	Reimbursement Policy

Subject: Emergency Services: Nonparticipating Providers and Facilities

Effective Date: **07/29/13**	Committee Approval Obtained: **05/01/17**	Section: **Administration**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/nv**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem). The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Anthem allows reimbursement for emergency services provided by nonparticipating providers and facilities unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Unless otherwise required by federal and/or state regulation or contract, reimbursement is based on the following:
	• **For Medicaid product lines only:**
	  ○ **Professional Reimbursement** — The amount that would have been reimbursed to the provider according to Nevada's State Fee-for-Service (FFS) Medicaid program
	  ○ **Facility Reimbursement** — For nonhospitals, reimbursement is the amount that would have been reimbursed to the provider

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according to Nevada's State Fee-for-Service (FFS) Medicaid program; for hospitals, reimbursement is the amount that would have been reimbursed to the provider according to the Host State's Fee-for-Service (FFS) Medicaid program
NOTE: California hospital facilities are reimbursed in accordance with Host State Medicaid rates. Other out-of-state hospitals will be reimbursed in accordance with Host State Medicaid rates if documentation is submitted with the claim verifying the Host State's payment rate to that hospital; documentation must be produced and generated by the Host State's Medicaid program.

- **For all other product lines:** The applicable out-of-network emergency rate for nonparticipating providers and facilities

Anthem adheres to the requirements of the Emergency Medical Treatment and Labor Act and the Federal Medicaid Managed Care Regulations.

Anthem will act in accordance with the Deficit Reduction Act (DRA) of 2005, Section 6085, with an effective date of January 1, 2007, that states:

> Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a state where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

Anthem shall develop and maintain a record pursuant to DRA stipulations for Anthem payment methodology according to Nevada's State's Fee-for-Service Medicaid Program guidance.

Anthem will not limit consideration of reimbursement for emergency services on the basis of lists of diagnoses or symptoms; however, additional medical record documentation may be required in order to

	clearly identify and determine appropriate reimbursement of emergency services. Claims for emergency services are subject to Eligible Billed Charges, Code and Clinical Editing, and Claims Requiring Additional Documentation policies.
History	• Effective **02/01/18**: Policy template updated • Biennial review approved **05/01/17**: Policy language updated; Policy template updated • Biennial review approved **11/09/15**: Policy language updated • Review approved **07/30/14**: Policy template updated • Biennial review approved and effective **07/29/13**: Policy template updated • Review approved and effective **08/27/12**: Policy template updated • Biennial review approved **08/15/11**: Policy template updated • Review approved **08/10/09** and effective **10/09/09**: Policy language updated • Initial review approved and effective **02/01/09**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • Deficit Reduction Act of 2005 (Pub. L. No. 109-171) • Emergency Medical Treatment and Labor Act
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submissions — Required Information for Facilities • Claims Submissions — Required Information for Professional Providers • Code and Clinical Editing Guidelines • Reimbursement for Eligible Billed Charges • Reimbursement of Sanctioned and Opt-Out Providers
Related Materials	• None