

# EMERGENCY HEALTH CARE SERVICES AND URGENT CARE CENTER SERVICES

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[Instructions for Use](#) ⓘ

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### Community Plan Policy

- [Emergency Health Services and Urgent Care Center Services \(Maryland Only\)](#)

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## COVERAGE RATIONALE

### **Indications for Coverage**

#### ***Emergency Health Care Services***

Emergency Health Care Services are always covered at the Network level of cost-sharing; even if an out-of-Network provider renders services. Emergency Health Care Services include, but are not limited to, all related:

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

#### ***Physician-Ordered Emergency Department Visit***

Emergency Department (ED) visits that are ordered by a physician (i.e., physician directs the member to the Emergency Department) for evaluation of a potential Emergency condition are covered services. Emergency Department visits that are ordered by a physician for evaluation of a potential Emergency condition are covered even if the member's condition does not meet the definition of Emergency or Emergency Medical Condition.

#### ***Screening and Stabilization of an Emergency Medical Condition (EMC)*** <sup>(2,3)</sup>

Services necessary to conduct a medical screening examination (MSE) are covered (Revenue code 0451) when required by applicable law. Individuals coming to the Emergency Department must be provided a medical screening examination appropriate to the individual's 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, computerized tomography (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>(2)</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 the Emergency Medical Treatment and Labor Act (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>(3)</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>(3)</sup> (From *Transmittal 60*)

Once the individual is screened and it is determined the individual has only presented to the Emergency Department for a non-Emergency purpose and does not require Stabilization (see next paragraph), the hospital's 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>(3)</sup> (From *Transmittal 60*)

The physician treating the member must decide when the member may be considered stabilized for transfer or discharge. Refer to the section, Post-Stabilization Care Services, [below](#) for the plan's obligations regarding services provided following Stabilization. <sup>(2)</sup>

### **Emergency Medical Treatment and Labor Act (EMTALA) Hospital's Obligations** <sup>(2,3,4)</sup>

EMTALA Federal labor law requires that if a patient is determined to have an Emergency Medical Condition then the Emergency Department Staff must screen and stabilize the patient, if possible, before asking about insurance. See [Definitions](#) section below.

### **Emergency Medical Condition**

Emergency Medical Condition status is not affected if a later medical review found no actual Emergency present. See [Definitions](#) section below. <sup>(2)</sup>

### **Examples of EMTALA Obligation – Examples of Emergency Medical Condition (EMC)** <sup>(3)</sup>

- Pharmacy: If an individual presents to an Emergency Department and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation.
- 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?).
- The circumstances surrounding why the request is being made would confirm if the hospital in fact has an EMTALA obligation.
- If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation.
- 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.
- 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.
- 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.
- 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>(2)</sup>

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

- Related to an Emergency Medical Condition; and
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the member's condition.

The plan or plan representative is financially responsible for Post-Stabilization care services obtained within or outside the plans 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 member'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 member'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 member'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 member'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 member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A plan representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

(After the plan assumes responsibility, further care will be covered under the member's benefit in accordance with the member specific benefit 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. The hospital must still meet the screening, treatment, and transfer requirements.

### **Additional Information**

- If the member leaves the Emergency Department for services in another department (for example radiology or surgical suite) and then returns to the Emergency Department for discharge, all such services are considered part of the Emergency Health Care Services benefit. For example, if the member has a broken arm and is brought from the Emergency Department to the operating room to reduce the fracture, and is then returned to the Emergency Department for discharge, all services in this encounter would be considered under the Emergency Health Care Services benefit (i.e., the services in the operating room are NOT considered under the outpatient surgery benefit).
- If the member is admitted to the hospital through the Emergency Department, the entire encounter is considered an inpatient admission (i.e., including the services rendered in the Emergency Department), and therefore only the inpatient benefits/copay apply. The fact that the member entered the hospital for admission through the Emergency Department (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 an out-of-Network facility, Network benefits will be applied. UnitedHealthcare may elect to transfer the member to a Network facility as soon as medically appropriate. If the member chooses to stay at the out-of-Network facility after the date that it is determined a transfer is medically appropriate, out-of-Network benefits will be applied for the remainder of the inpatient stay.
- The Emergency Health Care Services copayment or benefit level will apply if the member has been placed in an observation bed for the purpose of monitoring the member's condition, rather than being admitted as an inpatient in the hospital.

- State mandates for Emergency care impact the benefits for Emergency Health Care Services.
- Eligible Durable Medical Equipment (DME) that is given for take-home use from the Emergency Department is not covered under the Emergency Health Care Services benefit. Rather, eligible DME is covered under the DME section of the COC.
- Eligible accidental dental services performed in an Emergency Department are covered under the accidental dental benefit, not under the Emergency Health Care Services benefit.
- Eligible pharmaceutical products administered during an Emergency Department visit are covered under the Emergency Health Care Services benefit.
- When the Urgent Care Center is a free-standing facility or a part of a larger facility (e.g., hospital), if the member has additional services, such as diagnostic, therapeutic, or pharmaceuticals administered during the Urgent Care visit, a separate cost share may be applied to those services (e.g., a member is sent to the radiology department of that same facility for an x-ray, and is then returned to the Urgent Care Center for discharge. In this situation, a separate cost share may be applied). Refer to the member specific benefit plan document for cost sharing details.
- 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 member specific benefit plan document for coverage of Urgent Care Services (for Network vs. out-of-Network coverage).

