IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY
You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on UB-04 forms and, when specified, to those billed on 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees. Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee’s benefit coverage documents, and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations. UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication. CPT® is a registered trademark of the American Medical Association.
3. Serious dysfunction of any bodily organ or part.

**Reimbursement Guidelines**

In order to appropriately reimburse for services provided in the Emergency Room the following guidelines should be followed:

1. Emergency services should bill with revenue code 450 consistent with terms of the contract.
   a. If the provider bills RC 450 with CPT codes 99281-99285, 99291, G0380-G0384 and it **meets ER criteria** they will be reimbursed with the Emergency Room Level payment rate that is loaded to the room type profile.
      - Level 1: CPT/HCPC Codes: 99281,G0380
      - Level 2: CPT/HCPC Codes: 99282,G0381
      - Level 3: CPT/HCPC Codes: 99283,G0382
      - Level 4: CPT/HCPC codes: 99284,G0383
      - Level 5: CPT/HCPC Codes: 99285,G0384
      - Critical Care: CPT Codes: 99291
   b. If the provider bills RC 450 with no CPT code or CPT codes OTHER THAN 99281-99285, 99291, G0380-G0384 and it meets ER criteria, the reimbursement should default to the Emergency Room Level 1 payment rate.
   c. If the provider bills RC 450 and it does NOT meet ER criteria no matter what CPT/HCPC may or may not be submitted, UnitedHealthcare Community Plan shall pay the Emergency Medical Treatment and Labor Act (EMTALA) rate in accordance with the provider's agreement. In instances where the provider's agreement does not contain an EMTALA rate or otherwise provide a rate for service(s) that do not meet ER criteria, UnitedHealthcare Community Plan shall pay the provider no less than the lowest contracted EMTALA rate for the Grand Region where the provider is located.

2. If the provider bills the EMTALA revenue code 451
   a. If RC 451 is billed with no RC 452 or 459 on the claim, pay the EMTALA rate determined by the contract. In instances where the provider agreement does not contain an EMTALA rate or otherwise provide a rate for service(s) that do not meet ER criteria, UnitedHealthcare Community Plan shall pay the provider no less than the lowest contracted EMTALA rate for the Grand Region where the provider is located.
   b. If RC 451 is billed along with RC 452 or 459 and it meets ER criteria pay the appropriate ER Level Case rate.
   c. If RC 451 is billed along with RC 452 or 459 and it does NOT meet ER criteria, pay the EMTALA case rate determined by the contract. In instances where the provider agreement does not contain an EMTALA rate or otherwise provide a rate for service(s) that do not meet ER criteria, UnitedHealthcare Community Plan shall pay the provider no less than the lowest contracted EMTALA rate for the Grand Region where the provider is located.

**Provider Appeals Process**

In cases where an Emergency Room Claim is filed with Form Locators 67 and 70 with diagnosis codes that are not on the Emergency Criteria Diagnosis codes list, UnitedHealthcare Community Plan has implemented a prospective review process. This process will allow facilities to have their claims and medical records reviewed for medical emergency determination prior to claim being processed. Hospitals may attach the complete emergency room medical record to the claim upon initial submission. The claim and record will be pended for clinical review to determine if the services provided are a valid Emergency Medical Condition. Additionally, hospitals that have filed claims which have been processed and determined not to meet the Emergency Criteria, can appeal the denial by using the appeal process outlined in the UnitedHealthcare Community Plan Provider Administration Manual available on the company Web site.

**ER Criteria**

ER Criteria is identified by (ICD-10-CM) codes. These codes have been developed by the TennCare
REIMBURSEMENT POLICY
UB-04
Policy Number 2020F7004A-TN-1

contracted Managed Health Care Plans. Services will be considered an Emergency Medical Condition when:

1) ICD-10-CM codes will be used for medical emergency determination. When any presenting or final diagnosis is considered emergency, the ER charge and the ancillaries will be paid. However, a separate payment will not be made for the screening charge, if filed.

2) When the patient is less than 24 months of age regardless of the admitting or principle diagnosis code.

### Definitions

| Medical Screening | For purposes of this policy, a "medical screening examination" shall mean the examination conducted by the provider to determine whether an emergency medical condition exists. A claim that does not meet ER criteria shall be considered a medical screening examination for payment purposes. |

### Attachments

| UnitedHealthcare Community Plan Tennessee ER Policy Emergency ICD-10 Diagnosis List | List of accepted emergency ICD-10 diagnosis codes. |

### Resources

- Individual state Medicaid regulations, manuals & fee schedules
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- National Uniform Billing Committee (NUBC)

### History

| 4/7/2020 | Reimbursement Guidelines section: Changed verbiage from “ICD-10-CM codes filed in Form Locators 67 (primary – discharge diagnosis) or 70 (patient reason/presenting symptom) will be used for medical emergency determination. When either presenting or final diagnosis is considered emergency, the ER charge and the ancillaries will be paid” to "ICD-10-CM codes will be used for medical emergency determination. When any presenting or final diagnosis is considered emergency, the ER charge and the ancillaries will be paid. However, a separate payment will not be made for the screening charge, if filed.”
| 1/1/2019 | Annual Policy Version Change |

Attachments section: Updated excel file and verbiage
Footer section: Updated policy version from 2019F7004C to 2020F7004A
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