CareSource | NETWORK Notification

Notice Date:	**November 10, 2020**
To:	**Indiana Medicaid Providers**
From:	**CareSource**
Subject:	**Emergency Room Reimbursement Requests**

Summary
CareSource would like to remind emergency department (ED) providers of coverage for emergency services. In alignment with Indiana Health Coverage Program (IHCP) reimbursement policy, hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. Billing guidelines for the institutional claim (UB-04 claim form or electronic equivalent) depend on the result of the screening, as follows:

- **If the screening result does not meet the definition of an emergency visit, using the prudent layperson review criteria, the hospital should bill only for the screening service, using revenue code 451 – Emergency Medical Treatment and Labor Act [EMTALA] Emergency Medical Screening Services. No emergency room treatment services are reimbursed if billed in conjunction with revenue code 451.**
- **If the screening determines that the member does have an emergency condition, the hospital should not bill revenue code 451 for the screening. Instead, the hospital should bill for the medically necessary emergency services provided, using the appropriate revenue code (such as 450 – Emergency Room – General) along with applicable procedure codes.**

Physicians bill for their services on a professional claim (CMS-1500 claim form or electronic equivalent) and must use Current Procedural Terminology (CPT®1) codes 99281–99285 to reflect the appropriate level of emergency department screening exam performed.

CareSource follows IHCP guidance and 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. If the screening does not indicate an emergency medical condition, the hospital is reimbursed only for the screening itself, billed with revenue code 451. All ancillary charges submitted with revenue code 451 will be denied. When revenue code 451 is billed on an outpatient or outpatient crossover claim, all other services billed are not payable.

Physicians who provide services in an emergency department setting to patients whose screenings do not indicate an emergency medical condition should bill these nonemergency services using the applicable office visit procedure code instead of the emergency room screening procedure code. The claim should be billed with the applicable place-of-service code for the emergency department setting. CareSource will apply a site-of-service reduction in the reimbursement, if applicable, as described in the IHCP Medical Practitioner Reimbursement module.

CareSource has implemented a list of diagnosis codes established by IHCP to determine if a service meets an emergent level of care. CareSource will check the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list. If an emergent

diagnosis code is not used, the claim will be pended for a prudent layperson to review the claim and make a determination on the appropriate type of visit.

If the prudent layperson review determines the service was not an emergency, CareSource will reimburse for the medical screening examination and facility fee only, and any applicable copays will be applied. Providers can submit medical records or other supporting documentation within 120 days following the date of payment of the screening fees for re-consideration by the prudent layperson. This documentation should be submitted through the CareSource Provider Portal.

Copayment

All HIP members will incur an $8 copayment for all non-emergent ED visits. The copayment is waived if the member called the CareSource24 nurse hotline prior to the ED visit.

HIP members who are exempt from cost-sharing (for example, members who are pregnant or members identified as American Indians/Alaska Natives (AIs/ANs), pursuant to 42 CFR 136.12), and will not be required to pay copayments for nonurgent use of hospital ED services.

The member must receive an appropriate medical screening examination under Section 1867 of the Emergency Medical Treatment and Active Labor Act. Any applicable copayments must be waived or returned if the member is found to have an emergency condition, as defined in Section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act, or if the person is admitted to the hospital within 24 hours of his or her original visit.

If a copayment is collected at the time of service, the payment will need to be refunded back to the member and reimbursement for the visit will not be reduced by the amount of the copayment.

Notification

If a CareSource member presents to the emergency department for services, the provider may notify CareSource to allow for care management services, preparation for admission, or discharge planning. Calls to CareSource with the notification should be made to Provider Services at 844-307-2831. If the call occurs after hours, CareSource will return the call within 24 hours. If an inpatient admission is expected, a prior authorization may be needed. Additional information along with instructions to submit a request can found at CareSource.com.