10.2 - Emergent and Urgent Care

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.401) Each Medicare enrollee is entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the *Medicare cost plan* if those services are:

- Emergency services or urgently needed services as defined below. The *Medicare cost plan* must pay for emergent and urgently needed services even from providers and suppliers outside the *Medicare cost plan* and even in the absence of the *Medicare cost plan*'s prior approval (42 CFR 417.414(c)); or

- Services denied by the Medicare cost plan and found upon appeal to be services the enrollee was entitled to have furnished by the *Medicare cost plan*.

Emergency Services means covered inpatient or outpatient services that are furnished by an appropriate source other than the *Medicare cost pla*n that:

- Are needed immediately because of an injury or sudden illness; or

- Are such that the time required to reach the *Medicare cost plan*'s providers or suppliers (or alternatives authorized by the *Medicare cost plan*) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as *(a)* transfer of the enrollee to the *Medicare cost plan*'s source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would

be unreasonable, given the distance and the nature of the ***medical*** condition; and *(b)* such services must be, or appear to be, needed immediately.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. For example, if the attending physician orders diagnostic pulmonary angiography as part of the evaluation for a member who is treated in an emergency room for chest pain, then a retrospective review, cannot decide that the angiography was unnecessary and refuse coverage.

The Medicare cost plan is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, the Medicare cost plan is not responsible for any costs, such as a biopsy, associated with treatment of skin lesions performed by the attending physician who is treating a fracture.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the Medicare cost plan.

Urgently Needed Services means covered services that are needed by an enrollee who is temporarily absent from the *Medicare cost plan*'s geographic area and that:

- Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and
- Cannot be delayed until the enrollee returns to the *Medicare cost plan*'s geographic area.

The Medicare cost plan need not pay for post-stabilization services offered outside of its network or not approved by the *Medicare cost plan* if:

- These services are not emergency;
- These services are not urgently needed; and
- These services are not offered by the *Medicare cost plan* as a basic or optional supplemental benefit.

However, medically necessary follow-up care to emergency and urgent care is covered, if the care cannot be delayed without adverse medical effects.

Routine out-of-area renal dialysis is covered only under original Medicare.