

# EMERGENCY HEALTH SERVICES AND URGENT CARE CENTER SERVICES

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## INSTRUCTIONS FOR USE

*This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee’s specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.*

*UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines®, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.*

## COVERAGE RATIONALE

### Plan Document Language

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

### **For Medicaid Plans and State Contracts (Kansas, Nebraska, Maryland, Pennsylvania, Texas and Tennessee):**

Please see [Definitions](#) section for specific state definitions of emergency medical condition, emergency medical services, emergency room service and hospital emergency services before using the document. For all other states please review state contracts.

### Indications for Coverage

#### **Emergency Health Services:**

Emergency Health Services are always covered at the Network level; even if a non-Network provider renders services.

Emergency Health Services include, but are not limited to, all related:

- Diagnostic tests
- Treatment
- Supplies
- Physician charges, including but not limited to the Emergency Room physician, consultants, radiologists, anesthesiologists, and pathologists
- Facility charges

**Essential Health Benefits for Individual and Small Group:**

The Affordable Care Act of 2010 (ACA) requires insurers to provide coverage for ten benefit categories, including Emergency services, effective the first plan year on or after January 1, 2014. These requirements apply to all fully insured health plans offered in the Individual and Small Group insured markets (both inside and outside of Exchanges). Essential Health Benefit requirements do not apply to ASO plans (regardless of group size), fully insured Large Group plans or any grandfathered plans.

**Physician-Ordered Emergency Room Visit:**

Emergency room visits that are ordered by a physician (ie. physician directs the patient to the emergency room) for evaluation of a potential emergency condition are covered services. Emergency room visits that are ordered by a physician are covered even if the patient's condition does not meet the definition of Emergency or Emergency Medical Condition.

**Screening and Stabilization of an Emergency Medical Condition (EMC):** <sup>(3) (4)</sup>

Services necessary to conduct a medical screening examination (MSE) are covered (Revenue code 0451). Individuals coming to the emergency department must be provided a medical screening examination appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate medical screening examination may involve a wide spectrum of actions, ranging from:

- A simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures.
- The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred.
- There should be evidence of this ongoing monitoring prior to discharge or transfer. <sup>(3)</sup>

The medical screening examination must be the same medical screening examination that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care.

If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. If the medical screening examination is appropriate and does not reveal an EMC, the hospital has no further obligation under 42 CFR 489.24. <sup>(4)</sup>

Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). <sup>(4)</sup> *(From Transmittal 60)*

Once the individual is screened and it is determined the individual has only presented to the ED for a nonemergency purpose and does not require stabilization (see below), the hospital's Emergency Medical Treatment and Labor Act (EMTALA) obligation ends for that individual at the completion of the medical screening examination. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no EMC. <sup>(4)</sup> (From *Transmittal 60*)

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge. Refer to section below for the plan's obligations regarding services provided following stabilization. <sup>(3)</sup>

### **EMTALA (Hospital's Obligations)**

EMTALA Federal labor law requires that if a patient is determined to have an Emergency Medical Condition then the Emergency Room Staff must screen and stabilize the patient, if possible, before asking about insurance. See definition section below.

### **Emergency Medical Condition:**

Emergency medical condition status is not affected if a later medical review found no actual emergency present. See definition section below. <sup>(3)</sup>

### **Examples of EMTALA Obligation – Examples of Emergency Medical Condition (EMC):** <sup>(4)</sup>

1. **PHARMACY** - If an individual presents to an emergency department (ED) and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation.
2. Surveyors are encouraged to ask probing questions of the hospital staff to determine if the hospital in fact had an EMTALA obligation in this situation (e.g., did the individual present to the ED with an EMC and informed staff they had not taken their medication? Was it obvious from the nature of the medication requested that it was likely that the patient had an EMC?).
3. The circumstances surrounding why the request is being made would confirm if the hospital in fact has an EMTALA obligation.
4. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation.
5. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills.
6. **PREVENTIVE CARE** - If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test), the hospital is not obligated to provide a medical screening examination under EMTALA to this individual.
7. **MEDICAL SCREENING** - Attention to detail concerning blood alcohol testing (BAT) in the ED is instrumental when determining if a medical screening examination is to be conducted. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a **BAT only** and does not request examination or treatment for a medical condition, such as intoxication and a prudent layperson observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED a medical screening examination would be warranted to determine if an EMC exists.
8. When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an **EMTALA obligation to provide a medical screening examination to determine if an EMC exists**. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance.

