changes. 09/01/2014 – Updated to Fallon Health template. 09/01/2015 - Annual review and moved to new Plan template. 07/01/2016 – Annual review.
Connection date & details:	May 2017 – Annual review. July 2018 – Annual review, no updates. July 2019 – Annual review, no updates. October 2020 – Added billing instructions for naloxone nasal spray. October 2021 – Added trauma response team activation for Medicare Advantage, NaviCare and PACE plan members under Reimbursement section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.