

<b><i>Facilities Emergency Department Policy</i></b>
<b>Effective date:</b> July 1, 2020, for nonparticipating facilities and September 1, 2020, for participating facilities
<b>Scope</b>
This policy is applicable to emergency department (ED) services provided to members with Amerigroup Texas, Inc. and Amerigroup Insurance Company.
<b>Description</b>
This policy identifies the method of reimbursement for ED facility claims beginning with dates of service on or after July 1, 2020, for nonparticipating (NON-PAR) facilities and on or after September 1, 2020, for participating (PAR) facilities.
<b>Definitions</b>
<p><b>Emergency Medical Condition:</b> Any medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> <li>• Serious jeopardy to the health of the individual or in the case of a pregnant woman, the woman or her unborn child.</li> <li>• Serious impairment to bodily functions.</li> <li>• Serious dysfunction of any bodily organ or part.</li> </ul> <p>With respect to a pregnant woman who is having contractions, an emergency medical condition exists if there is inadequate time to affect a safe transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child.</p> <p><b>Emergency Services and Care:</b> These are covered inpatient services, outpatient services or medical transportation that are provided by a qualified provider and are needed to evaluate, treat or stabilize an emergency medical condition.</p> <p><b>Prudent Layperson (PLP) Review:</b> This is a review to reasonably determine whether an emergency medical condition, as defined above, exists. The reviewer does not have more than a high school education and does not have formal training in a medical, nursing or social work-related field.</p>
<b>Overview</b>
<p>This document describes reimbursement methodology in accordance with ED criteria for emergent and nonemergent services.</p> <p>Amerigroup will only process an ED facility claim as <b>emergent</b> and reimburse at the applicable contracted rate or valid out-of-network Texas Medicaid fee-for-service rate when a diagnosis from a designated auto-pay list is billed as the primary diagnosis on the claim.</p>

If the primary diagnosis is not on the auto-pay list, the facility must submit medical records with the claim. Upon receipt, the claim and records will be reviewed by a prudent layperson standard to determine if the presenting symptoms qualify the patient's condition as emergent. If the reviewer confirms the visit was emergent, according to the prudent layperson criteria, the claim will pay at the applicable contracted rate or valid out-of-network Texas Medicaid fee-for-service rate. If it is determined to be nonemergent, the claim will pay a triage fee.

In the event a claim from a facility is submitted without a diagnosis from the auto-pay list as the primary diagnosis and no medical records are attached, the ED facility claim will automatically pay a triage fee.

### Criteria

ED criteria requires the billing of defined ICD-10 diagnosis codes in specific claim form fields for our members who seek services in the ED:

- ICD-10 emergent diagnosis codes have been identified, and the list of emergent diagnosis codes can be found online on the provider website at <https://providers.amerigroup.com/TX>. The list of diagnoses, which includes the diagnosis codes for COVID-19 or Coronavirus, will be updated as needed and posted on the website under Provider Resources & Documents > Quick Tools.
- *UB-04* claim forms must identify a defined ICD-10 emergent diagnosis code in the *Principal DX (field 67)*.

### Reimbursement

- Emergency services do not require prior authorization or PCP referral and are provided for emergency services needed to screen and/or stabilize emergency physical/behavioral health conditions found to exist using the prudent layperson standard, regardless of the final diagnosis or whether these services are provided by a PAR or NON-PAR provider.
- If the provider bills with revenue codes 450 to 459 and the claim meets ED criteria, the PAR provider is automatically reimbursed in accordance with their Amerigroup contract. NON-PAR providers are automatically reimbursed the applicable out-of-network Texas Medicaid fee-for-service rate.
- If the claim does **not** meet defined ED criteria (auto-pay) and if the CPT® code is 99281 to 99285, PAR and NON-PAR providers are reimbursed an all-inclusive designated triage fee. The respective claim's *Explanation of Payment (EOP)* will provide an explanation code of *ER3 — Reimbursement for Non Emergent Triage*.
- If the claim does **not** meet defined ED criteria (auto-pay), but the provider submits medical records with the initial claim, then the claim and records will be reviewed by a prudent layperson standard to determine if the presenting symptoms qualify the patient's condition as emergent. If the reviewer confirms the visit was emergent, the claim will pay at the applicable contracted rate or valid out-of-network Texas Medicaid fee-for-service rate. If it is determined to be nonemergent, the claim will pay the all-inclusive designated triage fee. The respective claim's *Explanation of Payment (EOP)* will provide an explanation code of *ER3 — Reimbursement for Non Emergent Triage*.

## Claim appeal process

Amerigroup offers two different claim appeal processes:

1. The prospective review process is available for ED claims that do not have a defined emergent ICD-10 diagnosis code billed on the claim form. This process allows facilities to have their claims and medical records reviewed for medical emergency determination prior to the claim being processed. The facility may attach the complete ED medical record to the claim upon initial claim submission. The claim and records will be pended for review, in accordance with the prudent layperson standard, to determine if the services provided are a valid emergency medical condition. If the claim is determined to not meet ED criteria after medical record review, the respective *EOP* will provide an explanation code of *ERF — After MR-DX billed do not meet ER criteria*.
2. The retro-prospective review process is available for claims that have been filed and processed as not meeting ED criteria. This process allows facilities to have their claims and medical records reviewed for medical emergency determination after claims adjudication. Facilities that have filed claims that have been processed and determined to be a nonemergency may appeal the denial by using the normal appeal process. This process is outlined in the Medicaid/CHIP Provider Manual available online at <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Manuals & QRCs. Timely filing guidelines will apply, which are also set forth in the Medicaid/CHIP Provider Manual.

## Exceptions

None

## Other statutory and regulatory references

- 42 CFR §438.114; 42 CFR §438.116.42 CFR §422.113(c); Federal Requirement letter dated 04.05.2000 (“SMD Letter — Managed Care Provisions Regarding Coverage of Emergency Services by MCOs – 04.05.2000”)
- 42 CFR §489.20, 489.24 and 438.114 (b) &(c)
- 42 CFR Ch. IV (10-14-06 Edition):
  - §422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services
  - §422.214 Special rules for services furnished by non-contract providers.
  - 42 U.S.C §1395dd Emergency Medical Treatment and Active Labor Act (EMTALA)
- HHSC Uniform Managed Care Manual - Medicaid, CHIP, and Nursing Facility Member Handbooks:
- Medicaid Member Handbook Required Critical Elements — Ch. 3.4, Attachment H
- Texas Uniform Managed Care Contract Section 8.2.2.1