HIGHMARK HEALTH OPTIONS

Practitioner and Facility Emergency Department

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Application:	All participating hospitals and providers
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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

The scope of this policy is to define payment methodologies for emergent and non-emergent services performed in an emergency department and provided to Delaware Health Options members. This policy identifies the method of reimbursement for Emergency Department (ED) claims with emergent and non-emergent primary diagnosis beginning with dates of services July 1, 2016.

DEFINITIONS

Emergency Medical Condition – An illness, injury, symptom, or condition that causes a person to seek care right away.

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

POLICY POSITION

Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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, or
3. Serious dysfunction of any bodily organ or part.

A. Emergent Criteria – Emergency Department criteria requires the billing of the defined ICD-10 (or current version) emergent diagnosis codes in specific claim form fields for Health Option members who seek services in the Emergency Room.

1. Claim forms must identify a defined emergent diagnosis code and/or the Patient Reason for Visit Code. Failure to follow these guidelines may result in rejection of the claim or incorrect adjudication of your claim.

B. Reimbursement

FACILITY REIMBURSEMENT

The following guidelines apply when determining emergency and non-emergency reimbursement methodology for facility providers.

1. Emergency services do not require prior authorization or PCP referral and are provided for emergency services. If the emergency facility bills with Rev Code 0450 and the appropriate level of care and emergent diagnosis code(s) billed the claim will be reimbursed in accordance with the participating provider's Health Options contract. Non-participating providers will be reimbursed in accordance with Health Options non-participating provider policy.

POLICY UPDATE HISTORY

5/23/2022	Policy Approved in Governance