




<b>Binder:</b>	<u>OSF HealthPlans HCM Department</u>		
<b>Policy</b>			
<b>No./Title:</b>	<u>HCM.CML.005 Emergency Room or Urgent Care Claims</u>		
	<b>Original</b>		
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<b>Revision/Review</b>			
<b>Date(s):</b> <u>2/00;6/01; 5/02; 10/02; 10/03; 10/04 ; 10/05; 10/06; 10/07</u>			
<b>Approval:</b>		<b>Title:</b>	<b>Vice President and Chief Medical Officer</b>

**POLICY:** OSF HealthPlans provides coverage for emergency and urgent care services necessary to screen and stabilize members without pre-certification in cases where a prudent lay person, acting reasonably, would have believed that an emergency medical condition exists. OSF HealthPlans covers emergency and urgent care services if an authorized representative (primary care physician, specialist, OB/GYN or triage call center) acting for the managed care organization has authorized the provision of emergency services.

**PURPOSE:** To ensure benefit coverage for emergency or urgent care medical conditions manifesting itself by acute symptoms of sufficient severity such that a prudent lay person, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or the health of a women or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

**PROCEDURE:**

1. Emergency or urgent care services are covered when referred by participating PCP or specialist or other authorized representative as listed above.
2. If claim received and no referral/authorization on file:
  - Diagnosis on claim should be compared to the pend ER and urgent diagnosis list.
  - If diagnoses is not on the pend list, claim should be paid.
  - If diagnoses is on the pend list, the claim is to be sent to the HCM Department for review.
3. If a claim remains in question after HCM review, the claim, along with medical records will be referred to the Associate Medical Director for additional review.
4. Presenting symptoms will be considered when reviewing the ER or urgent care services retrospectively.
5. ER claims cannot be denied based solely on the discharge diagnoses.

6. If ER records are needed in order to review a post-service claim, the HCM Case Manager RN/LPN will send a medical record request to the member and provider. The member and physician will be allowed 45 days to provide the requested information. If the information is not received, the claim can be denied for lack of information.
7. Members and providers have the right to appeal denied ER claims.
8. ER and urgent diagnoses on claim "pend" list.

All V Codes:	VO1 - V82.9
All ICD-9 Codes:	635-639
Dental Codes:	520-526.9
All ICD-9 E Codes	E800 - E999
9. Mental health emergency room visits billed 290-319 are not covered by UBH, will be covered by OSF HealthPlans.