MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Subject: Policy and Reimbursement Changes for Emergency Room Professional Services

Effective: January 1, 2003

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

The purpose of this bulletin is to clarify policy for emergency services, change billing requirements for professional services rendered in the emergency department (ED) of a hospital, and to notify physicians of a change in the reimbursement methodology (emergency room case rate) for those services. Changes in billing and reimbursement apply to all services provided on or after January 1, 2003.

Clarification on Coverage and Definition of "Emergency Services"

The Medicaid program covers all medically necessary emergency services. "Emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. All services billed to the program must be identified as an emergency or not an emergency.

For the fee-for-service population, the Department defines an emergency medical condition using the federal EMTALA (Emergency Medical Treatment and Labor Act) language: "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in 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, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health and safety of the woman or unborn child.

For health plan enrollees, the provisions of The Balanced Budget Act (BBA) of 1997 apply to coverage of emergency services. The statute required Medicaid contracts with managed care organizations (health plans) to include coverage of emergency services without regard to prior authorization or the emergency provider's contractual relationship with the health plan. It created an obligation to pay for emergency services obtained by Medicaid enrollees and introduced the "prudent layperson standard." The BBA defined emergency medical condition as 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 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 body functions or serious dysfunction of any bodily organ or part. This requires health plans to base coverage decisions for emergency services on the severity of the symptoms at the time of presentation (not based on the final diagnosis) and cover examinations where the presenting symptoms were of sufficient severity to constitute an emergency medical condition in the judgment of the prudent layperson.

The Department is clarifying policy for both the fee-for-service Medicaid population and health plans to be consistent with EMTALA and the federal Medicaid law for health plan coverage of emergency services. EMTALA requires that a medical screening exam be provided to every patient presenting to the ED of a hospital asking for treatment for a medical condition. If it is determined that the patient has an emergency medical condition, then further medical examination and treatment to stabilize the condition must be provided without delay. The attending physician determines if a patient presenting to the ED has an emergency medical condition based on the results of the medical screening exam provided to the patient. The EMTALA does not include any mandate for payment of services; however, the Department has chosen to reimburse physicians for services necessary to provide the medical screening examination and determine if an emergency medical condition exists.

Physician Emergency Room Case Rate Revisions

The Physician Emergency Room Case Rate implemented on January 1, 2001 is being modified based on the twelve-month evaluation of the policy. Effective for all services rendered in the ED on or after January 1, 2003, the billing instructions are being revised to be HIPAA compliant, the "treat and release" or "admit/transfer" designations for level of payment are eliminated, and the professional services provided in the ED will be billed and reimbursed as individual services rather than as an all-inclusive bundled case rate. Critical care services (99291 and 99292) will be covered according to the HCPCS definitions and coding conventions for critical care. If critical care is required for a patient in the ED, then only the critical care codes 99291 and 99292 may be reported. ED evaluation and management (E&M) or visit codes will not be paid on the same day as critical care. Modifier 22 should no longer be reported to identify that the patient was admitted to the inpatient hospital.

On and after January 1, 2003, each time a patient is seen in the ED, the physician must bill the appropriate level of ED E&M service, procedure code range 99281 through 99285, unless another E&M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E&M service which includes the medical screening exam (99281 - 99285) will be reimbursed without regard to whether the patient was released or admitted, or whether the medical screening resulted in the service being deemed an emergency or not. The

result of the medical screening examination, along with any medically necessary appropriate diagnostic services, will determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient can be provided and billed in addition to the ED E&M service. HCPCS accepted coding conventions and program guidelines must be followed.

If the beneficiary is enrolled in a health plan and the physician determines that an emergency medical condition does not exist, the plan or member's primary care physician must be contacted for authorization for any further treatment. If the plan does not respond to the request within one hour, then treatment may be provided and the health plan is obligated to pay for necessary treatment services beyond the ED E&M service. For fee-for-service Medicaid beneficiaries, any medically necessary and appropriate professional services provided beyond the ED E&M service should be billed individually within HCPCS coding and program guidelines.

Diagnostic tests required to assist the physician in determining whether an emergency medical condition exists are covered as long as they are medically appropriate. The medical record must support the need for the type and extent of diagnostic services performed based on the presenting symptoms of the patient. The ED physician's review of x-rays and EKGs performed on the patient are normally part of the E&M service. A professional component billing based on a review of the findings of these procedures may be billed only by the provider who prepares a complete, written report of the findings for the medical record. If this is prepared by a specialist in the field, then the ED physician's review of the findings does not meet the conditions for separate payment of the service.

The ED E&M fee will be a two-tiered rate. The first four levels of the ED E&M service, procedure codes 99281 through 99284, will be reimbursed at a single rate. The highest level of service, procedure code 99285, will be reimbursed at a higher rate. Physicians must continue to bill the level of service as defined by the individual code description and the E&M coding guidelines. As the ED fees no longer include payment for other services provided on the same day, additional services can be billed separately and will be considered for reimbursement. Effective January 1, 2003, the fee screen for 99281 through 99284 will be $50 and the fee screen for 99285 will be $120. These rates represent a realignment with the Medicare maximum allowable amounts. Annually, when all physician rates are rebased using the most current RVUs (relative value units), historic utilization, and funds appropriated by the Legislature, the emergency department E&M fee screens will be adjusted accordingly.

The Department cannot reimburse more than the Medicare allowable amount for these services. When the beneficiary is covered by Medicare and Medicaid, our maximum allowed fee for the service will be compared to the Medicare payment and the lesser of the difference between the Medicare payment and Medicare allowable or our fee screen will be paid. If Medicare pays more than our fee screen for the service, no payment will be made. When other payers/insurers are involved, the Medicaid amount paid generally will be the difference between the other insurance payment and the other insurance allowed amount (i.e., the insured's liability) as long as the total payment to the provider does not exceed our fee screen. All third party liability policies apply. Refer to Section 5 of Chapter IV, Billing and Reimbursement, in the provider manual to determine how other insurance may affect the Medicaid payment.

Counties that administer their own State Medical (indigent care) Program may have different reimbursement policies for physician emergency department services. Physicians rendering care to these State Medical Program beneficiaries must contact the entity administering the county program for information on their reimbursement policies and rates.

The DCH will continue to evaluate the Physician Emergency Room Case Rate policy to determine the need for additional modifications.

Physician Emergency Room Case Rate Payment Policy

Claims for screening and stabilization related services provided by ED physicians under this policy will be processed for the appropriate case rate amount based on the information provided on the claim. All claims will be subject to the normal post-payment audit and review processes of the DCH or health plans. If these reviews reveal a shift in historic billing patterns by a physician or group(s) of physicians that results in a significant increase in the number of services provided at the highest E&M level (99285), the DCH or health plans may institute selective review of that physician(s)' claims on a pre-payment basis.

Manual Maintenance

Retain this bulletin for future reference. Bulletin MSA 00-12, Physician Emergency Room Case Rate, is obsolete and may be discarded.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

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