### **Post-Stabilization Care Services** <sup>(3)</sup>:

Post-stabilization care services are covered services that are (**all below**):

- Related to an emergency medical condition; and
- Provided after an enrollee is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the enrollee's condition.

The plan or plan representative is financially responsible for post-stabilization care services obtained within or outside the plan's network that:

- Are pre-approved by a plan provider or other plan or plan representative;
- Although not pre-approved by a plan provider or other plan or plan representative, are administered to maintain the enrollee's stabilized condition within one hour of a request to the plan for pre-approval of further post-stabilization care (This applies to CMS. Therefore, check the enrollee's state regulations to see if this applies)
- Although not pre-approved by a plan provider or other-plan representative, are administered to maintain, improve, or resolve the enrollee's stabilized condition when:
  - The plan does not respond to a request for pre-approval within one hour;
  - The plan cannot be contacted; or
  - The plan representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation. (In this situation, the plan must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.)

The plan's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- A plan representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

(After the plan assumes responsibility, further care will be covered under the enrollee's benefit in accordance with the enrollee specific plan document).

### **Special Considerations When Determining Stabilization:**

- Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints
- Women in Labor: Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer to hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

## **ADDITIONAL INFORMATION:**

- If the enrollee leaves the emergency room for services in another department (for example radiology or surgical suite) and then returns to the emergency room for discharge, all such services are considered part of the Emergency Health Services benefit. For example, if the enrollee has a broken arm and is brought from the emergency room to the operating room to reduce the fracture, and is then returned to the emergency room for discharge, all services in this encounter would be considered under the emergency health services benefit (i.e., the services in the operating room are NOT considered under the outpatient surgery benefit).
- If the enrollee is admitted to the hospital through the emergency room, the entire encounter is considered an inpatient admission (i.e., including the services rendered in the emergency room), and therefore only the inpatient benefits/copay apply. The fact that the enrollee entered the hospital for admission through the emergency room (versus the admissions door) does not change the benefit for the inpatient admission (i.e., only the inpatient benefit applies). If this emergency admission is at a non-network facility, network benefits will be applied. UnitedHealthcare may elect to transfer the enrollee to a network facility as soon as medically appropriate. If the enrollee chooses to stay at the non-network facility after the date that it is determined a transfer is medically appropriate, non-network benefits will be applied for the remainder of the inpatient stay.
- The Emergency Health Services copayment or benefit level will apply if the enrollee has been placed in an observation bed for the purpose of monitoring the enrollee's condition, rather than being admitted as an inpatient in the hospital.
- State mandates for emergency care impact the benefits for Emergency Health Services.
- Eligible Durable Medical Equipment (DME) that is given for take-home use from the emergency room is not covered under the Emergency Health Services benefit. Rather, eligible DME is covered under the DME section of the COC.
- Eligible accidental dental services performed in an emergency room are covered under the accidental dental benefit, not under the Emergency Health Services benefit.
- Eligible pharmaceutical products administered during an emergency room visit are covered under the Emergency Health Services benefit.
- When the Urgent Care Center is part of a larger facility (e.g. hospital), if the enrollee leaves the Urgent Care Center for services in other parts of the same facility (e.g., radiology department services) and then returns to the Urgent Care Center for discharge, all such services are considered part of the Urgent Care Center encounter. For example, if the enrollee has a fractured arm and is brought from the Urgent Care Center to the radiology department of that same facility for an x-ray, and is then returned to the Urgent Care Center for discharge, all services in this encounter would be considered under the Urgent Care Center services benefit (i.e., the radiology services are NOT applicable to, nor paid from, the outpatient diagnostic benefit).
- Urgent Care Center benefits are applied whether it is a free standing Urgent Care or part of a hospital facility (i.e., Urgent Care benefits, NOT outpatient diagnostic and/or therapeutic benefits, apply if the Urgent Care Center is part of a hospital facility).
- Eligible Durable Medical Equipment (DME) that is given for take-home use from an Urgent Care Center is not covered under the Urgent Care Center Services benefit. Rather, eligible DME is covered under the DME section of the COC.
- Eligible accidental dental services performed in an Urgent Care Center are covered under the accidental dental benefit, not under the Urgent Care Center Services benefit.

