INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Emergency Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 25, 2016	Semiannual review: • Moved the definition of emergency services to the *Introduction* section • Added a heading for *Emergency Service Coverage and Billing* and made the following updates: • Added a note box with information for managed care providers • Added information about Package E members, members with restricted utilization, and copayments • Added a statement about reporting emergency inpatient admissions to the prior authorization vendor • Added a *Cardiopulmonary Resuscitation* section • Broadened the focus of the *Post-Stabilization Care Services* section beyond managed care • Moved the *Emergency Department* section to the end of the module, and made the following updates: • Added subheadings for *Emergency Department Screenings* and *Nonemergency Services Provided in an Emergency Department* • Added copayment requirements and exemptions for nonemergency services in an emergency room setting	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.2	Policies and procedures as of April 1, 2016 Published: September 8, 2016	Removed the *Cardiopulmonary Resuscitation* section	FSSA and HPE
1.3	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	• Added references to Provider Healthcare Portal billing • Removed *Care Select* information • Updated explanation of benefits (EOB) code 4180 description	FSSA and HPE

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Note:	*For policy information regarding coverage of emergency services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

In accordance with *Indiana Code IC 12-15-12-0.5,* emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services
- Needed to evaluate or stabilize an emergency medical condition

Per *42 U.S.C. § 1395dd(e)(1),* an emergency medical condition 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 the following:

- 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
- Serious dysfunction of any bodily organ or part

Emergency Service Coverage and Billing

The Indiana Health Coverage Programs (IHCP) provides coverage for emergency services, and guidelines for these services are subject to the member's program enrollment.

Note:	*For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

Emergency services as defined in this document do not require prior authorization (PA). However, any inpatient stay resulting from an emergency admission does require PA, with the exception of stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). To receive IHCP reimbursement, emergency inpatient admissions must be reported to the PA contractor within 48 hours of admission, not including Saturdays, Sundays, or legal holidays.

Emergency services are excluded from copayment requirements. Members on restricted utilization through the Right Choices Program may receive treatment without a referral from the authorized provider if the diagnosis is an emergency diagnosis. Members enrolled in HIP, Hoosier Care Connect, or Hoosier Healthwise can seek emergency care from providers not contracted with the MCE without authorization, subject to the *prudent layperson standard* for emergency medical conditions.

Package E (Emergency Services Only) members receive *only* emergency services, and the services are reimbursed as fee-for-service. Package E services must meet emergency criteria noted in the *Introduction* section. In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions. Providers must indicate in the appropriate field on submitted claims that a provided service was an emergency for Package E members.

See the *Claim Submission and Processing* module for Package E billing instructions, as well as general claim submission and processing instructions.

Providers should bill using the appropriate type of claim for their provider type. For example, facilities should bill using the institutional claim type (*UB-04* claim form, Provider Healthcare Portal institutional claim, or 837I electronic transaction), and physicians should bill using the professional claim type (*CMS-1500* claim form, Provider Healthcare Portal professional claim, or 837P electronic transaction).

For information about emergency services related to specific specialties, see the appropriate module: *Inpatient Hospital Services*, *Dental Services*, *Pharmacy Services*, *Hospice Services*, or *Transportation Services*.

Post-Stabilization Care Services

Post-stabilization care services are covered services related to an emergency medical condition that are provided after a member is stabilized, to maintain the stabilized condition or to improve or resolve the member's condition.

For managed care members, the member's MCE is financially responsible for post-stabilization care services for members under the following conditions:

- The services are preapproved by a representative of the member's MCE.
- The services are not preapproved but are administered to maintain the member's stabilized condition within one hour of a request for preapproval of further post-stabilization care services.
- The services are not preapproved, but administered to maintain, improve, or resolve the member's stabilized condition if any of the following occur:
  - The MCE representative does not respond to a request for preapproval within one hour.
  - The MCE representative cannot be contacted.
  - The MCE representative and the treating physician cannot reach an agreement concerning the member's care, and a physician representing the MCE is not available for consultation.

If the MCE representative and the treating physician cannot reach agreement, the MCE allows the member's treating physician an opportunity to consult with a physician representing the MCE. The treating physician may continue with care of the member until a physician representing the MCE is reached or until one of the following criteria is met:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the member's care through transfer.
- The MCE and treating physician reach an agreement concerning the member's care.
- The member is discharged.

Emergency Department Coverage and Billing

The IHCP provides reimbursement to emergency department physicians who render emergency services to IHCP-eligible members, as described in this document and in *IC 12-15-15-2.5*.

Claims for related services (such as facility charge, lab, and x-ray) provided in an emergency room setting must include an emergency indicator and a diagnosis code that supports the emergency nature of the service; otherwise, the IHCP may suspend the claim for review to determine whether the prudent layperson standard has been met. If the IHCP review determines that the prudent layperson standard has not been met, the IHCP will deny the claim.

Emergency Department Screenings

The IHCP covers services for a member presenting to an emergency department with an emergency medical condition, as determined by the screening physician. When the screening does not meet the definition of an emergency visit, using the layperson review criteria, the provider should bill only for the screening service.

Current Procedural Terminology (CPT®[1]) codes 99281–99285 reflect the appropriate level of emergency department screening exam that providers must bill on a professional claim (*CMS-1500* claim form, Provider Healthcare Portal professional claim, or 837P transaction). For definitions of these codes, see the *Emergency Services Codes* on the *Code Sets* page at indianamedicaid.com.

Nonemergency Services Provided in an Emergency Department

The IHCP does not reimburse hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. Revenue code 451 – *EMTALA – Emergency Medical Screening Service* is reimbursed for the nonemergent screening. All ancillary charges submitted with revenue code 451 will be denied, with the explanation of benefits (EOB) code 4180 – *When revenue code 451 is billed on an outpatient or outpatient crossover claim, all other services billed are not payable.*

Hoosier Healthwise Package A and Hoosier Care Connect enrollees are required to pay a copayment for nonemergency services provided in the emergency department, with exemptions for the following services and categories of members:

- Family planning services
- Inpatients in hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disability (ICFs/IID), or other medical institutions
- Children 18 years old and younger
- Pregnant women
- Women enrolled in the Breast and Cervical Cancer Program (BCCP)
- Native Americans or Alaska Natives

Per federal regulations, IHCP providers may not deny services to any member due to the member's inability to pay the copayment on the date of service. This federal requirement does not apply to a member who is able to pay, nor does a member's inability to pay eliminate his or her liability for the copayment. It is the member's responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not made on the date of service.

[1]