Emergency Department Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)

☒ MassHealth ACO

☒ NaviCare HMO SNP

☒ NaviCare SCO (Medicaid-only)

☒ Summit Eldercare PACE

☒ Fallon Health Weinberg PACE

☐ Fallon Health Weinberg Managed Long-Term Care (This policy does not apply to Fallon Health Weinberg MLTC as Emergency Department Services are not covered under this plan.)

☒ Community Care (Commercial/Exchange)

Policy

The Plan covers services for the evaluation and stabilization of an emergency medical condition provided in an emergency department (ED).

An ED is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.

The ED must be available 24 hours a day, 7 days a week, with the exception of EDs providing Type B ED visits to Medicare (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, PACE) plan members.

Definitions

Emergency Medical Condition – A medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity including severe pain, such that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part, or with respect to a pregnant women, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

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

Reimbursement

Beginning in 2023, ED visits must be coded to the appropriate, medically necessary service level as defined in CPT 2023 (99281-99285) and medical decision making (MDM) will determine ED visit code selected. History and examination are required only as medically appropriate. Medical record documentation must support the level of service reported, and medical records may be requested to ensure appropriate documentation of services rendered and accuracy of coding. Documentation must support the level of MDM.

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 ED are not eligible for facility or professional reimbursement, except with prior authorization by the plan or PCP referral.

Member Copayments

- ED copayments apply to the technical component of the ED 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 ED 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 ED visit.

Charges for ED services resulting in or following an observation stay

- The ED 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 ED professional component will be reimbursed separately.

Charges for ED services resulting in a same-day surgery

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

Charges for ED services resulting in an admission

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

Charges for late-night services

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

Fast-track/urgent care

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

Physician Charges for Infusion/Injection Services in the ED

- 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 ED. Modifiers 26 and TC cannot be used with these codes.

Charges for Interpretation of X-ray or EKG in the ED

- When 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 for a patient in the ED, the ED physician should not bill for the interpretation. The Plan will pay for the claim submitted by the radiologist or cardiologist.

Charges for Direction of Emergency Medical Systems (EMS) Emergency Care

- The Plan does not reimburse directed emergency care, advanced life support (CPT 99288).

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.

Trauma Response Team Activation for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare and PACE Plan Members

Effective October 1, 2021, Fallon Health will reimburse trauma response team activation for Fallon Medicare Plus, Fallon Medicare Plus Central, 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 ED visits.

Billing/coding guidelines

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.

For 2023, the CPT® Editorial Panel revised the ED visit code descriptions to align with changes made to the office/outpatient Evaluation and Management (E/M) codes in 2021. The CPT E/M Guidelines for Medical Decision Making (MDM) apply.

The descriptor for CPT code 99281 was revised such that the service does not require the presence of a physician or other qualified health care professional, bringing 99281 in line with 99211. Regarding CPT code 99281, it is our understanding that the purpose of the CPT code revision was to create a parallel structure between ED visits and office/outpatient visits. For 2023, CMS has maintained active payment status for CPT code 99281 and will be monitoring claims to assess billing patterns for this code under the new reporting framework (CMS-1770-F, p. 69600).

Beginning in 2023, ED visits (CPT 99282-99285) must be coded to the appropriate, medically necessary level of medical decision making (MDM) as described in Table 1: Levels of Medical Decision Making (MDM) in the Evaluation and Management (E/M) Services Guidelines section of the CPT codebook. The only official source for the MDM is the CPT codebook. A combination of subcomponents determines the level of MDM:

- The number and complexity of problem(s) addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed.
- The risk of complicationsand/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s) and treatment (s).

Level of MDM is based on 2 out of 3 of the elements being met.

The concept of MDM does not apply to code 99281 since this level of service does not require the presence of a physician or other qualified health care professional. CPT 99281 may not require the presence of a physician or other qualified health care provider, but the service must be provided under the physician's or other qualified health care professional's supervision.

For 2023, a medically appropriate history and/or examination is included but can no longer be used as a factor in determining the level of ED visit selected. The nature and extent of the history and/or examination are determined by the treating physician or other qualified healthcare professional. A descriptive history and examination will ensure that the Plan will understand the complexity of problems addressed to the extent necessary to determine level of MDM accurately.

Time is not a factor for determining the E/M Level in the ED setting because ED services are typically provided on a variable intensity basis, often involving muptiple encounters with several patients over an extended period of time.

No distinction is made between new and established patients in the ED.

Per CPT® guidelines, the ED visit codes (CPT 99281-99285) are for reporting E/M services in a dedicated emergency department. Accordingly, professional claims for ED visits must be submitted with the Emergency Room – Hospital place of service (POS) CPT (POS 23). Professional claims for CPT 99281-99285 will be denied provider liable as if submitted with any POS other than 23.

Per CPT® guidelines, critical care services (CPT 99291, 99292) provided in the ED may be reported, when, after completion of the ED service, the condition of the patient changes and critical care services are required. Critical care services provided in the ED must be submitted with POS 23. To report critical care services, the CPT Guidelines for 99291 and 99292 must be

met and the specific code criteria for reporting these services clearly documented in the patient's medical record. The documentation of time is a requirement for reporting critical care services, which means that when performed in the ED, the provider must document the type of critical care services provided, why they are considered critical, and the time spent performing only those critical care services, so the separation of the ED services and the critical care time are clearly identifiable in the medical record.

Prolonged services are not reported in conjunction with ED visits or critical care services.

An emergency medical condition is defined under 42 CFR 489.24 as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected 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 to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Therefore, the Plan would expect that a hospital would not bill for scheduled or anticipated care in the ED. The status indicator for CPT 99202-99215 on the Medicare OPPS fee schedule is "B" which means "Not paid under OPPS."

Outpatient hospitals may report urgent care using revenue code 0456 with HCPCS code G0463.

Emergency Department Visit Codes

The CPT codes listed below may be used for ED visits for all lines of business.

Code	Description
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

The HCPCS codes listed below may be used to report Type B ED visits provided to Medicare members by outpatient hospitals reimbursed under Medicare OPPS payment methology.

Code	Description
G0380	Level 1 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that

	calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0381	Level 2 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382	Level 3 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0383	Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384	Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

Place of service

This policy applies to professional and facility charges for services provided in an emergency department.

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. July 2023 – Updated to align with CPT E/M changes effective January 1, 2023: Revision of Emergency Department Services E/M codes 99281-99285 and Guidelines.

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.