CHAPTER 1
SECTION 7.1

EMERGENCY DEPARTMENT (ED) SERVICES

Issue Date: March 3, 1992
Authority: 32 CFR 199.2(b), 32 CFR 199.4(b)(6) and (b)(7)

I. PROCEDURE CODE RANGE

99281 - 99285, 99288 (see EXCLUSIONS regarding 99288)

II. BACKGROUND

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed by President Clinton on March 26, 1997, to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." As part of its work, the President asked the Commission to draft a "consumer bill of rights."

In its report, the Commission stated that, "Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity--including severe pain--such that a 'prudent layperson' could reasonably expect the absence of medical attention to result in placing the consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Emphasis is placed on the patient's presenting symptoms rather than the final diagnosis.

In conjunction with the "prudent layperson" standard, TRICARE must also enforce the current provision that "appropriate medical care" required to provide "medically or psychologically necessary" services is to be furnished economically. That is, services are to be furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE. For care sought in an Emergency Department (ED), which was clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, an emergency, the ED is the inappropriate "medical environment" to seek the care. A physician's office, for example, would be a more adequate medical environment for non-emergency care. Non-emergent visits to the ED can be costly, contribute to overcrowded waiting rooms, divert resources away from other hospital-based care, and compromise the coordination and continuity of care.

This policy encompasses the Commission's recommendations and the TRICARE provision that benefits be extended for care that is "medically and psychologically

necessary" and "appropriate medical care".

III. DESCRIPTION

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

IV. POLICY

ED care to include professional and institutional changes is covered:

A. For medical, maternity or psychiatric emergencies that would lead a "prudent layperson," (someone with average knowledge of health and medicine), to believe that a serious medical condition existed or the absence of medical attention would result in a threat to his/her life, limb, or sight and requires immediate medical treatment or which manifest painful symptomatology requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary presents with severe pain.

B. For service and supplies, not otherwise excluded, that are ordered or administered in the ED to manage the care (e.g., tetanus toxoid injections, etc.).

V. POLICY CONSIDERATIONS

A. Medical emergency is the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition listed that is threatening to life, limb, or sight, and requires immediate medical treatment or manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering.

B. Maternity emergency is a sudden unexpected medical complication which puts the mother, or fetus, at risk.

C. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of mental disorder and requires immediate continuous skilled observation at the acute level of care.

D. Since claims are submitted with only the discharge diagnosis (not presenting symptoms), any ED claim about to be denied shall be suspended and developed prior to actual denial. Development shall determine whether the presenting symptoms meet the prudent layperson standard defined in policy above.

E. Pre-authorization is not required for ED services meeting the above "Policy".

F. An adverse determination of ED care claims is an appealable issue.

G. Admissions resulting from a psychiatric emergency should be reported to the TRICARE contractor within 24 hours of admission or the next business day after admission but must be reported within 72 hours of the admission. In the case of an emergency

admission, authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. If it is determined that the case was not an emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request or the date of admission, whichever occurs first. (Reference the Operations Manual)

H. Cost-sharing of emergency inpatient hospital services for non-enrolled MHS eligible beneficiaries will terminate 24 hours after written notice to the beneficiary that the nearest Uniformed Services Medical Treatment Facility (USMTF) capable of providing the required level-of-care has accepted the beneficiary for continued care. Neither the MCS contractor nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

I. Cost-sharing for TRICARE Prime beneficiaries shall follow the point-of-service cost-sharing provision 24-hours following receipt of written notice, by the contractor or MTF Commander, to the beneficiary (or responsible party) that transfer to a network facility is required to obtain maximum reimbursement. Neither the MCS contractor nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

J. ED services as defined in "POLICY" above are cost-shared as follows:

1. Outpatient care when the beneficiary is discharged home, regardless of any subsequent hospital admission related to the reason for the ED visit.

2. As inpatient care when:

a. An immediate inpatient admission for acute care follows the outpatient ED services.

(1) "Immediate" includes the time lapse associated with the beneficiary's direct transfer to an acute care facility more capable of providing the required level-of-care. ED care includes otherwise payable services of both the transferring and receiving facilities.

(2) This will be done even when the ED care is billed separately, as is required for all hospital services provided on an outpatient basis when the related inpatient stay is subject to the TRICARE DRG-based payment system. In determining if the ED care was immediately followed by an inpatient admission, the TRICARE contractor is required only to examine the claim for ED care for evidence of a subsequent admission and to examine its in-house claims records (history).

b. An ED patient dies while awaiting formal hospital admission for continued medically necessary acute care.

NOTE: *See the "LIMITATIONS" section of this Policy Manual issuance for PRIME, Extra, and Standard-specific cost-sharing provisions for non-emergency care sought in an ED.*

VI. LIMITATIONS

A. TRICARE PRIME BENEFICIARIES.

1. Prime enrollees must obtain all non-emergency primary health care from the Primary Care Manager (PCM) or from another provider to which the enrollee is referred by the PCM or an authorized Health Care Finder (HCF). Therefore, if a TRICARE PRIME beneficiary seeks treatment in an ED and there was not a referral by his/her Primary Care Manager, and it is clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in "POLICY" above, then payment shall be in accordance with the Point-of-Service option.

2. Claims shall not be denied or paid at the point-of-service option because a condition, which appeared to be a serious medical condition when presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

B. NON-ENROLLED TRICARE BENEFICIARIES (STANDARD AND EXTRA).

1. While TRICARE Extra/Standard beneficiaries have the freedom to choose a provider of care, all TRICARE benefits must be "medically necessary" and "appropriate medical care". (See the "BACKGROUND" section of this policy). If an Extra/Standard beneficiary seeks treatment in an ED and it was clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in "POLICY" above, then the facility charge shall be denied (i.e., the ED fee billed on the UB-92) and the professional services shall be allowed. Other professional ancillary services, including professional components of laboratory and radiology services, if appropriate can be also covered on an allowable charge basis. If an Extra or Standard beneficiary is referred to the ED by a HCF, (e.g., for after hours care), the care is to be allowed.

2. Claims shall not be denied because a condition, which appeared to be a serious medical condition upon presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis. (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

VII. EXCLUSIONS

A. In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy, are not emergency conditions for adjudication purposes.

B. For procedure code 99288 no separate payment will be made as payment for this service is included in the payment for other services.

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