MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Emergency Care Services**
Policy Number	**10.01.12**
Category	**Government Mandate**
Effective Date	**05/09/12**
Revised Date	**04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 04/25/19, 04/23/20**
Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.* • *If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.*

POLICY STATEMENT

I. The Health Plan defines "Emergency Condition" as a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
   A. Placing in serious jeopardy, the health of the person afflicted with such condition; or, with respect to a pregnant woman, the health of the woman or her unborn child; or, in the case of a behavioral condition, the health of such person or others; or
   B. Serious impairment to such person's bodily functions; or
   C. Serious dysfunction of any bodily organ or part of such person; or
   D. Serious disfigurement of such person.

   Medical conditions that are considered to be Emergency Conditions include, but are not limited to: severe chest pain, severe or multiple injuries, severe shortness of breath, sudden change in mental status (i.e., disorientation), severe bleeding, acute pain, or a condition requiring immediate attention, such as a suspected heart attack, appendicitis, poisoning, or convulsions. Conditions not ordinarily considered to be Emergency Conditions include a cough, runny nose, ear ache, or small cut or bruise.

II. The Health Plan defines "Emergency Services," with respect to an Emergency Condition, as:

   A. A medical screening examination that is within the capability of the Emergency Department of a hospital, including ancillary services routinely available to the Emergency Department to evaluate such Emergency Condition; and

   B. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

   For the purpose of this definition, "to stabilize" means, with respect to an Emergency Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a facility or the delivery of a newborn child (including the placenta).

III. Emergency Services are **eligible for coverage** regardless of whether the services are provided by a participating provider or a non-participating provider.

IV. The Health Plan does not require prior authorization for Emergency Services.

Refer to Corporate Medical Policy #11.01.15 Medically Necessary Services.

POLICY GUIDELINES

I. The Health Plan's coverage of Emergency Services is subject to the provisions of the member's subscriber contract and, as applicable, the emergency care provisions of the New York Insurance and Public Health Laws and the federal Patient Protection and Affordable Care Act (PPACA). This policy is not applicable to grandfathered, self-funded benefit plans; please refer to the member's plan document/summary plan description and/or benefit booklet for specific plan information.

II. Member cost-sharing for Emergency Services is the same whether the services are rendered within or outside of the Health Plan's participating provider network.

III. Some self-funded benefit plans require the Health Plan to conduct retrospective review of the medical necessity of Emergency Services. Please refer to the member's plan document/summary plan description and/or benefit booklet for specific plan information.

IV. If additional clinical information is needed in order to determine whether Emergency Services were truly provided to treat an Emergency Condition, as defined in Policy Statement I, the Health Plan requests it from the billing facility and allows the mandated timeframe for response. When the information is received, the Health Plan conducts a medical review based on the clinical documentation of the member's presenting symptoms and the prudent layperson standard. If no information is received within the required timeframe, the Health Plan conducts a medical review based on the information that it has received up to that point (e.g., the original claim) and the prudent layperson standard. Members have the right to appeal the denial of Emergency Services claims.

V. In general, care that is in follow-up to an emergency room visit (e.g., physical therapy) is not considered an emergency service to treat an emergency condition.

VI. Members may not be balance-billed for Emergency Services. A member is only responsible for the in-network cost-sharing specified in the member's subscriber contract.

DESCRIPTION

The Health Plan's definition of "emergency condition" is derived from the combined emergency care requirements of the New York Insurance and Public Health Laws and PPACA. It applies to all Health Plan members, with the exception of those covered under grandfathered, self-funded benefit plans that have not adopted the emergency care standards of state and federal law.

"Emergency Services" are services rendered in the Emergency Department of a hospital, to evaluate and stabilize and/or treat a patient's Emergency Condition.

Emergency Services rendered to a member shall not be subject to prior authorization, and reimbursement for Emergency Services shall not be denied retrospectively, if determined to be medically necessary to stabilize or treat an Emergency Condition. Benefit plans that are subject to the emergency care requirements of New York State and/or federal law (PPACA) are not permitted to impose limitations on emergency treatment rendered at an out-of-network facility that are more restrictive than those applicable to emergency treatment rendered at an in-network facility. In addition, a member's financial responsibility for Emergency Services is limited to the in-network cost-sharing of the member's subscriber contract.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

CPT Codes

Code	Description
Several	

HCPCS Codes

Code	Description
Several	

ICD10 Codes

Code	Description
Several	

REFERENCES

Federal Patient Protection and Affordable Care Act, Section 2719A.

New York State Insurance Laws. §4900 (c) and §4902 (a) (8).

U.S. Congress. Social Security Act, Section 1867, §1395dd.

*Key Article

KEY WORDS

Emergency services/care.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, emergency care service is not addressed in a National or Local Medicare coverage determination or policy.