### **Coverage Limitations and Exclusions**

- Use of Emergency Department 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 the member specific benefit plan document for possible coverage.
- Use of Urgent Care Center Services to treat non-urgent conditions (see definition of [Urgent Care Center](#)). Check the member specific benefit plan document for possible coverage.
- Non-Emergency Health Care Services received outside of the United States. Check the member specific benefit plan document for possible coverage.

For ASO plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for a description of Emergency Health Care Services.

## **APPENDIX**

### **Patient Protection and Affordable Care Act (PPACA) of 2010** <sup>(1)</sup>

(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 member specific benefit plan 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 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.

### **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 layperson, who possesses an average knowledge of health and medicine (rather than by reference to qualified medical personnel).

## **DEFINITIONS**

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Emergency (UHIC Plans):** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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:

- Placing the health of the Covered Person (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.

**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 Department services is 23 / Emergency Room - Hospital.

**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
- Such 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)).

**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:

- Placing the member's health in serious risk;
- Serious harm to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman, an active labor meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer the member to another hospital before delivery
  - 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.

**Emergency Medical Treatment and Labor Act (EMTALA) (Federal Labor Law):** Emergency Medical Condition means:

- 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:
  - 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
- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman.

**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:** 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.

**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.

**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 following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan 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 claim payment. Other Policies and Coverage Determination Guidelines may apply.

**Note:**

- Emergency Health Care Services and Urgent Care benefits are **not** limited to the following codes.
- Except for DME and Accidental Dental, all otherwise eligible CPT and HCPCS are also eligible when billed with ER place of service. (See [Indications for Coverage](#) section above for explanation regarding DME and Accidental Dental.)

CPT Code	Description
<b>Emergency Health Care Services</b>	
99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "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 outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
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 outpatient hospital "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 outpatient hospital "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.

CPT Code	Description
<b>Emergency Health Care Services</b>	
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.
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.
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.



CPT Code	Description
<b>Emergency Health Care Services</b>	
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, 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

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HCPCS Code	Description
<b>Emergency Health Care Services</b>	
<b>Note:</b> For Emergency Health Care Services HCPCS codes:	
<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 the Reimbursement Policy titled <a href="#">Emergency Department (ED) Facility Evaluation and Management (E&amp;M) Coding Reimbursement Policy for Commercial Plans</a>.</li> </ul>	
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 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)

HCPCS Code	Description
<b>Emergency Health Care Services</b>	
<b>Note:</b> For Emergency Health Care Services HCPCS codes:	
<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 the Reimbursement Policy titled <a href="#">Emergency Department (ED) Facility Evaluation and Management (E&amp;M) Coding Reimbursement Policy for Commercial Plans</a>.</li> </ul>	
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)
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

### Urgent Care

These codes may not be payable due to the Reimbursement Policy titled *Urgent Care Policy, Professional*. See Related Commercial Policies [above](#).

S9083	Global fee urgent care centers
S9088	Services provided in an urgent care center (List in addition to code for service)

Place of Service (POS) Codes	Description
20	Urgent care facility
23	Emergency room – hospital

Revenue Codes	Description
<b>Emergency Health Care Services</b>	
The Emergency Health Care Services are <b>not</b> limited to the following codes. All otherwise eligible Revenue codes are also eligible when billed with Emergency Room place of service.	
450	Emergency room – general
451	Emergency room – EMTALA emergency medical screening services

Revenue Codes	Description
<b>Emergency Health Care Services</b>	
The Emergency Health Care Services are <b>not</b> limited to the following codes. All otherwise eligible Revenue codes are also eligible when billed with Emergency Room place of service.	
452	ER beyond EMTALA screening
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>	
The Urgent Care benefits are <b>not</b> limited to the following codes. All otherwise eligible Revenue codes are also eligible when billed with Urgent Care Facility place of service.	
456	Urgent care
516	Urgent care clinic – hospital based
526	Urgent care clinic – free standing

## REFERENCES

1. Compilation of Patient Protection and Affordable Care Act: <http://docs.house.gov/energycommerce/ppacacon.pdf>. Accessed February 6, 2019.
2. 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.
3. 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.
4. State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_v\\_emerg.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf). Accessed February 6, 2019.

## GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
04/01/2019	<ul style="list-style-type: none"> <li>• Reorganized policy template: <ul style="list-style-type: none"> <li>○ Simplified and relocated <i>Instructions for Use</i></li> <li>○ Removed <i>Benefit Considerations</i> section</li> </ul> </li> <li>• Updated list of related policies; added reference link to the Reimbursement Policy titled <i>Urgent Care Policy, Professional</i></li> <li>• Updated coverage rationale; replaced references to “patient(s)” with “member(s)”</li> <li>• Updated list of applicable HCPCS codes for urgent care; added language to indicate [the listed] codes may not be payable due to the Reimbursement Policy titled <i>Urgent Care Policy, Professional</i></li> <li>• Archived previous policy version CDG.010.12</li> </ul>

## INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as

necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination 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.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.