

April 18, 2000

Dear State Medicaid Director:

In the letter that was issued on April 5, 2000, we inadvertently omitted a paragraph relating to notification requirements. Therefore, this letter replaces the April 5 letter. It is #21 in a series of letters on the managed care provisions of the Balanced Budget Act of 1997 (BBA). It is intended to clarify guidance issued in a similar letter issued on February 20, 1998 (#12 in the series). The February 20, 1998 letter explained the changes made by the BBA regarding coverage of emergency services by managed care organizations (MCOs). We apologize for any misunderstanding caused by the previous letters.

In the February 20, 1998 letter we stated that the BBA requires that contracts between MCOs and States specify that MCOs must cover (i.e., pay for) emergency services without prior authorization. The BBA requires that emergency services be covered in an MCO or a primary care case management (PCCM) setting without prior authorization, regardless of whether the enrollee obtains the services inside or outside the MCO or PCCM.

The BBA addresses emergency services using a prudent layperson standard. It defines an "emergency medical condition" as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

#### **Application to PCCMs**

This prudent layperson standard applies to a PCCM when it is determining if a Medicaid beneficiary must obtain prior authorization before seeking treatment. As payers for PCCM services under Section 1905(t) contracts, States are also bound by the statutory requirement when they are paying claims. Thus, in a fee-for-service PCCM arrangement in which States pay claims, States are required to cover (i.e., pay for) emergency services that meet the prudent layperson standard in exactly the same manner as are MCOs. States should make this obligation clear in all fee-for-service PCCM contracts.

#### **Program Limits on Emergency Visits**

The BBA requires that a Medicaid beneficiary be permitted to obtain emergency services immediately at the nearest provider when the need arises. When the prudent layperson standard is met, no restriction may be placed on access to emergency care. Limits on the number of visits are not allowed.

#### **Payment Requirements/Responsibilities under the Prudent Layperson Standard**

The determination of whether the prudent layperson standard is met must be made on a case-by-case basis. The only exceptions to this general rule are that payers may approve coverage on the basis of an ICD-9 code, and payers may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim).

Note that payers may not deny coverage solely on the basis of ICD-9 codes. Payers are also barred from denying coverage on the basis of ICD-9 codes and then requiring resubmission of the claim as part of an appeals process. This bar applies even if the process is not labeled as an

appeal. Whenever a payer (whether an MCO or a State) denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).

#### **Notification Requirements**

Section 1932(b)(2)(A)(i) prohibits prior authorization for coverage of emergency services. This means that services that meet the definition of emergency services must be covered, and beneficiaries must not be charged for these services, except for any permissible nominal cost-sharing amounts. Therefore, neither a State, in the context of a PCCM arrangement, nor an MCO, may make payment for emergency services contingent on the beneficiary providing the State or MCO with notification, either before or after receiving emergency services.

MCOs and States may, however, enter into contracts with providers or facilities that require, as a condition of payment, the hospital to provide notification after beneficiaries present at the emergency room, assuming adequate consideration is given for such a provision. In the case of States as payers (e.g., PCCMs), such notification requirements are permissible as long as they do not violate the State Plan (or that part is waivable). Such requirements might reasonably be thought to be an element of appropriately coordinating and managing care. Regardless of any contractual relationship between managed care entities and providers or facilities, beneficiaries may not be required to pay for covered services (other than allowable nominal cost-sharing).

#### **CPT Codes Indicating Moderate and Complex Emergencies**

Through its State Medicaid Manual, HCFA requires the acceptance and use of the HCFA Common Procedures Coding System (HCPCS). HCFA uses the American Medical Association's (AMA) Current Procedural Terminology (CPT) as part of the HCPCS system to determine service levels. CPT is the most widely accepted coding reference and has been used since 1966. Claims submitted to MCOs and States include the emergency levels of screening and treatment. They range from CPT 99281 ("straightforward medical decision making") to CPT 99285 ("medical decision making of high complexity"). These codes reflect not only the complexity of the treatment but also the time and difficulty of making a diagnosis. The AMA publishes guides that specifically describe the categorization of levels of emergency and give examples.

We strongly believe that, unless an MCO or a State has reason to believe that a provider is "up-coding" or engaging in activity violating program integrity, all claims coded as CPT 99283 through CPT 99285 are very likely to be appropriately regarded as emergency services for purposes of the BBA and should be approved for coverage regardless of prior authorization. This should not be taken to imply that claims coded as CPT 99281 and CPT 99282 will not also meet the BBA definition; they may, but, as opposed to those claims involving the higher CPT codes, there may be instances in which payers have a reasonable basis to disagree.

If you have any questions, please do not hesitate to contact Tim Roe at (410) 786-2006.

Sincerely,

/s/

Timothy M. Westmoreland  
Director

Enclosure

cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge - Director, Health Policy Unit American Public Human Services Association

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