Payment Policy: Leveling Professional Fees for Emergency Room Services

Reference Number: GA.PP.053
Product Types: MEDICAID
Effective Date: 11/05/2018
Last Review Date: (10/02/18)

Policy Overview

The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.

Application
Physicians or other qualified health professionals.

Policy Description
The Federal Balanced Budget Act (BBA) of 1997 and the Medicaid statute has established the definition of an “Emergency Medical Condition (EMC)” as follows:

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:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any body organ or part.

The hospital’s Emergency Medical Treatment and Labor Act (EMTALA) provides that a hospital with a dedicated emergency department must provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists. The hospital must also provide stabilizing treatment or an appropriate transfer to a more appropriate setting. The purpose of the medical screening examination is to determine whether or not an emergency medical condition exists.

Prior authorization is not required for emergency medical services.

Nothing in this policy excludes the provider’s responsibility to perform the medical screening examination.
PAYMENT POLICY
LEVELING OF PROFESSIONAL FEES FOR EMERGENCY ROOM SERVICES

Reimbursement
The Center for Medicaid and Medicare Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.

When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a level 3 (99283) reimbursement rate as outlined in the most current state Medicaid fee schedule. Downgraded payments can be appealed with medical records.

Documentation Requirements
The patient’s primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2018 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Emergency Department Services-New or Established Patient

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<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Descriptor</th>
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<tr>
<td>99281</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: - A problem focused history; - A problem focused examination; and – Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor.</td>
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<tr>
<td>99282</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: - An expanded problem focused history; - An expanded problem focused examination; and – Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor.</td>
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## Definitions

**Prudent Layperson** – One who possesses an average knowledge of health and medicine who believes an emergency situation exists that may cause 1) serious medical harm, or 2) serious impairment of bodily function, or 3) serious dysfunction of any bodily organ.

### Revision History

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<th>Date</th>
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<tbody>
<tr>
<td>09/21/2018</td>
<td>Corporate policy modified to implement for Georgia. Updated Effective Date: 10/01/2018 to 11/01/2018 (CHOA 01/01/2019)</td>
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<tr>
<td>10/02/2018</td>
<td>Changed Effective Dates to 11/05/18 and 02/05/19 (CHOA)</td>
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References

2. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*