Refer to enrollee's plan specific document for coverage of Urgent Care Services (for network vs. non-network coverage).

### **Coverage Limitations and Exclusions**

1. Use of Emergency Room to treat a non-emergency situation (see definition of Emergency) other than services necessary to conduct a medical screening examination and stabilization

services (revenue code 0451). Check enrollee's plan specific documents for possible coverage.

2. Use of Urgent Care Center Services to treat non-urgent conditions (see definition of Urgent Care Center). Check enrollee's plan specific documents for possible coverage.
3. Non-emergency health care services received outside of the United States. Check enrollee's plan specific documents for possible coverage.

For ASO plans with SPD language other than fully-insured Generic COC language Please refer to the enrollee's plan specific SPD for a Definition for Emergency Health Services and/or a list of diagnoses that are considered Emergency Health Services.

## APPENDIX

### **Patient Protection and Affordable Care Act (PPACA) of 2010 (Effective for plan years on or after September 23, 2010)**

**The following information only applies to plans that are subject to the PPACA (Plan's Obligations).** Grandfathered plans, as that term is defined under PPACA, are not required to comply with the patient protection provisions under the law; although a grandfathered plan may amend its plan document to voluntarily comply. Please refer to the enrollee plan specific document for details. *(Also see Appendix for PPCA Regulations.)*

The PPACA rules apply to plans and health insurance issuers that provide benefits with respect to emergency services in an emergency room department of a hospital.

- **Prior Authorization Prohibited:** The rules prohibit prior authorization requirements for emergency services, even if the emergency services are provided by an out-of-network provider.
- **Cost Sharing (Coinsurance and Copayment) Restrictions:** The rules also prohibit plans and issuers from charging higher cost sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network.
- **Calculating a Reasonable Allowed Amount with Respect to Balance Billing:** The rules do not prohibit balance billing, but require that a "reasonable amount" be paid before the member is subject to balance billing.
- **Anti-Abuse Rule:** The rules include an anti-abuse provision with respect to other cost-sharing requirements so that the purpose of limiting copayment and coinsurance amounts for emergency services rendered by out-of-network providers cannot be thwarted by manipulation of other cost-sharing requirements.
- **Application of Other Plan Requirements:** The emergency services must be provided without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under Part 7 of ERISA, Part A of title XXVII of the PHS Act, or Chapter 100 of the Code, or applicable cost-sharing requirements.
- **Prohibition on More Restrictive Administrative Requirements:** Plans and issuers may not impose an administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

**While the rules regarding emergency services do not apply to Grandfathered Plans, other federal and state laws related to these patient protections may apply.**

**Reimbursement of Out-of-Network Providers/Balance Billing** – Because the PPACA does not require plans or issuers to cover balance billing amounts, the rules set forth standards to ensure that a reasonable amount be paid by the plan or issuer for services from out-of-network providers before the member is subject to balance billing. Specifically, a plan or issuer satisfies the

copayment and coinsurance limitations if it provides benefits for out-of-network emergency services in an amount equal to the greatest of three possible amounts:

- The amount negotiated with in-network providers for the emergency service furnished;
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as usual, customary and reasonable charges (UCR)), but substituting the in-network cost sharing provisions for the out-of-network cost sharing provisions; or
- The amount that would be paid under Medicare for the emergency service.

Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the member or member.

