

Reimbursement Of Emergency Inpatient Admissions To Unauthorized Facilities

Issue Date: September 11, 2000

Authority: [32 CFR 199.4\(b\)\(7\)](#) and [32 CFR 199.6\(a\)\(1\)](#)

1.0 ISSUE

To establish guidelines for reimbursement of emergency inpatient admissions to unauthorized facilities.

2.0 POLICY

2.1 The contractor may cost-share otherwise covered medically necessary services and supplies rendered in emergency situations by an unauthorized provider. Medically necessary inpatient emergency service are those that are necessary to prevent the death or serious impairment of the health of the patient, and that because of the threat to the life or health of the patient, necessitate the use of the most accessible hospital available that is equipped to furnish the services. In the case of inpatient psychiatric emergencies, payment will be extended when the patient is determined to be 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.

2.2 When a case qualifies as an emergency at the time of admission to an unauthorized institutional provider and the provider notifies the managed care support contractor of the admission, payment can be extended for medically necessary and appropriate care until a transfer is medically feasible (i.e., coverage will be extended up to the point of discharge or until a medically appropriate and legally authorized transfer can be initiated). The timing of the transfer will be based on the availability of authorized facility beds.

2.3 Conditions for reimbursement of emergency inpatient admissions to unauthorized facilities.

2.3.1 At the time of admission to an unauthorized institutional provider, the beneficiary's condition must meet the definition of medical or psychiatric emergency as prescribed in [32 CFR 199.2](#).

2.3.2 The contractor must be notified as soon as possible after the emergency admission (preferably within 24 hours) so that arrangements can be made to transfer the beneficiary once the emergency no longer exists, or until such time as a medically appropriate and/or legally authorized transfer can be initiated.

2.3.3 The provider must submit the necessary medical records and other documentation required in the processing and payment of emergency inpatient admissions. These records are

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 1, Section 29

Reimbursement Of Emergency Inpatient Admissions To Unauthorized Facilities

essential in substantiating that an emergency condition did exist at the time of the admission and that care provided to the beneficiary after the emergency no longer existed, but before a medically appropriate transfer could be initiated, was medically necessary. Refusal to submit the appropriate medical documentation will result in the denial of payment for the entire stay in the facility, including the emergency portion of the patient's care.

2.3.4 A determination must also be made that treatment was received at the most accessible (closest) hospital available that was equipped to furnish the medically necessary care.

2.4 Reimbursement guidelines for emergency inpatient admissions to unauthorized facilities.

2.4.1 Billed charges will be paid for all medically necessary care up until such time as an appropriate and/or legally authorized transfer can be initiated by the contractor. Payment will only be made if there was a true medical/psychiatric emergency as defined in [32 CFR 199.2](#), at the time of admission and only for that care extending beyond stabilization of the patient (care extending beyond the emergency treatment of the patient), as long as it was deemed medically necessary and appropriate.

2.4.2 The copayment/cost-share for an inpatient emergency admission to an unauthorized facility is dependent on the eligibility and enrollment status of the beneficiary at the time the services are rendered. Refer to [Chapter 2, Section 1](#), for inpatient beneficiary copayments/cost-shares.

2.4.3 **Conditions for direct payment to an unauthorized facility.**

2.4.3.1 The signature-on-file procedure may be used as a means of ensuring patient confidentiality, while at the same time allowing direct payment to the facility. This procedure involves incorporating the following language into the permanent records of TRICARE beneficiaries for whom the facility is seeking payment under emergency provision [32 CFR 199.6\(a\)\(2\)](#).

"I request payment of authorized benefits to me or on my behalf for any services furnished me by (**Name of Provider**), including physician services. I authorize any holder of medical or other information about me to release that information in accordance with the provisions of The Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, Public Law (PL) 102-321 and Privacy Act of 1974."

2.4.3.2 Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 instructions shall be followed for certifying signature on file, except that the permanent hospital record containing a release statement will be recognized. The unauthorized facility will be responsible for ensuring that the beneficiary's signature is on file, attesting to the above language as soon as possible after the emergency crisis has passed (i.e., after patient stabilization).

2.4.4 If the signature-on-file procedure is not utilized by the unauthorized provider, payment must be made directly to the beneficiary.

- END -