

## CHAMPVA POLICY MANUAL

**CHAPTER:** 2  
**SECTION:** 8.2  
**TITLE:** **EMERGENCY DEPARTMENT (ED) SERVICES**

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**AUTHORITY:** 38 USC 1713; 38 CFR 17.270(a) and 17.272(a)

**RELATED AUTHORITY:** 32 CFR 199.2(b) and 32 CFR 199.4(b)(6) and (b)(7)

**TRICARE POLICY MANUAL:** Chapter 1, Section 7.1

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### I. PROCEDURE CODE(S)

99281-99285, 99291-00292, 99440, 99058

### II. DESCRIPTION

A. An emergency department is an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

B. Medical emergency is the sudden and unexpected onset of medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative effort to relieve suffering.

C. Maternity emergency is a sudden unexpected medical complication which puts the mother, or fetus, at risk.

D. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

### III. POLICY

A. Emergency care is covered for medical, maternity or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine), to believe that a serious medical condition existed or the absence of medical attention would result in threat to his/her life, limb, or sight and requires immediate medical treatment or which manifest painful symptomatology requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary presents with severe pain.

B. Emergency care is covered for services and supplies, not otherwise excluded that are ordered or administered in the ED to manage the care (e.g., tetanus toxoid injections, etc.).

C. The level of ED services is based on the:

1. approach and detail of the medical history,
2. extent of the examination,
3. complexity of the decision making process, and
4. severity of the presenting problem.

#### IV. POLICY CONSIDERATIONS

A. Pre-authorization is not required for ED services meeting "Policy" requirements.

B. An adverse determination of ED care claims is an appealable issue.

C. Admissions resulting from a psychiatric emergency should be reported to the Director, Health Administration Center (or designee) within 24 hours of admission or the next business day after admission, but must be reported within 72 hours of the admission. In the case of any emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request or the date of admission, whichever occurs first (see [Chapter 2, Section 18.10](#), *Preauthorization for Acute Psychiatric Care*).

D. ED services as defined in "Policy" above are cost shared as follows:

1. As outpatient care when the beneficiary is discharged home, regardless of any subsequent hospital admission related to the reason for the ED visit.

2. As inpatient care when:

a. An immediate inpatient admission for acute care follows the outpatient ED services.

(1) "Immediate" includes the time lapse associated with the beneficiary's direct transfer to an acute care facility more capable of providing the required level-of-care. ED care includes otherwise payable services of both the transferring and receiving facilities.

(2) Inpatient cost sharing is appropriate when the ED care is billed separately, as is required for all hospital services provided on an outpatient basis, when the related inpatient stay is subject to DRG-based payment system.

b. An ED patient dies while awaiting formal hospital admission for continued medically necessary acute care.

## **V. EXCLUSIONS**

A. In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation, when associated with a pregnancy, are not emergency conditions for adjudication purposes.

B. For procedure code 99288 (physician direction of EMS, emergency care and advanced life support), no separate payment will be made for this service as it is considered included within the payment for other services.

**\*END OF POLICY\***