Emergency and Urgent Services

Policy Number: BIP058.K
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➲ Instructions for Use

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Related Benefit Interpretation Policy

- Ambulance Transportation

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

No Surprises Act - Federal Register: Requirements Related to Surprise Billing; Part I

See link below for information on the act.

- https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- Surprise Medical Bills: New Protections for Consumers Take Effect in 2022 | KFF

The above indicates that the Federal Register states the following to be covered:

Consumer Protections Under Federal Law

- Health plans must cover surprise bills at in-network rates.
- Balance billing is prohibited.
- Out-of-network providers cannot send patients bills for excess charges.
- Specific oversight and enforcement activities are required.

Resolving Payment Amount for Surprise Bills

Other Provisions

- Health plans must provide an advanced explanation of benefits.
- Health plans must provide transitional continuity of coverage when a provider leaves the network.
- Health plans must maintain accurate provider network directories.
- Health plans must disclose information about broker commissions.

42 Code of Federal Regulations (CFR) Section 489.24, Emergency Medical Treatment and Active Labor Act (EMTALA)

- (Full text available at http://www.emtala.com/law/index.html)
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-B/section-489.24
- https://crsreports.congress.gov/product/pdf/IF/IF12355
- 42 USC 1395dd: Examination and treatment for emergency medical conditions and women in labor

"All hospitals, regardless of contractual relationship, must provide for an appropriate medical screening exam (MSE). The hospital's emergency room department is required to determine whether an emergency medical condition exists or whether the member is in active labor. The hospital may not delay the examination or treatment in order to inquire into the member's method of payment or insurance status. This law was enacted due to complaints that hospitals were refusing to treat indigent patients in their emergency rooms and referring (dumping) them to county facilities for care.

If an emergency medical condition exists (e.g., if the member's health is in serious jeopardy or if there is a reasonable likelihood of serious impairment to bodily functions or of serious dysfunction of any bodily organ or part) or if a pregnant woman is in labor, the hospital must either:

- Provide further medical examination and treatment as may be required to stabilize the member's medical condition or provide for treatment of the labor; or
- Transfer the individual to another medical facility if such a transfer is appropriate. If the member refuses to be treated or does not consent to an appropriate transfer, the hospital will be deemed to have met its obligations under its provider agreement. [SSA 1867(b)].

The transfer of an emergency room patient who has not been properly treated, as described above is not appropriate unless the member (or a person acting in his behalf) requests a transfer or a physician has certified that the medical benefits to be obtained from appropriate medical treatment outweigh the risks of transfer and the receiving hospital must agree to accept the member, and it must be provided with all relevant medical records from the transferring hospital. Participating hospitals with specialized facilities cannot refuse to accept a member who needs those facilities. The transfer must be effectuated by qualified personnel using appropriately equipped transportation. [SSA 1867(c)]

House of Representatives 3590, Section 2719A, Federal Regulation 37188 (Jun. 28, 2010)

https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Non-grandfathered plans are required to afford members several patient protections, including:

- The ability to select any participating primary care provider (PCP) as their PCP;
- The ability for parents to select a participating pediatrician as their child's PCP; and
- For female members, direct access to a participating OB/GYN professional without the need to obtain a prior authorization or referral.

Non-grandfathered plans that provide benefits for services in the emergency department of a hospital also must comply with a number of rules, including:

- A prohibition on prior authorization requirements for emergency services, even if the services are rendered by an out-of-network provider;
- A requirement that cost-sharing requirements (i.e., copayment and coinsurance) for out-of-network emergency services not exceed cost-sharing requirements for in-network emergency services;
- A requirement to pay a "reasonable amount" to out-of-network providers before the member is subject to balance billing; and
- A prohibition on applying administrative requirements or benefit limitations to out-of-network emergency services that are more restrictive than requirements or limitations applied to in-network emergency services.

These provisions apply to fully insured and self-funded plans, group and individual insurance coverage. They are effective for plan years beginning on or after September 23, 2010.

Oklahoma

Oklahoma Statutes Title 36, Section 6907 (L), (M), (N), (O), and (P)

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=436553

(L) Decisions by a health maintenance organization to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:
  (1) Jeopardy to the health of the patient;
  (2) Impairment of bodily function; or
  (3) Dysfunction of any bodily organ or part.

(M) Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO.

(N) Health maintenance organizations shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the HMO contract.

(O) If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a health maintenance organization fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate

specialist that are medically necessary to attain stabilization of an emergency medical condition, and the HMO shall not deny coverage for the services due to lack of prior authorization.

