

Medicare Advantage Regulations

Source: Title 42, Code of Federal Regulations, Section 422.113
www.ecfr.gov

Sec. 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.

- (a) *Ambulance services.* The MA organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.
- (b) *Emergency and urgently needed services—*
- (1) *Definitions.*
 - (i) **“Emergency medical condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—
 - (A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
 - (B) Serious impairment to bodily functions; or
 - (C) Serious dysfunction of any bodily organ or part.
 - (ii) **“Emergency services”** means covered inpatient and outpatient services that are—
 - (A) Furnished by a provider qualified to furnish emergency services; and
 - (B) Needed to evaluate or stabilize an emergency medical condition.
 - (iii) **“Urgently needed services”** means covered services that are not emergency services as defined this section, provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required—
 - (A) As a result of an unforeseen illness, injury, or condition; and
 - (B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.
 - (2) *MA organization financial responsibility.* The MA organization is financially responsible for emergency and urgently needed services—

- (i) Regardless of whether the services are obtained within or outside the MA organization;
 - (ii) Regardless of whether there is prior authorization for the services.
 - (A) Instructions to seek prior authorization for emergency or urgently needed services may not be included in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.
 - (B) Instruction to seek prior authorization before the enrollee has been stabilized may not be included in any materials furnished to providers (including contracts with providers);
 - (iii) In accordance with the prudent layperson definition of *emergency medical condition* regardless of final diagnosis;
 - (iv) For which a plan provider or other MA organization representative instructs an enrollee to seek emergency services within or outside the plan; and
 - (v) With a limit on charges to enrollees for emergency department services that CMS will determine annually, or what it would charge the enrollee if he or she obtained the services through the MA organization, whichever is less.
- (3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.
- (c) *Maintenance care and post-stabilization care services* (hereafter together referred to as “post-stabilization care services”).
- (1) *Definition.* **“Post-stabilization care services”** means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee’s condition.
 - (2) *MA organization financial responsibility.* The MA organization—
 - (i) Is financially responsible (consistent with Section 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;
 - (ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee’s stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;
 - (iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee’s stabilized condition if—
 - (A) The MA organization does not respond to a request for pre-approval within 1 hour;
 - (B) The MA organization cannot be contacted; or

- (C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in Section 422.113(c)(3) is met; and
 - (iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.
- (3) *End of MA organization's financial responsibility.* The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—
 - (i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
 - (ii) A plan physician assumes responsibility for the enrollee's care through transfer;
 - (iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or
 - (iv) The enrollee is discharged.