**Median In-Network Rate:** If a plan or issuer has more than one contracted rate with in-network providers for a particular emergency service, the plan uses the median of these amounts in determining the negotiated rate as described above. In determining the median, the amount negotiated with each provider is treated as a separate amount (even if the same amount is paid to more than one provider). For example, if for a given emergency service a plan negotiated a rate of \$100 with three providers, a rate of \$125 with one provider and a rate of \$150 with one provider; the amounts taken into account to determine the median would be \$100, \$100, \$100, \$125, and \$150. The median for that service would be \$100.

If there is an even number of negotiated amounts, the median is the average of the middle two. In-network cost sharing imposed with respect to a member would be deducted from this amount before determining the greatest of these three amounts.

For plans under which there is no per-service amount negotiated with network providers (such as under a capitation arrangement), the median in-network rate is disregarded, meaning that the greatest amount is going to be either the out-of-network amount or the Medicare amount.

**General Out-of-Network Rate (e.g., UCR):** The second amount is calculated using the same method the plan generally uses to determine payments for out-of-network services, but without reduction for out-of-network cost sharing. For example, if the plan generally pays 70 percent of UCR, the second amount would be 100 percent of UCR, reduced by the in-network copayment or coinsurance had the service been provided in-network.

**Medicare:** As of the date of publication of the IFR, the Medicare rates are available at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf>.

**Anti-Abuse Rule** – Under the rules any other cost sharing requirement, such as deductible and out-of-pocket maximum, may be imposed for out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may only be imposed for out-of-network emergency services as part of a deductible that generally applies to out-of-network benefits. Similarly, if an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services. The anti-abuse rule is designed to prohibit a plan or issuer from fashioning other cost sharing tools in a way that requires the member to pay more for emergency services than for general out-of-network services.

**Defined Terms** – In applying the rules related to emergency services, the statute and IFR define the terms emergency medical condition, emergency services and stabilize. These terms are generally defined in accordance with their meaning under the Emergency Medical Treatment and Labor Act (EMTALA). There are, however, some variances from EMTALA. One of these differences is that under PPACA, whether an individual is in an emergency medical condition is determined by reference to a prudent lay person, who possesses an average knowledge of health and medicine (rather than by reference to qualified medical personnel).

## DEFINITIONS

**Note: Emergency Care state mandates may override the following definitions.**

**Emergency (UHC plans):** A serious medical condition or symptom resulting from Injury, Sickness or [1Mental Illness][2mental illness] which is both of the following:

- Arises suddenly
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health

**Emergency Medical Condition (EMC):** A medical condition recognizable by symptoms (including severe pain, serious injury) that a person, with an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in:

- a) placing the member's health in serious risk;
- b) serious harm to bodily functions;
- c) serious dysfunction of any bodily organ or part; or
- d) in the case of a pregnant woman, an active labor meaning labor at a time when either of the following would occur:
  - 1. there is not enough time to safely transfer the member to another hospital before delivery
  - 2. the transfer may pose a threat to health and safety of member or unborn child

Note: Emergency medical condition status is not affected if a later medical review found no actual emergency present.

**EMTALA (federal labor law):** Emergency medical condition means:

- (i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - a. 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;
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunction of any bodily organ or part; or
- (ii) With respect to a pregnant woman who is having contractions:
  - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - b. That transfer may pose a threat to the health or safety of the woman.

### **Kansas Medicaid**

**Emergency Medical Condition (for Kansas Medicaid):** Eligibility exists under this section only if a person has experienced an approved emergency medical condition. The emergency service must be required after the sudden onset of a medical condition (including labor and delivery) 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:

- 1. Placing the patient's health in serious jeopardy;
- 2. Serious impairment to bodily functions; or
- 3. Serious dysfunction of any bodily organ or part.

### **Maryland Medicaid**

**Emergency Room Services - for Maryland Medicaid:** COMAR 10.09.62.01B paragraph (45) states, "Emergency services means 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 the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- a) Placing the patient's health, or with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;
- b) Serious impairment to bodily functions; or
- c) Serious dysfunction of any bodily organ or part."