(P) The reimbursement policies and patient transfer requirements of a health maintenance organization shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of an HMO is transferred from a hospital emergency department facility to another medical facility, the HMO shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

Oklahoma Administrative Code Section 365:40-5-20, Basic Health Care Services

- http://www.oar.state.ok.us/oar/codedoc02.nsf/frmMain?OpenFrameSet&Frame=Main&Src=_75tnm2shfcdnm8pb4dthj0chedppmcbq8dtmmak31ctijujrgcln50ob7ckj42tbkdt374obdcli00_
- https://regulations.justia.com/states/oklahoma/title-365/chapter-40/subchapter-5/part-5/section-365-40-5-20/

Basic health care services shall include:

(5) Medically necessary emergency health services, which shall include instructions to enrollees on how to get medically necessary emergency health services both in and out of the service area.

Oregon

Oregon Revised Statutes Section 743A.012, Emergency Services

https://www.oregonlaws.org/ors/743A.012

(1) As used in this section:

(a) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(b) "Behavioral health clinician" means:

(A) A licensed psychiatrist;
(B) A licensed psychologist;
(C) A licensed nurse practitioner with a specialty in psychiatric mental health;
(D) A licensed clinical social worker;
(E) A licensed professional counselor or licensed marriage and family therapist;
(F) A certified clinical social work associate;
(G) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or
(H) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(c) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

(d) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
(i.) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
(ii.) Result in serious impairment to bodily functions; or
(iii.) Result in serious dysfunction of any bodily organ or part;
(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child; or
(C) That is a behavioral health crisis.

(e) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(f) "Emergency medical service provider" has the meaning given that term in ORS 682.025 (Definitions). (https://oregon.public.law/statutes/ors_682.025 means a person who has received formal training in prehospital and emergency care, and is licensed to attend any person who is ill or injured or who has a disability. Police officers, firefighters, funeral home employees and other persons serving in a dual capacity one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of this chapter.)

(g) "Emergency medical services transport" means an emergency medical services provider's evaluation and stabilization of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

(h) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical services transport;
(B) An emergency medical screening exam or behavioral health assessment 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 medical condition; and
(C) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(i) "Grandfathered health plan" has the meaning given that term in ORS 743B.005.
(j) "Health benefit plan" has the meaning given that term in ORS 743B.005.
(k) "Prior authorization" has the meaning given that term in ORS 743B.001.
(l) "Stabilize" means to provide medical treatment as necessary to:
(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and
(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.
(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:
(a) For the services of participating providers, without regard to any term or condition of coverage other than:
(A) The coordination of benefits;
(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;
(C) An exclusion other than an exclusion of emergency services; or
(D) Applicable cost-sharing; and
(b) For the services of a nonparticipating provider:
(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;
(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;
(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and
(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.
(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:
(a) What constitutes an emergency medical condition;
(b) The coverage provided for emergency services;
(c) How and where to obtain emergency services; and
(d) The appropriate use of 9-1-1.
(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.
(6) This section is exempt from ORS 743A.001. [Formerly 743.699; 2011 c.500 §38; 2017 c.273 §4; 2019 c.358 §41]

Texas

Texas Insurance Code (TIC), Health Maintenance Organizations, General Provisions, Section 843.002, Definitions

https://texas.public.law/statutes/tex._ins._code_section_843.002

(7) "Emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:
(A) Place the individual's health in serious jeopardy;
(B) Result in serious impairment to bodily functions;
(C) Result in serious dysfunction of a bodily organ or part;
(D) Result in serious disfigurement; or
(E) For a pregnant woman, result in serious jeopardy to the health of the fetus.

TIC, Preferred Provider Benefit Plans, General Provisions, Section 1301.155, Emergency Care

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1301.htm#1301.155

(a) In this section, "emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
  (1) Placing the person's health in serious jeopardy;
  (2) Serious impairment to bodily functions;
  (3) Serious dysfunction of a bodily organ or part;
  (4) Serious disfigurement; or
  (5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:
  (1) A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;
  (2) Necessary emergency care services, including the treatment and stabilization of an emergency medical condition;
  (3) Services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and
  (4) Supplies related to a service described by this subsection.

(c) For emergency care subject to this section or a supply related to that care, an insurer shall make a payment required by this section directly to the out-of-network provider not later than, as applicable:
  (1) The 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or
  (2) The 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(d) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:
  (1) Is based on:
    (A) The amount initially determined payable by the insurer; or
    (B) If applicable, a modified amount as determined under the insurer's internal appeal process; and
  (2) Is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.

