



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

The prudent layperson standard is used as a basis for payment. The prudent layperson standard 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.

Benefits application

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCareSM

Reimbursement

Services must be coded to the appropriate, medically necessary level of intensity. FCHP recognizes CPT's definitions of services and follows the CMS 1995/1997 documentation guidelines for evaluation and management (E&M) services. Medical records must support the reported levels of service based on the CMS 1995/1997 documentation guidelines, and records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding.

The presence of documentation that meet the specific CMS 1995/1997 documentation guidelines is not the sole determinant of whether or not a level of service will be reimbursed. The reason for the visit must medically support the extent of the history, exam and/or discussion time noted. Documentation should support the level of service reported, and the volume of documentation should not be the primary factor upon which a specific level of service is billed. It is expected that E&M levels billed will be consistent with the descriptions of level of severity of the presenting problem(s) which appear as part of CPT's descriptions of the corresponding levels of ED E&M service.

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 prior authorization by the plan or PCP referral.

Member 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/Schedule of Benefits*) 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.

Charges for late-night services

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

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

Prior authorization is not required for payment. FCHP shall determine coverage based on the Reimbursement criteria outlined above.

Billing/coding guidelines

Services must be coded to the appropriate, medically necessary level of intensity. FCHP recognizes CPT's definitions of services and follows the CMS 1995/1997 documentation guidelines for E&M services. Medical records must support the reported levels of service based on the CMS 1995/1997 documentation guidelines, and records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding.

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FCHP requires all professional charges to be submitted on a CMS1500 claims form and hospital charges to be submitted on a UB04 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, 03/01/09, 07/01/09 07/01/09 – Updated Reimbursement explanation of Emergency Department services resulting in or following observation and resulting in admission.
Connection date & details:	March 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.

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.