INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Emergency Services

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2026185 – IHCP updates Emergency Services Only billing requirements*

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Revision History

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1.2	Policies and procedures as of April 1, 2016 Published: Sept. 8, 2016	Interim update	FSSA and HPE
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7.0	Policies and procedures as of Jan. 1, 2024 Published: March 27, 2024	Scheduled update: • Edited text as needed for clarity • Added a note in the *Introduction* section about emergency department autopay lists • Updated the note in the *Nonemergency Services Provided in an Emergency Department* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
7.1	Policies and procedures as of Jan. 1, 2024 Published: Oct. 29, 2026	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2026185*	FSSA and Gainwell

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> *Note:* *The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*
>
> *For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

Emergency services include unscheduled episodic services provided to individuals who require immediate medical attention. An **emergency service** is a service provided to a member after the sudden onset of an emergency medical condition.

As defined by *Indiana Administrative Code 405 IAC 5-2-9* and *United States Code 42 USC 1395dd(e)(1)*, an **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

> *Note:* *IHCP contractors may use a designated list of diagnosis codes to automatically qualify a condition as an emergency. If a managed care entity (MCE) chooses to use such a list, their list must include, at a minimum, all the codes on the Emergency Department Autopay List, accessible from the Code Sets page at in.gov/medicaid/providers. This list closely aligns with the fee-for-service (FFS) emergency diagnosis list.*
>
> *If a provider believes that a situation meets the definition of an emergency medical condition, but is concerned that the applicable diagnosis code may not be included in the contractor's emergency department autopay list, the provider may submit medical records with the initial claim for a prudent layperson review.*

Emergency Service Coverage and Billing

The Indiana Health Coverage Programs (IHCP) provides reimbursement for emergency services provided to IHCP members. Guidelines for these services are subject to the member's program enrollment.

Providers should bill for emergency services using the appropriate type of claim for their provider type and specialty. For example, facilities should bill using the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [IHCP Portal] institutional claim or 837I electronic transaction), and physicians

should bill using the professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P electronic transaction).

For information about emergency services related to specific specialties, see the appropriate module, such as *Behavioral Health Services*, *Dental Services*, *Hospice Services*, *Inpatient Hospital Services*, *Pharmacy Services* or *Transportation Services*.

Exclusions for Prior Authorization, Referrals and Copayments

Emergency services as defined in this document do not require prior authorization (PA). However, any inpatient stay resulting from an emergency admission *does* require PA, with the exception of stays for burn care with an admission of type 1 (emergency) or type 5 (trauma) or stays for services that are exempt from inpatient PA requirements, as described in the *Inpatient Hospital Services* module. To receive IHCP reimbursement for inpatient services, the emergency admission must be reported to the PA contractor within 48 hours after admission, not including Saturdays, Sundays or legal holidays.

Emergency services are self-referral services, including for members with an assigned primary medical provider (PMP) through managed care or the Right Choices Program (RCP). Emergency services are excluded from fee-for-service copayment requirements.

Package E and Package B Members

The IHCP provides emergency services only (ESO) coverage for qualifying non-U.S. citizens. ESO coverage is provided under two benefit plans:

- *Package E – Emergency Services Only* benefits are limited to **only** services that meet the emergency criteria noted in the *Introduction* section. In the case of pregnant women with Package E coverage, labor and delivery services are considered emergency medical conditions.
- *ESO Coverage with Pregnancy Coverage* (also known as Package B) provides the same benefits as Package E **plus** prenatal and postpartum services.

Covered services for ESO members are reimbursed under the fee-for-service delivery system. Claims for Package E and Package B members must indicate, as appropriate, that the service rendered meets the definition of an emergency service (or, in the case of Package B, a pregnancy- or postpartum-related service). Providers are responsible for maintaining documentation to support the claim and the appropriateness of the service.