Texas Administrative Code (TAC), Title 28, Section 11.506 (9), Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=506

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions:
  (9) Emergency services. A description of how to obtain services in emergency situations including:
    (A) What to do in case of an emergency occurring outside or inside the service area;
    (B) A statement of any restrictions or limitations on out-of-area services;
    (C) A statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;
    (D) A statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition; and
    (E) A statement that where stabilization of an emergency condition originated in a hospital emergency facility or comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that:
      (i) The HMO must approve or deny coverage of post stabilization care as requested by a treating physician or provider; and

(ii) The HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request; and

(F) For purposes of this paragraph, "comparable facility" includes the following:

(i) Any stationary or mobile facility, including but not limited to Level V Trauma Facilities and Rural Health Clinics that have licensed or certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002 (concerning Definitions);

(ii) For purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

(I) A facility operated by the Texas Department of State Health Services;

(II) A private mental hospital licensed by the Texas Department of State Health Services;

(III) A community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment);

(IV) A facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) An identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) A hospital operated by a federal agency.

TAC Title 28, Section 11.508, Mandatory Benefit Standards

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9) or §11.506(b)(14) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):

(1) Outpatient services, including the following:

(J) Emergency services as required by Insurance Code §1271.155(concerning Emergency Care), including emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus;

TIC Benefits Provided by Health Maintenance Organizations, Evidence of Coverage; Charges, General Provisions, Section 1271.155, Emergency Care

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1271&Phrases=1271.155&HighlightType=1&ExactPhrase=False&QueryText=1271.155

(a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) A medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) Necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and

(3) Services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d).

(c) A health maintenance organization shall approve or deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees.

(f) For emergency care subject to this section or a supply related to that care, a health maintenance organization shall make a payment required by Subsection (a) directly to the non-network physician or provider not later than, as applicable:
  (1) The 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or
  (2) The 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(g) For emergency care subject to this section or a supply related to that care, a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that:
  (1) Is based on:
    (A) The amount initially determined payable by the health maintenance organization; or
    (B) If applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and
  (2) Is not based on any additional amount determined to be owed to the physician or provider under Chapter 1467.

(h) This section may not be construed to require the imposition of a penalty under Section 843.342.

Washington

Revised Code of Washington (RCW) Section 48.43.005, Definitions (Effective Until Jan. 1, 2020)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.005

(13)"Emergency medical condition" means 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 a condition (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.

(14)"Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

RCW Section 48.43.005, Definitions (Effective Until Jan. 1, 2022)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.005

(15)"Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including but not limited to severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (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.

(16) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

RCW Section 48.43.005, Definitions (Effective Jan. 1, 2022)

(17)"Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (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.

(18)"Emergency services" means:

(a) (i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;

(ii) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid 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, or serious dysfunction of any bodily organ or part; or

(b) (i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid 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, or serious dysfunction of any bodily organ or part.

RCW Section 48.43.093, Health Carrier Coverage of Emergency Medical Services – Requirements – Conditions (Effective Until Jan. 1, 2020)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.093

(1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital emergency department would result in a delay that would worsen the emergency.

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce

payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

(c) Coverage of emergency services may be subject to applicable co-payments, coinsurance, and deductibles, and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars. Differential cost sharing for emergency services may not be applied when a covered person presents to a nonparticipating hospital emergency department rather than a participating hospital emergency department when the health carrier requires preauthorization for post-evaluation or poststabilization emergency services if:
   (i) Due to circumstances beyond the covered person's control, the covered person was unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health; or
   (ii) A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health.

(d) If a health carrier requires preauthorization for post-evaluation or poststabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for post-evaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary post-evaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

(e) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if a nonparticipating emergency provider and health plan cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

(2) Nothing in this section is to be construed as prohibiting the health carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services. [1997 c 231 § 301.]

RCW Section 48.43.093, Health Carrier Coverage of Emergency Medical Services – Requirements – Conditions (Effective Until Mar. 31, 2022)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.093

(1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from an out-of-network hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person. In addition, a health carrier shall not require prior authorization of the services provided prior to the point of stabilization.

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

(c) Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.

(2) If a health carrier requires preauthorization for post evaluation or post stabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for post evaluation or post stabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the

health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary post evaluation and post stabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

(3) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if an out-of-network emergency provider and health carrier cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

(4) Nothing in this section is to be construed as prohibiting the health carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services.

RCW Section 48.43.093, Health Carrier Coverage of Emergency Medical Services – Requirements – Conditions (Effective Mar. 31, 2022)

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.093

(1) (a) A health carrier shall cover emergency services provided to a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of emergency services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating hospital emergency department or behavioral health emergency services provider, a health carrier shall cover emergency services. In addition, a health carrier shall not require prior authorization of emergency services.

