MPC ED Claim Payment Process Policy for Provider Submitted ED Claims

Maryland Physicians Care (MPC), as a contractor to the Maryland Department of Health for the HealthChoice (Medicaid) Program, is required to follow and adhere to certain statutes and regulations that are promulgated by the Federal Government, the State of Maryland, and the Maryland Department of Health.

Emergency department (ED) claims are reviewed against the requirements of the Emergency Medical Treatment & Labor Act (EMTALA) and the regulatory determination of medical necessity.

Emergency services are defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing a person's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMTALA defines an emergency medical condition as:

"a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

EMTALA requires screening and stabilization of a patient, and once achieved, further medical services may be provided based on the clinical judgment of the provider, so long as they meet the regulatory determination of medical necessity.

The Code of Maryland Regulations (COMAR) defines medical necessity as:

COMAR 10.67.01.01 (B.112)

"Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with current accepted standards of good medical practice;

(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.

When ED claims are received by MPC, if no associated medical records are submitted with the claim, it can be difficult to fully assess ancillary services for medical necessity. In an effort to balance obligations under State and Federal law against administrative burden on providers, and to achieve fair and consistent reimbursements of ED claims, MPC applies its ED claims payment process as follows:

All ED Claims: To allow for the determination of the existence of an emergency medical condition, EMTALA screening and basic ancillary charges are automatically reimbursed. When an ED claim is received, those fees, which include the EMTALA screening fee (Rev code 451) and certain basic ancillary triage, laboratory and radiology services, will be reimbursed automatically. The basic ancillary services are posted on our website and are available for download and review here Billing and Claims - Maryland Physicians Care. In addition, all provider fees billed are reimbursed in full.

Age Criteria: If the member/patient is less than or equal to 24 months of age, the claim will be reimbursed in full regardless of any other criteria. NO other criteria need be met if the member is under 2 years of age.

Auto Pay List (APL): The APL is a series of ICD diagnosis codes that our Medical Directors have determined likely indicate the patient presented with an emergency medical condition at triage, satisfying the requirements of EMTALA. If one of the APL codes is included on the ED claim form, in any position, the entire claim will be reimbursed without further documentation. The APL is available on MPC's website and can be downloaded for review here Billing and Claims - Maryland Physicians Care. The APL is reviewed on a regular basis and updates are posted to our website when changes are made.

Cost Criteria: In a further effort to reduce the administrative burden on providers, MPC will reimburse any claim with a total billed charge below a certain threshold even if the claim does not meet the APL or Age Criteria. As of January 1, 2026 that threshold is $720. This amount is subject to change and is currently set based on the statewide median charge for ED claims submitted to MPC.

Services Criteria: After the All ED Claims reimbursement has been made, if the ED claim does not meet the APL criteria, age criteria, or cost threshold and accompanying medical records are not submitted with the claim, MPC requests medical records and related documentation be submitted in order to determine further reimbursement of the claim. This decision will be indicated on the claims remit with the following CARC codes: **CO-252/N391** (AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE; MISSING EMERGENCY DEPARTMENT RECORDS; PLEASE SUBMIT MEDICAL RECORDS).

Medical Records: MPC requires that all ED claims that do not meet the APL criteria, age criteria or cost threshold be submitted with accompanying medical records to constitute a clean claim that can be processed. Medical records can be submitted with the initial claim either via the HIPAA 275 transaction or via paper submission. If medical records are received with the claim, the medical records will be reviewed for reimbursement of services. If certain services do not meet the applicable EMTALA or Medicaid criteria, then those services will be denied with the following CARC remit code: **CO-40** (CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENT/URGENT CARE).

After receiving a request for medical records or a denial of an unclean claim, the provider can request additional reimbursement by supplementing its initial claim. Or, after receiving a denial, the provider can request additional reimbursement payment through MPC's appeals process, which is explained in detail in the relevant section of this manual.

Behavioral Health (BH) and Substance Abuse ED Visits: ED visits that are primarily for behavioral health and/or substance abuse are not the responsibility of MPC. Claims with the **primary** diagnosis code of either BH or SA will be denied using CARC CO-256 (Service Not payable per Managed Care Contract). When the provider receives this denial, the claim should be submitted to the BH MCO. At present, the BH MCO is Carelon.