AmeriHealth.

PROVIDER BULLETIN
#16-2013

TO: Participating hospitals in Pennsylvania and Delaware

FROM: Daniel Brown
Director, Provider Reimbursement Analysis Administration

DATE: September 30, 2013

SUBJECT: Important reminder regarding ER follow-up care denials

The purpose of this bulletin is to remind you of a change in the processing of claims for routine (nonemergent) follow-up care provided in the emergency room/department (ER) setting.

As of July 1, 2013, claims billed for routine (nonemergent) follow-up care provided in the ER setting that contain a routine follow-up diagnosis code are automatically denied.

Routine follow-up diagnosis codes that will cause automatic claim denials include: V58.30, V58.31, V58.32, and V68.1. Please note that additional codes may be added to or removed from this list without prior notice.

In addition to automatic denials, we will continue to perform post-audit review and retract any inappropriately paid claims for ER services determined to be follow-up care.

As per the terms of your Participating Provider Agreement, when follow-up care provided in the ER setting is denied as a noncovered service, commercial members may be billed for such noncovered services. However, in order to bill members for these services, **you must provide the member with prior written notice indicating that follow-up care in the ER setting is not a covered benefit and that they will be financially responsible for any follow-up care given in the ER setting.**

If you have any questions regarding this change, please contact your Network Coordinator.

We encourage you to share this information with appropriate members of your staff.