CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 206	**Date: April 10, 2015**
	Change Request 9116

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

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Benefit Policy Manual to align it with recently revised regulations regarding emergency care services and opt out appeals.

EFFECTIVE DATE: July 13, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 13, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/40.29/Definition of Emergency and Urgent Care Situations
R	15/40.36/Appeals

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 206	Date: April 10, 2015	Change Request: 9116

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I. GENERAL INFORMATION

A. Background: Effective January 1, 1998, section 1802(b) of the Act permits certain physicians and practitioners to opt-out of Medicare if certain conditions are met, and to furnish through private contracts services that would otherwise be covered by Medicare. For those physicians and practitioners who opt-out of Medicare in accordance with section 1802(b) of the Act, the mandatory claims submission and limiting charge rules of section 1848(g) of the Act would not apply. As a result, if the conditions necessary for an effective opt-out are met, physicians and practitioners are permitted to privately contract with Medicare beneficiaries and to charge them without regard to Medicare's limiting charge rules. Regulations governing the requirements and procedures for private contracts appear at 42 CFR Part 405, subpart D.

B. Policy: The Centers for Medicare & Medicaid Services (CMS) modified the private contracting regulations at 42 C.F.R. 405.400 and 405.450 on November 13, 2014. See Federal Register Volume 79, Number 219, page 68001 (Thursday, November 13, 2014). Because the process for appealing opt out determinations was inadvertently changed in previous rulemaking, CMS corrected sections 405.450(a) and (b) of the private contracting regulations so those sections no longer cite to incorrect cross-references. On November 13, 2014, CMS also corrected the definition of *Emergency care services* in section 405.400 so that definition no longer cites to an incorrect cross-reference. Therefore, as a result of those changes to the regulations, CMS is amending Pub. 100-02, chapter 15, sections 40.29 and 40.36 in order to make it consistent with the current regulations.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9116.1	Contractors shall follow the revised instructions described in Pub. 100-02, chapter 15, sections 40.29 and 40.36.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9116.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Grabau, 410-786-0206 or Frederick.Grabau@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

40.29 - Definition of Emergency and Urgent Care Situations

(Rev. 206, Issued: 04-10-15, Effective: 07-13-15, Implementation: 07-13-15)

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.* 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, CMS would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the eardrum. The patient's 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.

40.36 - Appeals

(Rev. 206, Issued: 04-10-15, Effective: 07-13-15, Implementation: 07-13-15)

A determination by CMS that a physician or practitioner has failed to properly opt out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out is an initial determination for purposes of 42 CFR *498.3(b)*.

A determination by CMS that no payment can be made to a beneficiary for the services of a physician who has opted out is an initial determination for purposes of 42 CFR 405.*924*.

See the Medicare Claims Processing Manual, Chapter 29, "Appeals of Claims Decisions," for additional information on appeals.