### **Nebraska Medicaid**

**Emergency Medical Condition - for Nebraska Medicaid:** A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy,
- b) serious impairment to such person's bodily functions,
- c) serious impairment of any bodily organ or part of such person, or
- d) serious disfigurement of such person

### **Emergency Room Services - for Nebraska Medicaid:**

18-004.20 Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (a medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances that may present a substantial risk to an individual's health unless immediate medical assessment and/or treatment is done);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be submitted with the claim);
4. The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly. When the facility or the Department determines service are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. When these conditions are met, **the physician's fee will be disallowed to the rate of a comparable office service.**

**Hospital Emergency Services - for Nebraska Medicaid:** Services that are necessary to prevent the death of the client or serious impairment of the client's health and, because of the threat to the life or health of the client, necessitate the use of the most accessible hospital equipped to provide the necessary services

### **Pennsylvania Medicaid**

**Emergency Medical Condition - for Pennsylvania Medicaid:** 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:

- i. 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,
- ii. serious impairment to bodily functions, or
- iii. serious dysfunction of any bodily organ or part.

[Emergency Situation: A condition in which immediate medical care is necessary to prevent the death or serious impairment of health of the individual.]

**Emergency Medical Care - for Pennsylvania Medicaid:** For Medical care rendered in response [to the sudden onset of a medical condition requiring medical, nor surgical, intervention to sustain the life of the person or to prevent damage to the person's **health** and which the recipient secures immediately after the onset, or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset] an emergency medical condition as defined in § 1101.21 of this title. [In order to determine whether a medical emergency existed and, therefore, whether benefits for outpatient services in connection with the treatment of the condition are payable on an emergency basis, the following criteria shall be applied:

- i. *Severe symptoms have to occur*--The symptoms must be sufficiently severe to cause a person to seek immediate medical aid. Some symptoms or conditions indicating medical emergency care are listed in Appendix A.
- ii. *Severe symptoms must occur suddenly and unexpectedly*--Subacute symptoms of a chronic condition would not qualify as a medical emergency. However, chronic symptoms that suddenly become severe enough to require immediate intervention would qualify.]

**Note:** Payment will not be made to clinics or emergency rooms for the following services or items: Non-emergency use of the emergency room. Services **[to patients who do not exhibit symptoms or have a diagnosis that is listed in Appendix A] that do not meet the definition of emergency medical care of this chapter** are not reimbursable unless the recipient declares that he/she does not have access to a primary care physician or an outpatient clinic to **[treat nonemergency situations] receive nonemergency care**. The hospital emergency room staff and/or the emergency room physician must document in the patient's medical record the declaration of no access to primary care

#### **APPENDIX A. MEDICAL EMERGENCY CARE SYMPTOMS for Pennsylvania Medicaid**

Allergy Reactions, Acute (Except Allergy Tests)  
 Appendicitis, Acute  
 Asthma, Acute  
 Breathing Difficulties or Shortness of Breath  
 Bronchitis, Severe  
 Bursitis, Severe Onset  
 Chest Pain, Severe  
 Choking  
 Colitis  
 Coma  
 Convulsions and/or Seizures  
 Cystitis  
 Dermatitis or Hives (Resulting From Internal or Unknown Causes)  
 Diabetic Coma  
 Diarrhea, Severe  
 Drug Reaction  
 Earache, Severe  
 Epistaxis (nosebleed)  
 Fainting  
 Fecal Impaction, Severe  
 Food Poisoning

Frost Bite  
 Gall Bladder, Acute Attack  
 Gastritis  
 Gastro-intestinal Conditions, Acute  
 Glaucoma, Severe  
 Headache, Severe  
 Heart Attack, Suspected  
 Hemorrhage  
 Hysteria  
 Insulin Shock (Overdose)  
 Kidney Stones  
 Maternity Complications, Such As Suspected Miscarriage  
 Pain, Sudden or Severe Onset  
 Pleurisy  
 Pneumonitis  
 Poisoning (including overdose)  
 Pyelitis  
 Pyelonephritis (Shock)  
 Spasms, Cerebral or Cardiac  
 Spontaneous Pneumothorax  
 Stomach Pain, Severe  
 Strangulated Hernia  
 Stroke  
 Sunstroke  
 Swollen Ring Finger  
 Tachycardia  
 Thrombosis and/or Phlebitis  
 Unconsciousness  
 Urinary Retention, Acute  
 Vision Loss, Sudden Onset Vomiting, Severe]

