

## EMERGENCY CARE RELATED CLAIMS

Issue Date: May 23, 1988

Authority: [32 CFR 199.2\(b\)](#); [32 CFR 199.4\(b\)\(6\)](#) and [\(b\)\(7\)](#)

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### I. POLICY

A. A Nonavailability Statement (NAS) is not required to adjudicate a claim for emergency care which is determined to meet the definition of a bona fide emergency as defined in [Chapter 1, Section 7.1](#), which results in either treatment in an emergency room, treatment in an emergency room followed by an immediate hospital admission, or immediate emergency inpatient hospital admission without treatment in an emergency room.

1. Following are examples of diagnoses, conditions, or circumstances which can be expected to require treatment in an emergency room setting:

- a. Severe allergic reaction (e.g., animal bites, drug reaction, etc.)
- b. Cardiac arrhythmias
- c. Severe cardiac disease (e.g. myocardial infarction, etc.)
- d. Cerebral vascular accident
- e. Convulsion
- f. Severe self-inflicted injuries (e.g., drug overdose, lacerated wrists, etc.)
- g. Kidney stone(s)
- h. Poisoning
- i. Shock
- j. Traumatic injury (e.g., amputations, dislocations, lacerations, electrical shock, etc.)
- k. Unconsciousness
- l. Acute respiratory distress (e.g., status asthmaticus, etc.)

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- m. Second and third degree burns
  - n. Ruptured aneurysm
  - o. Diabetic acidosis or coma, or insulin shock
  - p. Drowning
  - q. Acute Abdomen (e.g., appendicitis, etc.)
  - r. Complications of labor or delivery (e.g., placenta previa, abruption placenta, or woman and/or newborn transferred from a TRICARE authorized birthing center, etc.)
  - s. Other conditions determined by medical review to require emergency room care level of treatment (see [Chapter 1, Section 7.1](#) for definition of emergency care).

2. The emergency inpatient hospital admission must be to the closest hospital available that is equipped to furnish the medically necessary care.

3. TRICARE cost-share of emergency inpatient hospital services will terminate 24 hours after written notice to the beneficiary that the nearest Uniformed Services Medical Treatment Facility (MTF) capable of providing the required level-of-care has accepted the beneficiary for continued care.

4. Childbirth is not considered a medical emergency simply because of the beneficiary's inability to timely travel to the responsible MTF, regardless of the distance to the responsible MTF.

*NOTE: A retroactive NAS may be issued if the services could not have been rendered in the MTF, or it would have been medically inappropriate to have sought MTF admission at the time services were delivered in the civilian sector. Local commanders shall use their discretionary authority to assess individual medical needs and personal constraints on an individual's ability to use, or get to, the MTF.*

B. Emergency room (ER) services 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 ER visit.

2. As inpatient care when:

a. An immediate inpatient admission for acute care follows the outpatient ER 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. ER services include otherwise payable services of both the transferring and receiving facilities.

(2) This will be done even when the emergency services are billed separately, as is required for all hospital services provided on an outpatient basis when the related inpatient stay is subject to the TRICARE/CHAMPUS DRG-based payment system. In determining if the emergency services were immediately followed by an inpatient admission, the contractor is required only to examine the claim for emergency services for evidence of a subsequent admission and to examine its in-house claims records (history).

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

C. Professional claims for multiple same-day visits involving care for an authentic medical emergency are adjudicated as follows:

1. Only the hospital-based physician charge for ER services may be cost-shared when both the hospital-based physician and a non-hospital based physician submit charges for ER services provided on the same day.

2. Only the charge for the initial critical care may be cost-shared when an ER visit and initial critical care are billed for the same day.

3. Only the visit with the higher prevailing charge may be cost-shared when an ER visit and hospital visit are billed for the same day by the same professional provider.

4. If an emergency room visit and hospital visit are rendered/billed by different providers, both procedures will be allowed at 100 percent of the prevailing on billed whichever is the lowest.

5. Both an ER visit and a minor surgical procedure billed for the same day may be cost-shared.

6. Emergency outpatient or otherwise authorized emergency inpatient hospital services for any woman transferred from a TRICARE authorized birthing center are to be adjudicated as related maternity care.

D. Services and supplies, not otherwise excluded, ordered or administered in the emergency room to manage a medical, maternity, or psychiatric emergency may be cost-shared when determined to be medically necessary and appropriate (e.g., tetanus toxoid injections, etc.).

## II. POLICY CONSIDERATIONS

An adverse determination of an emergency care related claim based upon medical factors is an appealable issue.

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