Commercial Reimbursement Policy

Subject: **Emergency Room Transfers – Facility**	
Policy Number: **C-20006**	Policy Section: **Facilities**
Last Approval Date: **07/17/2024**	Effective Date: **07/17/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's benefit plan. 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 Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for one emergency room visit when a patient is transferred between outpatient facilities operating under the same agreement, with the same tax identification number (TIN), or under common ownership unless provider, state, federal contracts and/or mandate requirements indicate otherwise.

Anthem considers these transfers to be a single episode of care and the transferring facility will not be eligible for separate reimbursement.

Related Coding

Code	Description
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

Policy History

07/18/2024	Policy approved and effective: updated code list descriptions; removed *episodes of care* from Definition section
12/09/2020	Initial approval 12/02/2020 and effective 05/01/2021

References and Research Materials

This policy has been developed through consideration of the following:

- American College of Emergency Physicians (ACEP)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Optum EncoderPro 2024

Definitions

Emergency Services	A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in (a) placing the health of an individual in serious jeopardy, (b) serious impairment to bodily function, (c) serious dysfunction of any bodily organ or part, (d) serious disfigurement, or (e) in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
General Reimbursement Policy Definitions	

Related Policies and Materials

None

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date

that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.