Payment Policy: Multiple ER Visits, Same Day

Reference Number: LA.PP.XX **Implications**
Coding
Effective Date: **Revision Log**
Last Review Date: 12/24

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

Louisiana Medicaid providers must bill outpatient emergency room services using revenue code 450 or 459, and only one of these codes can be used per visit. The codes must be accompanied by the appropriate Current Procedural Technology (CPT) codes. Claims for emergency room services cannot be billed as a single line item.

Reimbursement

An enrollee can receive multiple services from more than one provider on the same day, the services must be medically necessary and not duplicative

Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed and certified hospital. The hospital must also be Medicare certified. Covered outpatient hospital services provided to Medicaid beneficiaries are reimbursable.

Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. Billing outpatient services for a beneficiary who is admitted as an inpatient within 24 hours of the performance of the outpatient service is not allowed and the facility may be subjected to financial sanctions.

Outpatient services (including diagnostic testing) that are related to an inpatient admission and are performed either during or within 24 hours of the inpatient admission, regardless of hospital ownership, will not be reimbursed separately as an outpatient service. The inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

The only exceptions to this policy criteria are:

- **Outpatient therapy services performed within 24 hours before an inpatient admission or 24 hours after the beneficiary's discharge that are either related or unrelated to the inpatient stay; and**
- **Transfers from a hospital emergency department to a different hospital/provider for inpatient admission.**

If one of the above exceptions are met, separate billing and payment for the outpatient hospital
service are allowed.

If a enrollee is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided that the beneficiary is not admitted as an inpatient.

Physicians responsible for a beneficiary's care at the hospital are responsible for deciding whether the beneficiary should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for beneficiaries who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered a number of factors. Admissions of particular beneficiaries are not covered or non-covered solely on the basis of the length of time the beneficiary actually spends in the hospital.

Louisiana Medicaid is not obligated to pay for non-emergency (routine) care provided in the emergency room (ER), unless the person has presenting symptoms of 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 medical attention to result in:

- **Placing the health of the individual, or in the case of a pregnant woman, the health of the woman or their unborn child, in serious jeopardy;**
- **Serious impairment of bodily function; or**
- **Serious dysfunction of any organ or body part**

Application
Hospitals, free-standing emergency centers, physicians or other qualified health professionals.

Modifiers

Modifier	Description
27	Indicate multiple visits on the same day

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	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

HCPCS Codes	Description
450	Billing code for a general emergency room
459	Other Emergency room

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
New Policy	12/2024		

References

1. https://www.lamedicaid.com/provweb1/providermanuals/manuals/Hosp/Hosp.pdf
2. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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