Amerigroup RealSolutions in healthcare

Tennessee

Practitioner and Facilities Emergency Department Policy

Effective date: November 1, 2012

Scope

This policy is applicable to Emergency Department (ED) services provided to Amerigroup Community Care members enrolled in TennCare (Medicaid), Amerigroup Amerivantage (Medicare Advantage) and TennCare CHOICES Long-Term Services & Supports.

Description

This policy identifies the method of reimbursement for ED claims beginning with dates of service for November 1, 2012.

An emergency medical condition as defined by the state of Tennessee managed care organization *Contractor Risk Agreement (CRA)* is a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

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
3. Serious dysfunction of any bodily organ or part

Definitions

None.

Overview

This document describes reimbursement methodology in accordance with ED criteria for emergent and nonemergent services effective November 1, 2012.

Criteria

ED criteria requires the billing of defined ICD-10 diagnosis codes in specific claim form fields for Amerigroup 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 under *Claims Submission and Reimbursement Policy* at https://providers.amerigroup.com.
- *UB-04* claim forms must identify a defined ICD-10 emergent diagnosis code in the Principal DX (field 67) and/or the Patient's Reason for Visit Code (field 70A).
- *CMS 1500* claim forms must identify a defined ICD-10 emergent diagnosis code in the Diagnosis or Nature of Injury (field 21), spaces one and/or two only.
- TennCare ID numbers are required for all providers practicing and facilities located in Tennessee for both emergent and nonemergent claims reimbursement consideration. A complete and accurate *Disclosure of Ownership* form is required for all providers and facilities before their nonemergent claims will be considered for reimbursement by Amerigroup.

Patients 24 months of age and under are excluded from the ED criteria regardless of the diagnosis code billed.

Reimbursement

Practitioner

The following guidelines apply when determining ED reimbursement methodology for practitioner providers:

1. If the provider bills with CPT codes 99281–99285 and the claim meets ED criteria, the Participating (Par) provider is reimbursed in accordance with their Amerigroup contract. Nonparticipating (NonPar) providers are reimbursed the equivalent reimbursement as a Par provider in accordance with TennCare *Rule 1200-13-13-08(2)* (no less than 80% of the lowest rate paid by Amerigroup to an equivalent Par provider for the same service).
2. Effective July 1, 2011, if the provider bills with CPT codes 99281–99285 and the claim does not meet defined ED criteria, Par providers are reimbursed a maximum of $50 or their contracted reimbursement, whichever is less. NonPar providers are reimbursed a maximum of $50 or the equivalent Par provider contracted amount, whichever is less in accordance with TennCare *Rule 1200-13-13-.08(2)*. The respective claim's *Explanation of Payment (EOP)* will provide an explanation code of "ERC – DX billed does not meet ER criteria."

Facility

The following guidelines apply when determining ED reimbursement methodology for facility providers:

1. Emergency services do not require prior authorization or primary care physician 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 contract or noncontract provider.
2. If the facility is contracted on levels for ED services and a nonemergent diagnosis code is in box 67 or 70A, claims will be paid at the lowest-level emergency room level contracted rate (99281) or billed charges, whichever is less.
3. If the facility is contracted with nonurgent ED rates and a nonemergent diagnosis code is in box 67 or 70A, claims will be paid the nonurgent contracted rate or billed charges, whichever is less.
4. If the facility is contracted other than on levels or with a nonurgent ED rate and a nonemergent diagnosis is in box 67 or 70A, claims will be paid at the *Emergency Medical Treatment and Labor Act* calculated rate (revenue code 0451/CPT 99281) per the contract. The revenue code 0451/CPT 99281 rates will be calculated and paid regardless of the services billed. No additional ancillary services will be paid.
5. If the facility bills only a screening charge (revenue code 0451), the claim will be paid regardless of the primary diagnosis or presenting symptom in accordance with *CRA A.2.7.1.3*. The payment for a screening is all-inclusive, and no additional ancillary services will be paid.

Claim appeal processes

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 providers and facilities to have their claims and medical records reviewed for medical emergency determination prior to the claim being processed. The provider or facility may attach the complete ED medical record to the claim upon initial claim submission. 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 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 providers and 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 either file for the screening fee or

may appeal the denial by using the appeal process. This process is outlined in the Amerigroup manual available online at https://providers.amerigroup.com. Timely filing guidelines will apply.
Exceptions
None
Other statutory and regulatory references
• *Emergency Medical Treatment and Labor Act (EMTALA)*, codified at *42 USC 1395dd* • NCQA 2012 UM 12A 1-2 • *CRA Section A.2.7.1 and A.2.14.4.1*
Related policies or procedures
Not applicable.
Related materials
Not applicable.
Attachments
None.
History/updates
Effective date of process: November 1, 2012 Date process last reviewed: March 23, 2017 Date process last revised: October 1, 2015