For coverage of emergency services rendered to Package E and Package B members, claims must indicate that the service is an emergency as follows:

- **Professional** claims (*CMS-1500* claim form or electronic equivalent) must have the emergency indicator (EMG) field marked for each service detail.
- **Institutional outpatient** claims (*UB-04* claim form or electronic equivalent) must include an emergency diagnosis code in the principal (primary) position.
- **Institutional inpatient** claims (*UB-04* claim form or electronic equivalent) must include an admission type code of 1, indicating an emergency admission.
- **Dental** claims must have the word *Emergency* in the Predetermination/Preauthorization Number field for paper claims (*ADA 2012* claim form) or the emergency indicator field marked for electronic claims (IHCP Portal dental claim or 837D electronic transaction), and the procedure must be for an IHCP-designated emergency dental service (see the *Dental Procedure Codes Allowed for Emergency Services Only (Package E and Package B) Members* table in *Dental Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers).

- **Pharmacy** claims must have the emergency indicator field marked, must be for a limited-supply prescription (a maximum of four days) associated with a covered emergency medical service, and must be submitted on a paper pharmacy claim.

For more detailed billing instructions for members with ESO benefits, see the *Claim Submission and Processing* module. For more information about ESO eligibility and coverage, see the *Member Eligibility and Benefit Coverage* module.

Services Provided in an Emergency Department

The IHCP covers services for a member presenting to an emergency department with an emergency medical condition, as determined by the screening physician:

- The IHCP provides reimbursement to emergency department physicians who render medically necessary emergency services to IHCP members.
- Claims for related services (such as facility charge, lab and X-ray) provided in an emergency room setting must include a principal diagnosis code that supports the emergency nature of the service; otherwise, the IHCP may suspend the claim for review to determine whether the prudent layperson standard (as described in the *Introduction* section) has been met. If the IHCP review determines that the prudent layperson standard has not been met, the IHCP will deny the claim.

Facility charges for emergency department visits are billed and reimbursed as described in the *Outpatient Facility Services* module. If the emergency department visit results in an inpatient stay, reimbursement is included in the inpatient diagnosis-related group (DRG), as described in the *Inpatient Hospital Services* module.

Emergency Department Screenings

Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. Billing guidelines for the institutional claim (*UB-04* claim form or electronic equivalent) depend on the result of the screening, as follows:

- If the screening result does **not** meet the definition of an emergency visit, using the prudent layperson review criteria, the hospital should bill **only** for the screening service, using revenue code 451 – *Emergency Medical Treatment and Labor Act [EMTALA] Emergency Medical Screening Services*. No emergency room treatment services are reimbursed if billed in conjunction with revenue code 451.
- If the screening determines that the member **does** have an emergency condition, the hospital should **not** bill revenue code 451 for the screening. Instead, the hospital should bill for the medically necessary emergency services provided, using the appropriate revenue code (such as 450 – *Emergency Room – General*) along with applicable procedure codes.

Physicians bill for their services on a professional claim (*CMS-1500* claim form or electronic equivalent), and they must use Current Procedural Terminology (CPT®[1]) codes 99281–99285 to reflect the appropriate level of emergency department screening exam performed.

Nonemergency Services Provided in an Emergency Department

The IHCP does not reimburse hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. If the screening does not indicate an emergency medical condition, the hospital is reimbursed only for the screening itself, billed with revenue code 451. All ancillary charges submitted with revenue code 451 will be denied, with the explanation of benefits (EOB) 4180 – *When revenue code 451 is billed on an outpatient or outpatient crossover claim, all other services billed are not payable.*

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Physicians who provide services in an emergency department setting to patients whose screenings do not indicate an emergency medical condition should bill these nonemergency services using the applicable office visit procedure code instead of the emergency room screening procedure code. The claim should be billed with the applicable place-of-service code for the emergency department setting. The IHCP will apply a site-of-service reduction in the reimbursement, if applicable, as described in the *Medical Practitioner Reimbursement* module.

> *Note: Members with Presumptive Eligibility – Adult coverage are required to pay an $8 copayment for nonemergency services provided in the emergency department. See the Presumptive Eligibility module for details. Copayments may also apply under certain managed care benefit plans; consult the member's managed care entity (MCE) for details.*