### **Tennessee Medicaid - TennCare**

**Emergency Medical Condition - for Tennessee Medicaid (TennCare):** The regulations from the Balanced Budget Act (BBA) of 1997 that govern Medicaid managed care programs require use of the “prudent layperson” standard. Per 42 C.F.R. § 438.114(a),<sup>8</sup> an emergency is defined as a situation in which 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.”

“All labor and delivery is considered emergency labor and delivery.” This definition is applicable to the groups of aliens who cannot get full Medicaid. **Note that the prudent layperson does not apply to legal or illegal aliens.**

### **Texas Medicaid – Texas Star Plan**

**Emergency Behavioral Health Condition – for Texas Star Plan:** Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- 1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or

- 2) that renders Members incapable of controlling, knowing or understanding the consequences of their actions.

**Emergency Medical Condition – for Texas Star Plan:** means a medical condition manifesting itself by acute symptoms of recent onset and 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 care could result in:

- 1) placing the patient's health in serious jeopardy;
- 2) serious impairment to bodily functions;
- 3) serious dysfunction of any bodily organ or part;
- 4) serious disfigurement; or
- 5) serious jeopardy to the health of a pregnant woman or her unborn child.

A Provider does not need the medical consent of the Member's Medical Consenter to provide Emergency Services for a Member that has an Emergency Medical Condition. The MCO must contractually require the Provider to notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Texas Family Code §266.009. The notification must be documented in the Member's Health Passport

When the medical screening examination determines that an Emergency Medical Condition or an Emergency Behavioral Health Condition exists, the MCO must pay for Emergency Services performed to stabilize the Member (Post-Stabilization Care Services). The emergency physician must document these services in the Member's medical record. The MCO must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

The MCO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope required by 42 C.F.R. §438.114(b)&(e) and 42 C.F.R. §422.113(c).  
[http://www.hhsc.state.tx.us/medicaid/STAR\\_Health.pdf](http://www.hhsc.state.tx.us/medicaid/STAR_Health.pdf)

**Emergency Department:** A portion of a hospital where staff provide emergency diagnosis and treatment of illness or injury. These centers provide access to major surgeries and special care units, as they are located within a hospital. The correct place of service code to use when billing for emergency room services is 23 / Emergency Room.

**Stabilization (CMS):**

Section 42 CFR 489.24(b) defines stabilized to mean:

"... that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that a woman has delivered the child and the placenta."

The regulation sets the standard determining when a patient is stabilized.

**Urgent Care Center (UHIC 2007 and 2011 COC):** A facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**Urgent Care Center (UHIC 2001 COC):** A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**Urgent Care:** Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgently Needed Services:** Covered services provided when you are temporarily absent from the Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your network Medical Provider is temporarily unavailable or inaccessible), when such services are Medically Necessary and immediately required: 1) as a result of an unforeseen illness, injury or condition; and 2) it is not reasonable, given the circumstances, to obtain the services through your network Medical Provider.

## APPLICABLE CODES

The codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply.

CPT<sup>®</sup> is a registered trademark of the American Medical Association.

<b>Limited to specific procedure codes?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <ul style="list-style-type: none"> <li>The Emergency Health Services and Urgent Care benefits are <b>not</b> limited to the following codes.</li> <li>Except for DME and Accidental Dental, all otherwise eligible CPT and HCPCS are also eligible when billed with ER place of service. (See <a href="#">Indications for Coverage</a> section above for explanation regarding DME and Accidental Dental.)</li> </ul>
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Emergency Health Services CPT <sup>®</sup> Codes	
CPT <sup>®</sup> Code	Description
99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

<b>Emergency Health Services CPT® Codes</b>	
<b>CPT® Code</b>	<b>Description</b>
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

