

<b>MEDICAL PAYMENT and PRIOR-AUTHORIZATION POLICY</b>	
<b>Policy Name:</b>	Practitioner and Facility Emergency Department Policy
<b>Policy #</b>	PP-101-MD-DE
<b>Approved by:</b>	Gregory Busch, CMO
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### **Disclaimer**

***Medical Payment and prior authorization policy is intended to serve only as a general reference regarding payment and coverage for services described. This policy does not constitute medical advice and is not intended to govern and/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 [EMC]** is a 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.

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## PROCEDURES

### Authorizations are not required for emergency services.

**A. Emergent Criteria** – ED 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. UB04 claim form/CMS-1450 [or its successor] must identify a defined emergent diagnosis code in the Principal DX field 67 and/or the Patient Reason for Visit Code field 70 A-C. 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 (e.g. 99281-99285 or 99291-99292) and emergent diagnosis code(s) billed in Box 67 and/or Box 70A-C, 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.

**Prospective Review Process** is available for emergency claims that do not have an emergency diagnosis code(s) in the proper field on the claim form. Practitioners and facilities may bill their initial claims with medical records to have their claims reviewed pre-payment to determine medical emergency prior to the claim being processed. The practitioner or facility may attach the complete emergency medical record to the claim and 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 emergency medical criteria after medial review, the respective explanation of payment will provide an appropriate denial.

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