



Emergency Department Payment Policy

Policy

Fallon Community Health Plan (FCHP) will pay claims for services provided in an Emergency Department setting for all services meeting prudent layperson definition as defined below.

Definition

This policy applies to the payment of professional and facility claims that are submitted with a place of service indicating an emergency department.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

The "prudent layperson standard" is used as a basis for payment. This 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, DMA, DOI and NCQA requirements.

If case review does occur, reimbursement will be based solely on the review of presenting symptoms.

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

Routine and/or scheduled follow up visits to the emergency department are not eligible for facility or professional payment, except with preauthorization by the plan.

Copayments

- Emergency department copayments apply to the technical component of the emergency department visit.
- For Fallon Senior Plan members receiving treatment at out-of-network facilities, FCHP 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*) 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 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.

Ambulance

- Arrival by ambulance does not by itself establish the medical appropriateness of the emergency department visit.
- Ambulance claims are reviewed in accordance with the FCHP policy regarding coverage of ambulance transportation.

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), FCHP will not reimburse practitioners for these services when provided in an emergency room setting. Modifiers -26 and -TC cannot be used with these codes.

Referral/notification/preauthorization requirements

Preauthorization is not required for payment. FCHP shall determine coverage based on the reimbursement criteria outlined above.

Billing/coding guidelines

FCHP requires all professional charges to be submitted on a CMS 1500 claims form and hospital charges to be submitted on a UB-04 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. FCHP will pay for the claim submitted by the radiologist or cardiologist.

Place of service

This policy applies to professional and facility services that are submitted with a place of service 23 indicating 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
	03/1/09 – Updated “Reimbursement” section to include attending emergency physician determination language; replaced deleted CPT codes 90760-90799 with 96360-96379.
Connection date & details:	05/01/09 – Updated “Reimbursement” explanation of emergency department services resulting in or following observation and resulting in admission.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. 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. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.