

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Private Contracting: Definition of Emergency Care Services and Appeals of Opt Out Determinations

Note: The article was revised on July 27, 2016, to add a reference to MLN Matters® Article [MM9616](#) to advise physicians and practitioners who are planning to opt out of Medicare or who have already opted out that a valid opt-out affidavit, signed on or after June 16, 2015, will expire 2 years after the effective date of the opt-out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all contractors with which they would have filed claims absent the opt-out. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians and practitioners who opt-out of Medicare, and beneficiaries that receive services from opt out physicians and practitioners.

Note: The private contracting regulation at 42 CFR 405.450 describes certain opt-out determinations made by Medicare, and the process that physicians, practitioners, and beneficiaries may use to appeal those determinations. The cross references to the processes used to appeal the determinations described in Section 405.450 were updated in the November 13, 2014 Federal Register (Volume 79, Number 219). The definition of *Emergency care services* at 42 CFR 405.400 was also corrected in that November 13, 2014 Federal Register.

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Provider Action Needed



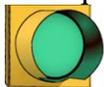
STOP – Impact to You

The cross reference to Section 405.803 in Section 405.450(a) of the private contracting regulations was replaced with a cross reference to [Section 498.3\(b\)](#). The cross reference to Section 405.803 in Section 405.450(b) of the private contracting regulations was replaced with a cross reference to Section 405.924. Corresponding edits to Section 498.3(b) and Section 405.924 were also made to note that the determinations under Section 405.450(a) and (b) of the private contracting regulations are initial determinations. The definition of Emergency care services at [Section 405.400](#) was also revised to cite to the definition of Emergency services in Section 424.101.



CAUTION – What You Need to Know

Be aware that a physician or practitioner who is dissatisfied with a Medicare determination under Section 405.450(a) may utilize the enrollment appeals process currently available for providers and suppliers in Part 498. Be aware that a determination described in Section 405.450(b) (that payment cannot be made to a beneficiary for services furnished by a physician or practitioner who has opted out) is an initial determination for the purposes of [Section 405.924](#) and may be challenged through the existing claims appeals procedures in Part 405 subpart I. Be aware that emergency care services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.



GO – What You Need to Do

Make sure that your billing staffs are aware of this information.

Background

Emergency care services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and because of the danger to life or health, which require use of the most accessible hospital available that is equipped to furnish those services.

Congress intended that the term “emergency or urgent care services” not be limited to emergency services since they also included “urgent care services.” Urgent Care Services are defined in [42 CFR 405.400](#) as services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

For example, if a beneficiary has an ear infection with significant pain, the Centers for Medicare & Medicaid Services (CMS) would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the eardrum. The patient’s

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condition would not meet the definition of emergency medical condition because immediate care is not needed to avoid placing the health of the individual in serious jeopardy or to avoid serious impairment or dysfunction. However, although it does not meet the definition of emergency care, the beneficiary needs care within a relatively short period of time (which CMS defines as 12 hours) to avoid adverse consequences and the beneficiary may not be able to find another physician or practitioner to provide treatment within 12 hours.

Additional Information

The official instruction, CR 9116, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R206BP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Document History

Date	Description
July 27, 2016	The article was revised to add a reference to MLN Matters® Article MM9616 to advise physicians and practitioners who are planning to opt out of Medicare or who have already opted out that a valid opt-out affidavit, signed on or after June 16, 2015, will expire 2 years after the effective date of the opt-out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all contractors with which they would have filed claims absent the opt-out.
April 3, 2015	Initial article released

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