(b) A health carrier shall cover emergency services without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. Any determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms and not solely on the final diagnosis.

(2) Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.

(3) Nothing in this section is to be construed as prohibiting a health carrier from:

(a) Requiring notification of stabilization or inpatient admission within the time frame specified in its contract with the hospital or behavioral health emergency services provider or as soon thereafter as medically possible but no less than twenty-four hours; or

(b) Requiring a hospital or emergency behavioral health emergency services provider to make a documented good faith effort to notify the covered person's health carrier within 48 hours of stabilization, or by the end of the business day following the day the stabilization occurs, whichever is later, if the covered person needs to be stabilized. If a health carrier requires such notification, the health carrier shall provide access to an authorized representative seven days a week to receive notifications.

(4) Except to the extent provided otherwise in this section, follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services.

State Market Plan Enhancements

Oklahoma

- An **emergency medical condition** is any injury, illness or condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the member, as a prudent layperson, to result in any of the following:
  - Placing the member's health in serious jeopardy (or in the case of a pregnant woman, serious jeopardy to the health of the fetus);
  - Serious impairment to his or her bodily functions;
  - A serious dysfunction of any bodily organ or part.

  Note: An emergency medical condition **does not** include services provided at a hospital emergency room that a prudent layperson could have obtained at their contracting primary care physician's office or where there is a pattern of the member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.
- **Urgently needed services:** Covered services that, due to an unforeseen illness or injury, appear to be required in order to prevent serious deterioration of the member's health when the member is temporarily absent from the service area (out of area) and receipt of healthcare services cannot by delayed until the member returns to the service area.
- Refer to the *Federal/State Mandated Regulations* section for the definition of "**emergency services**".

An emergent referral out of the service area is covered when authorized by UnitedHealthcare or the medical group.
  - The most appropriate form of transportation, based on the member's medical condition, will be covered to and from the out of area facility (for example, the member may be transferred to the facility via air ambulance and returned via economy/coach on a commercial airline).
  - Travel related to emergent referrals is only applicable to the member who needs medical care and is not applicable to family members.

Oregon

Emergency medical condition as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the member, as a prudent layperson, to result in any of the following:

- Placing the member's health in serious jeopardy;
- Serious impairment to his or her bodily functions;
- A serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would happen:
- There is not enough time to effect a safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the member or unborn child.
- **Note**: An emergency medical condition **does not** include services provided at a hospital emergency room that a prudent layperson could have obtained at their network PCP's office or where there is a pattern of the member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.

Emergency Health Care Services – With Respect to an Emergency

A medical screening exam (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) 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, and further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)). (For a detailed explanation of emergency health care services, refer to the *Federal/State Mandated Regulations* section above.)

Urgently Needed Services

Are covered health care services that are provided when the member's network medical group is temporarily unavailable or inaccessible. This includes when the member is temporarily absent from the geographic area served by their network medical group. These services must be medically necessary and cannot be delayed because of an unforeseen illness, injury, or condition.

Emergency Health Care Services from an Out-of-Network Provider

The following provisions apply for emergency medical services from an out-of-network provider:

- Are covered without applying any additional requirements or coverage limitations that are more restrictive than those covered when receiving treatment from a network providers;
- Are covered at the same share of co-payment or co-insurance amount as when services are received from a network providers;
- Are covered without imposing additional or separate deductible; and
- Are covered without imposing additional or separate out-of-pocket limit that applies to all services from network providers.

Texas

- **Emergency Services**: Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
  - Placing the member's health in serious jeopardy;
  - Serious impairment to bodily functions;
  - Serious dysfunction of any bodily organ or part;
  - Serious disfigurement; or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

  Note: An emergency service **does not** include services provided at a Hospital emergency room that a prudent layperson could have obtained at their contracting primary care physician's office or where there is a pattern of the member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.

- **Urgently Needed Services:** Health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.
- **Post Stabilization Care:** Services originating in a hospital emergency department or comparable facility following the provision of emergency services must be coordinated and approved by the member's contracting medical group/IPA or contracting primary care physician. The contracting medical group/IPA or contracting primary care physician will approve or deny coverage of post-stabilization treatment as requested by a hospital emergency department or treating physician within the time appropriate to the condition of the member, but in no case to exceed one hour.

If a non-contracting provider is utilized for the emergency services, UnitedHealthcare or the member's contracting medical group/IPA or contracting primary care physician may elect to transfer the member to a contracting primary care physician, medical group/IPA or provider designated by UnitedHealthcare or the contracted medical group/IPA or contracting primary care physician provided the transfer would not be detrimental to the member's health.

