



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

Reimbursement Policy	
Subject: Emergency Services: Non-Participating Providers and Facilities	
Policy Number: G-06092	Policy Section: Administration
Last Approval Date: 09/06/2024	Effective Date: 09/06/2024

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to providerpublic.mybcbswny.com. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the 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, Highmark BCBS may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark BCBS strives 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

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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

Highmark BCBS allows reimbursement for emergency services provided by nonparticipating professional providers and facilities unless provider, state, federal, or CMS contracts and/or requirements state otherwise. Reimbursement is based on the following:

- For Medicaid product lines only: The amount that would have been reimbursed to the provider by the New York's State Fee-for-Service (FFS) Medicaid program
- For all other product lines: The applicable out-of-network emergency rate for nonparticipating providers and facilities

Highmark BCBS follows the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) and the Federal Medicaid Managed Care Regulations.

Highmark BCBS 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.”

Highmark BCBS shall develop and maintain a record, pursuant to DRA stipulations, for its payment methodology according to New York's FFS Medicaid program.

Highmark BCBS 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 the Eligible Billed Charges, Code and Clinical Editing Guidelines, and Claims Requiring Additional Documentation reimbursement policies of Highmark BCBS.

Related Coding

Standard correct coding applies

Policy History

09/06/2024	Review approved: no changes
04/29/2022	Review approved and effective
09/30/2019	Review approved: policy template updated

12/01/2018	Policy template updated
05/01/2017	Review approved and effective: policy template updated
11/09/2015	Initial review approved 11/09/2015 and effective 01/01/2017

References and Research Materials	
This policy has been developed through consideration of the following:	
<ul style="list-style-type: none"> • CMS • Deficit Reduction Act of 2005 (Pub.L. No. 109-171) • Emergency Medical Treatment and Labor Act (EMTALA) • State contract • State Medicaid 	

Definitions	
General Reimbursement Policy Definitions	

Related Policies and Materials	
Claims Requiring Additional Documentation	
Claims Submissions — Required Information for Facilities	
Claims Submissions — Required Information for Professional Providers	
Code and Clinical Editing Guidelines	
Eligible Billed Charges	
Sanctioned and Opt-Out Providers	