



FAQ – Emergency Room Claims Processing Procedures

Q. Why should I call the Nurse Line?

A. Medical Mutual's Nurse Line staff is trained and equipped to quickly assess situations and determine if a referral to the emergency room is necessary. When a referral is made, our connectivity with Nurse Line will ensure claims will process under the medical emergency use of the ER benefit.

Q. My emergency room claim was denied for medical records.

A. If an emergency room claim is submitted with emergency room codes that are on our auto-approve list the claim will process without the need for additional information. Other claims will require medical records to make a determination. We will request those records from your providers and they will be given 45 days to submit their report.

Q. If I have a claim that is not auto-approved and pends for clinical review, what happens?

A. Claims processing ensures that emergency room claims that were potentially made for non-emergency reasons are paused (pended) and medical record information is requested and reviewed. The purpose of this clinical review is to determine if prudent layperson criteria are met and apply the correct emergency or non-emergency level of benefit to the claim.

The focus of the prudent layperson standard is based on why emergency care was sought. The benefit decision of the emergency room review is not based on the outcome of the visit.

Q. Some emergency rooms are better than others about submitting documentation. Is Medical Mutual addressing this?

A. We are in the process of communicating with our hospital partners about the importance of sending us emergency room reports. We are also conducting an internal review to determine if specific hospitals or systems require additional education regarding our process.

Q. How will I know what has been coded as an emergency?

A. We use the primary diagnosis code on the claim to determine emergency vs non-emergency services received in the emergency room setting. The diagnosis codes were thoroughly reviewed by the Medical Mutual clinical staff to determine which codes should automatically be considered medical emergencies or emergency accidents, and those that will require review of clinical records from the facility that provided the emergency services.

Q. How do Medical Mutual Certificates define what is an emergency?

A. Emergency Medical Condition – 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 attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services – medical screening examinations as required by federal law that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical conditions; and such further medical examinations and treatments, 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) to stabilize the patient.

Q. What is the prudent layperson standard?

The prudent layperson standard is defined as something serious enough that a person with average knowledge of health and medicine can reasonably assume that immediate attention is absolutely necessary.

Q. What do you consider to be an emergency?

A. An emergency, as defined in our certificate book, is a medical condition characterized by the sudden onset and symptoms of severity (sudden/serious), including severe pain that the absence of immediate medical attention could result in placing the members' health in serious jeopardy; serious impairment to bodily function(s); or serious dysfunction of any bodily organ or part.

Q. My claim still denied, what should I do?

A. Members have the right to appeal any decision they deem to be adverse and should follow the appeal procedures listed in their certificate books. Members can also find appeal forms on My Health Plan under Forms in the Resources & Tools section, or by calling Customer Care.

Once you have exhausted your internal appeals, you may have the right to an external review by an Independent Review Organization (IRO). This right may be available if we deny, reduce or discontinue coverage for a service on the basis of medical necessity, appropriateness of care, healthcare setting, level of care, effectiveness of a covered benefit, or an experimental or investigational determination. You should review your Certificate or Benefit Book for information if this is available.