<b>Emergency Health Services CPT® Codes</b>	
<b>CPT® Code</b>	<b>Description</b>
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

<b>Emergency Health Services CPT® Codes</b>	
<b>CPT® Code</b>	<b>Description</b>
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99288	Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support

<b>Emergency Health Services HCPCS Codes</b>	
<ul style="list-style-type: none"> <li>• These G-codes are only to be used by facility providers. These codes should not be used by physicians.</li> <li>• These codes may not be paid separately; refer to Reimbursement Policy.</li> </ul>	
<b>HCPCS Code</b>	<b>Description</b>
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care
G0380	Level 1 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without

**Emergency Health Services HCPCS Codes**

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- These codes may not be paid separately; refer to Reimbursement Policy.

HCPCS Code	Description
	requiring a previously scheduled appointment)
G0381	Level 2 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382	Level 3 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0383	Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

<b>Emergency Health Services HCPCS Codes</b>	
<ul style="list-style-type: none"> <li>• These G-codes are only to be used by facility providers. These codes should not be used by physicians.</li> <li>• These codes may not be paid separately; refer to Reimbursement Policy.</li> </ul>	
<b>HCPCS Code</b>	<b>Description</b>
G0384	Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0390	Trauma response team associated with hospital critical care service

<b>Urgent Care Codes</b>	
<b>Code</b>	<b>Description</b>
S9083	Global fee urgent care centers
S9088	Services provided in an urgent care center (list in addition to code for service)

<b>Limited to specific diagnosis codes?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (see note)
<b>This benefit <u>cannot</u> solely be administered via diagnosis codes.</b>	

<b>Limited to place of service (POS)?</b>	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
	<b>Emergency Health Services:</b> Emergency room – hospital (23)  <b>Urgent Care:</b> Urgent Care Facility (20)

<b>Limited to specific provider type?</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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<b>Limited to specific revenue codes</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>The Emergency Health Services and Urgent Care benefits are NOT limited to the following codes. All otherwise eligible Revenue codes are also eligible when billed with Emergency Room or Urgent Care Facility place of service.</i>
<b>Emergency Health</b>	
450	Emergency room – general
451	Emergency room – emtala emergency medical screening services
452	ER beyond emtala screening

<b>Limited to specific revenue codes</b>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>The Emergency Health Services and Urgent Care benefits are NOT limited to the following codes. All otherwise eligible Revenue codes are also eligible when billed with Emergency Room or Urgent Care Facility place of service.</b>
459	Emergency room – other emergency room
681	Trauma response – level 1
682	Trauma response – level 2
683	Trauma response – level 3
684	Trauma response – level 4
689	Trauma response – other
760	Treatment or observation room – general
762	Treatment or observation room – observation room
981	Professional fees – emergency room
<b>Urgent Care</b>	
456	Urgent care
516	Urgent care clinic – hospital based
526	Urgent care clinic – free standing

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2. Major Provisions of the Patient Protection and Affordable Care Act and their Relevance to the American Medical Association’s Health Insurer Code of Conduct Principles: <http://www.ama-assn.org/resources/doc/psa/ppaca-coc-relevance.pdf>
3. Medicare Managed Care Manual (Pub. 100-16), Chapter 4 Benefits and Beneficiary Protections, Section 20 Ambulance, Emergency and Urgently Needed, and Post-Stabilization Care Services: <http://www.cms.gov/manuals/downloads/mc86c04.pdf>.
4. CMS Manual System, Pub. 100-07 State Operations, Provider Certification, Transmittal 60, Date: July 16, 2010, SUBJECT: Revisions to Appendix V-Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R60SOMA.pdf>
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11. Texas Star Plan  
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**GUIDELINE HISTORY/REVISION INFORMATION**

<b>Date</b>	<b>Action/Description</b>
08/01/2014	<ul style="list-style-type: none"><li data-bbox="574 289 1395 321">• Routine review; no change to coverage determination guidelines</li><li data-bbox="574 321 1395 352">• Archived previous policy version CDG.010.01</li></ul>