## INSTRUCTIONS FOR COMPLETING THIS REPORT

### Inputs for the Report

<table>
<thead>
<tr>
<th>Step</th>
<th>Description of Step</th>
<th>Attestation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Complete the MCO Name field</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Enter the date the report was run.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Enter the name of the employee attesting to the accuracy of the report.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Enter the incurred FROM DATE. Format (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Enter the incurred TO DATE. Format (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Enter the paid FROM DATE. Format (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Enter the paid TO DATE. Format (MM/DD/YYYY)</td>
<td></td>
</tr>
</tbody>
</table>

### Flagging Emergency Room Claims

#### Outpatient ER Claim Logic:

1. **a.** Claim type should be an outpatient facility claim and the type of bill should equal 131.
2. **b.** Select claims with revenue codes in (0450, 0451, 0452, and 0459).
3. **c.** Exclude claims designated as urgent care (revenue codes 0456, 0516, 0526).
4. **d.** Exclude visits resulting in an inpatient hospital stay or observation bed (revenue code 0762).

#### Evaluate the Primary/Principal diagnosis code on the ER claims selected in Step 1 against the ICD-9 / ICD-10 list provided. Use both lists outlined in Tables 1 and 2. Note, ICD-9 codes should be used for dates of service prior to 10/1/2015 and ICD-10 after 10/1/2015.

1. Codes that match the list should be flagged and reported as Low Acuity.
2. Codes that do not match the diagnosis codes in Tables 1 and 2 should be flagged and reported as Non-Low Acuity.

#### For the claims selected in Step 1, analyze all claims for the member in the 12 months prior for the presence of a mental health diagnosis code. If the member who used an ER service from Step 1 has a claim in the prior 12 months that matches the diagnosis codes in Tables 3 and 4 then add a flag and report the unique count of members in the field |MH|.

1. Note: Table 3 are ICD-9 codes and should be used to evaluate claims with incurred dates prior to 10/1/2015. Table 4 are ICD-10 codes and should be used to evaluate claims with incurred dates after 10/1/2015.

#### For the claims selected in Step 1, analyze all claims for the member in the 12 months prior for the presence of a mental health diagnosis code. If the member who used an ER service from Step 1 has a claim in the prior 12 months that matches the diagnosis codes in Tables 5 and 6 then add a flag and report the unique count of members in the field |SUD|.

1. Note: Table 5 are ICD-9 codes and should be used to evaluate claims with incurred dates prior to 10/1/2015. Table 6 are ICD-10 codes and should be used to evaluate claims with incurred dates after 10/1/2015.

#### Assign program using the cohort of the member in the month the visit occurs and indicates which tab should be utilized for reporting. The reporting period is 12 months and some cases a member may be classified in different cohorts or programs during the 12 month period. Refer to Table 7 - Cohort Assignment for the correct assignment.

1. Assign the region using the location of the ER facility provider. The reporting period is 12 months and in some cases a member may visit an ER facility in different regions. Refer to Table 8 - Provider Regional Assignment and definitions for correct assignment.

#### Using the ER claims and members identified in Step 1 aggregate all professional and ancillary service claims associated with the ER claim. See definitions below for.

1. Although not required for the report output, the MCO is instructed to maintain the ER facility National Provider Identifier for ad hoc follow up purposes.

### Aggregating the Data into the Report Tabs
1. Aggregate the data selected based on the Evaluation and Management (E&M) code used for the ER visit by the program and regions outlined in Tables 7 and 8 based on Low Acuity vs Non-Low Acuity. Acceptable E&M codes are 99281-99285 and an "not classified" column exists to report ER facility claims without E&M codes.
   - Summarize MCO Paid Amount for the facility claim.
   - Count ER facility visits
   - Group all members and count the number of unique members.
   - Count all unique members with a mental health diagnosis.
   - Count all unique members with a substance abuse diagnosis.

   Note, certain members may have a mental health and substance abuse diagnosis and should be counted for each column.

2. Aggregate the MCO paid amount for any professional and ancillary services associated with the ER visit (see Step 7 of Flagging the Data).

**DEFINITIONS**

| Attestation: | This column shall be entered each time a report is submitted and indicate that the report has been checked for adherence to the instructions as well as the accuracy of the data reported. |
| Evaluation and Management (E&M) Code: | The report requires the MCO to input the count of facility visits and cost for the facility visit to the Emergency room based on the E&M code. The only valid values are codes 99281 through 99285. For any ER facility claims without an E&M code please use the "not classified" designation. |
| ER Facility Claim: | **Outpatient ER Claim Logic:**
   a. Claim type should be an outpatient facility claim and the type of bill should equal 131.
   c. Revenue codes 0450, 0451, 0452 and 0459 ONLY
   d. Exclude revenue codes 0456, 0516, 0526 (Urgent Care) AND
   e. Exclude visits resulting in an inpatient hospital stay including an inpatient stay at another facility. |
| Professional / Ancillary Claims: | These are claims associated with the ER visit but not included as part of the facility claim. Examples include but are not limited to:
   1. The attending physician that submits a claim separately for their services.
   2. Radiologist claims for the reading of an X-ray taken during the ER visit. |
| Primary Diagnosis: | The ER facility claims should be evaluated using the Principal diagnosis for designating Low Acuity vs Non-Low Acuity. |
| Mental Health (MH) Diagnosis: | As outlined in Step 3 of Flagging the data, members claims (professional and institutional) should be evaluated for the 12 months prior to the ER visit for diagnosis codes, in any position (primary, secondary etc), using tables 3 and 4. |
| Substance Use Disorder (SUD) Diagnosis: | As outlined in Step 4 of Flagging the data, members claims (professional and institutional) should be evaluated for the 12 months prior to the ER visit for diagnosis codes, in any position (primary, secondary etc), using tables 5 and 6. |
| Region Assignment: | The provider location and regional assignment is the physical location of the ER Facility and not the billing location for the provider. For example if a facility is located in Farmington, NM but their billing is performed in Albuquerque you must use Farmington. |