



Free Standing Emergency Room Provider Specific Policy

Revision Table

Effective Date of Revision	Sections Revised	Description
1/26/06	ALL	New Manual

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Free Standing Emergency Room

Provider Specific Policy

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Free Standing Emergency Room Provider Specific Policy

Free Standing Emergency Room (FSER) services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). FSER services are included in the MCO benefits package. All Medicaid clients who are enrolled with an MCO must receive FSER services through the MCO.

This manual reflects the policies as they relate to Medicaid clients who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

1.0 General Information

1.1 Free Standing Emergency Room

1.1.1 The State of Delaware defines “Free Standing Emergency Center” as a facility physically separate from a hospital, which uses in its title or in its advertising, the words “emergency”, “urgent care”, or parts of those words or other language or symbols which imply or indicate to the public that immediate medical treatment is available to individuals suffering from a life-threatening medical condition. The facility rendering such care is capable of treating all medical emergencies that have life-threatening potential.

1.1.2 FSERs, for the purpose of this manual are Free Standing Emergency Centers which are licensed by the Delaware Division of Public Health.

2.0 Billing Information

2.1 Billing Form

2.1.1 FSERs must use the CMS 1500 or the 837 Professional claims form.

2.2 ICD-9-CM Diagnosis Codes

2.2.1 FSERs must use ICD-9-CM diagnosis codes. ICD-9-CM diagnosis codes are common classifications of disease and related entities. The ICD-9-CM code describes the clinical picture of the patient. The ICD-9-CM diagnosis codes used must accurately describe the diagnosis of the patient.

2.3 HCPCS Procedure Codes

2.3.1 FSERs must use HCPCS procedure codes. HCPCS codes are a listing of descriptive terms for reporting medical services and procedures performed. The purpose of the terminology is to provide a uniform language that will accurately

designate medical, surgical, and diagnostic services. The HCPCS procedure codes used must accurately describe the services provided. (Refer to Appendix A for specific code information.)

2.4 Multiple Daily Visits

2.4.1 In the event that more than one (1) FSER visit is provided within a day, the provider shall bill a single claim detail with the appropriate number of units and attach documentation for each FSER visit.

3.0 Reimbursement

3.1 Methodology

3.1.1 The DMAP's reimbursement for FSER services shall be based on a global encounter fee per visit.

3.1.1.1 The reimbursement includes all services rendered per visit including but not limited to:

- Professional Services
- Laboratory Services
- Radiology Services (professional and technical components)
- Pharmacy Services
- Supplies and Equipment



Appendix A

4.0 Appendix A – HCPCS Procedures Codes

The following procedure code is to be used for billing services when a FSER visit occurs. The code is the ONLY code that a FSER can bill.

Code	Description
S9083	Global Fee Urgent Care Centers