Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

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MMA - Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

Note: This article was revised to contain web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same. .

Provider Types Affected

Hospitals, including critical access hospitals (CAHs)

Provider Action Needed

Although voluntary, it is to the provider's benefit to bill presenting symptoms or complaints in addition to the principal diagnosis. To ensure you are paid appropriately for your services, you may use Form Locator 76 of the UB-92 claim form to bill for the ICD-9-CM code that represents the patient's reason for the visit. Although only one diagnosis code for the reason for the visit may be recorded in Form Locator 76, at the provider's discretion additional diagnoses not inherent in the final diagnosis may be reported in Form Locators 68 through 75.

Providers may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45X, 0516, or 0526 to ensure appropriate payment. We support hospitals' efforts to educate physicians on documentation to support correct coding, and contractors should assist hospitals in providing this education when requested.

This instruction is pursuant to Section 1867of the Social Security Act (EMTALA) for services provided on or after January 1, 2004.

Background

This instruction addresses implementation of provisions contained in the Medicare Modernization Act (MMA) regarding payment for EMTALA-mandated screening and stabilization services.

The MMA (Section 944(a)) requires that determinations of whether items and services provided in Emergency Departments (EDs) are reasonable and necessary 1) be made on the basis of information available to the treating physician or practitioner at the time the item or service was ordered or furnished by the physician or practitioner, and 2) take into consideration the patient's presenting symptoms or complaint, and not only on the patient's principal diagnosis. The frequency with which a patient receives a service may not be considered.

To ensure that current Local Coverage Determinations (LCDs)/Local Medical Review Policies (LMRPs) do not inappropriately deny ED claims, FIs have been instructed as a result of the related change request to discontinue LMRP/LCD frequency edits for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45X, 0516, or 0526 to assure appropriate payment.

While the frequency that a patient receives a service before and after admission may not be considered, medical review can be targeted at potentially aberrant ED billing, but decisions must be based on the information available to the ED physician, including the patient's presenting conditions, as required by the MMA provision.

In the past some hospitals may have been hesitant to submit the full array of diagnosis codes, believing them in conflict with existing coverage policies. Consistent with the law, hospitals may now submit the codes related to the patient's presenting symptoms or complaints. For further discussion of when a claim would be considered fraudulent, see the Medicare Program Integrity Manual at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

In summary, providers should be aware that Medicare FIs will, as of the implementation date of the related instruction:

- Consider the diagnoses in Form Locator 76 and Form Locators 68-75 for payment decisions and may target medical review at ED billing, when data indicates there may be a problem;
- Make decisions based on the information available to the ED physician or practitioner, including the patient's presenting conditions, when performing medical review;
- Discontinue automated frequency edits resulting from LMRPs/LCDs with a 45X, 0516, or 0526 revenue code, or for items or services, including

diagnostic tests, performed under EMTALA, to ensure that current LMRPs/LCDs do not inappropriately deny ED claims; and

- Reopen claims for ED services provided on or after January 1, 2004 that were previously denied prior to the issuance of this instruction if the provider so requests.

Implementation

The implementation date for this instruction is November 22, 2004.

Additional Information

Hospitals should be aware that The Medicare Program Integrity Manual (Pub 100-08), Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 5.1.1 (Prepayment Edits) is being revised. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction at *http://www.cms.hhs.gov/Transmittals/downloads/R86PI.pdf* on the CMS website.

If you have any questions, contact your intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.