Emergency Department Services Professional Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who render professional services in an emergency department.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers emergency department (ED) services based on the member’s “prudent layperson” judgment to seek emergency treatment, as described below. Surgical or inpatient services that are rendered as a result of an emergency may be compensated at the surgical or inpatient rate when performed as part of the same event.

DEFINITION
An emergency is defined as an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in one of the following:

- Serious jeopardy to physical and/or behavioral health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part, or in the case of pregnancy, a threat to the safety of the member and her unborn child.

GENERAL BENEFIT INFORMATION
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

AUTHORIZATION REQUIREMENTS
Emergency services do not require a prior authorization or referral. However, if a member’s condition results in an inpatient admission, an inpatient notification is required prior to services being rendered. Refer to the Authorization Policy for more information.

BILLING INSTRUCTIONS
ED physicians who perform pre-operative and surgical services only should append modifier 54 to the surgical procedure code(s) to indicate that a different physician will perform the post-operative services.

Follow-Up Care
Tufts Health Plan encourages members to be seen by their PCP or specialist following an ED visit. In instances when a member's PCP and/or an appropriate specialist is unable to render the necessary follow-up care in a timely fashion, or appropriate continuity of care dictates it, it is appropriate for the ED physician to perform post-operative care.

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Providers should submit the same surgical procedure code billed by the ED physician with a modifier 55 appended to indicate only post-operative services were rendered or by submitting the appropriate evaluation and management (E&M) code.

**Consultative Services**
Physicians called into the ED to perform consultative or operative services should submit the appropriate CPT, HCPCS or ICD-CM code to indicate the services performed. Consultative procedure codes are within CPT procedure code range 99241-99245.

**COMPENSATION/REIMBURSEMENT INFORMATION**
Tufts Health Plan compensates for one E&M procedure code per member per date of service when billed by the same provider specialty.

**Cardiopulmonary Resuscitation**
Tufts Health Plan does not routinely compensate for ED E&M services when billed with cardiopulmonary resuscitation (CPR) services, as the ED E&M service is considered a component part of the CPR. Tufts Health Plan may consider compensation for the ED E&M service if the appropriate modifier is appended to the procedure code.

**Critical Care Services**
When a provider bills both a critical care service (99291-99292) and an ED visit (99281-99285), only the critical care service will be compensated. Tufts Health Plan may consider compensation for the ED service if the appropriate modifier is appended to the procedure code.

**Inpatient Admission or Consultation**
Tufts Health Plan does not routinely compensate for ED services when billed with initial hospital care.

**Intravenous Infusion Services**
Tufts Health Plan does not routinely compensate for ED E&M services when billed with intravenous infusion services, as the ED E&M service is considered a component part of the intravenous infusion. Tufts Health Plan may consider compensation for the ED E&M service if the appropriate modifier is appended to the procedure code.

**DOCUMENT HISTORY**
- June 2018: Template updates
- March 2017: Policy reviewed
- January 2017: Template updates
- September 2015: Template conversion
- July 2015: Added inpatient admission or consultation policy effective for dates of service on or after October 1, 2015
- June 2015: Template updates
- April 2015: Added information regarding Tufts Medicare Preferred HMO and Tufts Health Plan SCO, template updates
- November 2013: Template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, no content changes
- March 2011: Policy reviewed, no content changes
- August 2008: Added that Tufts Health Plan may consider reimbursement for an ER service when billed with a critical care service if the appropriate modifier is appended to the procedure code
- June 2008: Revised content regarding intravenous infusion services in the ER, removed January 1, 2008 effective date and CPT procedure codes
- May 2008: Clarified that CPT procedure code, 92950, is for CPR services
- February 2008: Revised general benefit information with self-service channels information
- November 2007: Added intravenous infusion services in the Emergency Department information

**AUDIT AND DISCLAIMER INFORMATION**
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to
refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.