Bulletin

Michigan Department of Community Health

Distribution: Hospitals 00-12
Practitioner 00-08
Qualified Health Plans 00-10

Issued: December 1, 2000

Subject: Physician Emergency Room Case Rate

Effective: January 1, 2001

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

This bulletin provides information and claims submission instructions related to the Physician Emergency Room Case Rate that has been developed in accordance with Section 1690 of PA 114 of 1999 and Section 1690(4) of PA 296 of 2000.

As required by PA 114, a workgroup was convened to recommend reasonable Medicaid reimbursement rates for hospital emergency room services. It was the workgroup's recommendation that an all-inclusive, two-tiered case rate be developed for physician emergency room services, with the level of reimbursement based on whether a patient is treated and released or treated and admitted/transferred.

The emergency room case rates will be effective for services rendered on or after January 1, 2001, for all Medicaid, Children's Special Health Care Services, and State Medical Program beneficiaries whether enrolled in a health plan (qualified health plan or special health plan) or fee for service plan. The case rate fee for a patient that is treated and released will be $68.49. The case rate for a patient that is treated and admitted/transferred will be $166.78. The only exception to these rates will be when a health plan has negotiated a contract with providers that specifies different reimbursement rates and procedures for services provided by physicians in a hospital emergency room. This policy is not applicable to Wayne County's Plus-Care program or to the indigent care programs in Ingham and Muskegon counties.

The instructions noted below apply to claims submitted to health plans and to the Medical Services Administration (MSA). As agreed by the workgroup, this policy will be evaluated within twelve months to assess implementation and identify areas for modification.

CLAIMS SUBMISSION

To receive the emergency room case rate, the attending physician must provide the emergency services in the emergency department of a licensed acute care hospital which is designated as the location where ambulances are directed to deliver patients. The physician must bill one of the following HCPCS emergency department services or critical care services evaluation and management (E&M) procedure codes:

- 99281
- 99282
- 99283
- 99284
- 99285
- 99291

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital must be billed by the attending physician utilizing the appropriate office or other outpatient services E&M procedure codes (99201-99215) along with the appropriate HCPCS codes for any additional professional services rendered.

If the patient is treated and released, the ER physician must bill the proper E&M code, and other appropriate HCPCS codes for additional professional services provided, with a place of service "hospital emergency room." The charge for each service must be aligned with the appropriate procedure code. A single, all-inclusive payment will be made at the lower tier level. The payment will appear with the E&M code—all other procedure codes will indicate a zero payment.

To receive the higher-level reimbursement for a patient that is treated and admitted/transferred, the physician must bill the proper E&M code, and other appropriate HCPCS procedure codes for ancillary services provided, with a place of service (hospital emergency room). In addition, modifier 22 (unusual procedural services) must be entered with the E&M code. Note: If the emergency room attending physician is also the admitting physician, then these instructions do not apply. All services must be reported under the appropriate inpatient hospital initial day E&M code.

Observation is not a covered service for Fee For Service Medicaid, CSHCS, or SMP beneficiaries.

Radiology and pathology procedures are excluded from the case rate.

Additional professional services provided by other physicians on the same date as an emergency room encounter are to be paid without judgment applied as to whether the attending emergency room physician could or should have performed the service. The emergency room case rate methodology explicitly excluded any amounts related to services performed by other physicians.

REPORTING OTHER INSURANCE AND MEDICARE PAYMENTS

Claims for beneficiaries with other insurance and/or Medicare must be submitted to the other carrier(s) prior to submission to the health plan or MSA. All charges and insurance/Medicare payments for services rendered in the emergency room must be reported with the appropriate procedure code. The emergency room case rate will be reduced by the amount paid by the other carriers.

PAYMENT POLICY

Claims for the emergency room case rate submitted for eligible beneficiaries with a date of service on or after January 1, 2001 will be processed for the appropriate rate based on the information provided on the claim.

All claims will be subject to the normal post-payment audit and review processes of the MSA or health plans.

MANUAL MAINTENANCE

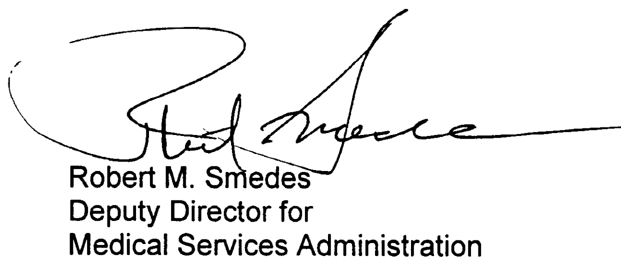
Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979. Providers may phone toll free 1-800-292-2550.

APPROVED

James K. Haveman, Jr.
Director



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