Washington

Refer to the *Federal/State Mandated Regulations* section for more information regarding "**emergency medical condition**" and "**emergency services**".

- **Emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the member, as a prudent layperson, to result in any of the following:
  - Placing the member's health in serious jeopardy;
  - Serious impairment to his or her bodily functions;
  - A serious dysfunction of any bodily organ or part; or
  - With respect to a pregnant woman, placing the health of the woman or unborn child in serious jeopardy.

  Note: An emergency medical condition **does not** include services where there is a pattern of the member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.
- **Urgent care** is defined as care provided when an unforeseen illness or injury is severe or painful enough to require treatment within 24 hours and a delay beyond 24 hours could lead to deterioration of the member's health and/or well-being with a potential for an adverse clinical outcome.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Explanation of Benefits (EOB)/Schedule of Benefits (SOB) for additional information.

- Emergency health care services and urgently needed services when the member is in his or her service area (**Note:** Refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for market-specific definitions of emergency health care services and urgent services).
- Coverage of emergency health care services and urgently needed services, transportation, and patient management when the member is out-of-area will be based on the following (**Note:** Refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for market-specific definitions of emergency health care services and urgent services):
  - **Emergency Health Care/Urgently Needed Services**
    - Requested services are medically necessary;
    - Requested services are considered covered benefits by UnitedHealthcare;
    - Requested services are necessary to enable the member to return to the service area, or to prevent serious deterioration of the member's condition;
    - For members who are hospitalized, determine a coordination plan. The treating physician must be in agreement with the plan's proposed coordination plan before the member is clinically stable to return to the service area. If not, a network physician, ideally with privileges at the facility, will assume care of that member and authorize transfer of the member back to the service area. If not, the plan must attempt to reach an agreement with the treating physician concerning appropriateness of discharge or transfer for the member. Until such agreement is reached, the plan, in the majority of cases, may be financially responsible for such services until an agreement is reached.

- **Transportation**
  Determine transportation method for member transfer. A consensus among the treating physician, the PCP or plan specialist, and the plan's medical director is required regarding the member's medical stability for transfer and the proposed transportation method. Refer to the Benefit Interpretation Policy titled Ambulance Transportation.
- **Patient Management**
  Management of the patient should be based on the following:
  - Post-stabilization care cannot be limited except when there is a network physician who will assume appropriate care of the member who remains out-of-area;
  - All medically necessary covered benefits requested and ordered by the treating physician are covered without distinction that the member is out-of-area;
  - Denial of coverage may be issued if:
    - The care or services requested are not a plan covered benefit;
    - The services were not medically necessary;
    - Services could await the member's return to the service area without putting the member in danger of serious deterioration or bodily functional loss;
    - The treating physician is in agreement with the transfer; there is a physician willing to accept the member's care, but the member refuses. If the member can reasonably return to the service area but the member refuses, the plan must explain the denial of continued out-of-area coverage and give the member a written notice and a reasonable time in which to return to the service area.
  - The plan is responsible for medically necessary nurse-companion or other medical or health care services that are ordered by a treating physician and/or are a condition of the member's discharge (At UnitedHealth care's discretion and only if cost effective);
  - Return transportation to the service area if the member can return safely by common carrier, including medically necessary special accommodations that are not health services (e.g., first class airline ticket seat or two or three economy seats for the member to elevate extremity) are the responsibility of the member;
  - The members' coverage may be further mandated by the individual state laws governing basic healthcare and out-of-area coverage.

Not Covered

Services that do not qualify as Urgent or Emergent as defined in the *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, or *Covered Benefits* sections.

An emergency medical condition **does not** include services where there is a pattern of the member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.

Oregon

The **out-of-area services** that are not covered include but are not limited to:

- Routine follow-up care to emergency health care or urgently needed services, such as treatments, procedures, x-rays, lab work and doctor visits, rehabilitation services, skilled nursing care or home health care.
- The fact that the member is outside the service area and that it is inconvenient for the member to obtain the required services from the network medical group will not entitle the member to coverage.
- Medical care for a known or chronic condition without acute symptoms as defined under "emergency health care services" or "urgently needed services."
- Non-emergency care when traveling outside of the United States.

Oklahoma, Texas, and Washington

The **out-of-area services** that are not covered include but are not limited to:

- Routine follow-up care to emergency or urgently needed services, such as treatments, procedures, X-rays, lab work and doctor visits, rehabilitation services, skilled nursing care or home health care.
- Medical care for a known or chronic condition without acute symptoms as defined under "emergency services" or "urgently needed services."

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
02/01/2025	All	• Routine review; no change to coverage guidelines • Archived previous policy version BIP058.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.