

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

ACCESS TO EMERGENCY SERVICES AND

PAYMENT

BEHAVIORAL HEALTH SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this February 10, 2014 Technical Assistance Guide renders all other versions obsolete.

BEHAVIORAL HEALTH TAG

ACCESS TO EMERGENCY SERVICES AND PAYMENT

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Requirement ER-001: Emergency Services Authorizations

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1317.1

Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a)(1) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2)(A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts

(D) This paragraph does not expand, restrict, or otherwise affect, the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient's health in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

- (1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
- (2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

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- (d) "Hospital" means all hospitals with an emergency department licensed by the state department.
- (e) "State department" means the State Department of Public Health.
- (f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.
- (g) "Board" means the Medical Board of California.
- (h) "Within the capability of the facility" means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.
- (i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and the specialty physicians, includes review of the patient's medical record, examination and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.
- (j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

CA Health and Safety Code section 1371.4(a)

(a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

CA Health and Safety Code section 1371.4(b)

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

CA Health and Safety Code section 1371.4(c)

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a

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provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

CA Health and Safety Code section 1371.4(d)

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

CA Health and Safety Code sections 1317.4a.(a) and (d)

(a) Notwithstanding subdivision (j) of Section 1317.1, a patient may be transferred for admission to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, for care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, provided that, in the opinion of the treating provider, the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, a transfer of the patient. A provider shall notify the patient's health care service plan, or the health plan's contracting medical provider of the need for the transfer if identification of the plan is obtained pursuant to paragraph (1) of subdivision (b).

(d) If a transfer made pursuant to subdivision (a) is made to a facility that does not have a contract with the patient's health care service plan, the plan may subsequently require and make provision for the transfer of the patient receiving services pursuant to this section and subdivision (a) of Section 1317.1 from the noncontracting facility to a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that has a contract with the plan or its delegated payer, provided that in the opinion of the treating provider the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, the transfer of the patient.

CA Health and Safety Code sections 1317.4a.(b)(1) and (c)(1)

(b) A hospital that transfers a patient pursuant to subdivision (a) shall do both of the following:
(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record. The hospital's attempt to ascertain the information shall include requesting the patient's health

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care service plan member card, asking the patient, the patient's family member, or other person accompanying the patient if he or she can identify the patient's health care service plan, or using other means known to the hospital to accurately identify the patient's health care service plan.

(c) (1) A hospital shall make the notification described in paragraph (2) of subdivision (b) by either following the instructions on the patient's health care service plan member card or by using the contact information provided by the patient's health care service plan. A health care service plan shall provide all noncontracting hospitals in the state to which one of its members would be transferred pursuant to paragraph (1) of subdivision (b) with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

CA Health and Safety Code section 1374.72(g)(2)

A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

28 CCR 1300.67(g)

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:

(g)(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area.

Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.

"Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

28 CCR 1300.67.2(c)

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week.

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28 CCR 1300.74.72(a)

(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

28 CCR 1300.71.4(c)

(c) In the case where a plan denies the request for authorization of post stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:

(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,

(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.

28 CCR 1300.71.4(b) and (d)

(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized.

Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for

(A) the delivery of such necessary post-stabilization medical care or

(B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

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(3) Notwithstanding the provisions of Subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

***Key Element 1 is not applicable to EAP Plans. This Element refers to 24/7 availability of ER medical services, not EAP 24/7 availability of providers. Treatment of emergency conditions is outside the scope of an EAP.**

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Claims
- Utilization Management Director
- Quality Management Director

DOCUMENTS TO BE REVIEWED

- Utilization Management policies and procedures/protocols regarding ER services, including:
 - Triage center protocols for receiving and handling ER and emergency admissions notifications;
 - Triage center protocols for authorizing ER transportation for involuntary admissions and claims procedures for paying for this transportation;
 - Claims procedures for paying for authorized ER transportation (above);
 - Utilization Management and Claims processing rules for payment of ER and emergency admissions, both voluntary and involuntary;
 - Claims processing guidelines, including procedures on payment denials, for ER service claims;
 - Requirements for a psychiatric evaluation or criteria to determine whether an enrollee can be transferred or discharged after a voluntary or involuntary admission;
 - Reimbursing providers and facilities for emergency services;
 - Protocols for when the Plan and provider disagree regarding the need for necessary medical care, following stabilization of the enrollee;
- ER access studies/reports to 24/7 emergency services.

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- Logs or other evidence supporting 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care.
- Sample of out-of-area ER files to be reviewed onsite.
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ER-001 - Key Element 1:

1. The Plan shall ensure the availability of, and accessibility to, emergency health care and mental health care services within the service area twenty-four (24) hours-a-day and seven (7) days-a-week.

CA Health and Safety Code section 1374.72(g)(2); 28 CCR 1300.67(g); 28 CCR 1300.67.2(c); 28 CCR 1300.74.72(a)

Assessment Questions	Yes	No	N/A
1.1 Do the Plan's policies and procedures specify that emergency services shall be available and accessible within the service area 24 hours-a-day and 7-days-a-week?			
1.2 Does the Plan have emergency health care services available and accessible within the service area 24 hours-a-day and 7 days-a-week?			
1.3 Does the Plan have contracts with mental health practitioners, programs, and facilities to provide services to enrollees that require urgent or emergent mental health care?			
1.4 Do these services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area 24 hours-a-day, 7 days-a-week?			
1.5 Do these services include ambulance services for the area served by the Plan to transport the enrollee to the nearest 24 hour emergency facility with Physician coverage designated by the health care service plan?			

ER-001 - Key Element 2:

2. The Plan shall provide timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely.

CA Health and Safety Code section 1371.4(a); 28 CCR 1300.71.4(b) and (d)

Assessment Questions	Yes	No	N/A
2.1 Do the Plan's policies and procedures specify 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely?			

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Assessment Questions	Yes	No	N/A
2.2 Does the Plan provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely?			
2.3 Does the Plan have a process to receive notification of emergency room evaluations and subsequent admissions, whether voluntary or involuntary, 24 hours-a-day, 7 days-a-week?			
2.4 Does the Plan or its delegate pay for all involuntary admissions (5150 admissions)?			
2.5 Do the Plan’s policies and procedures specify that the Plan shall approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request?			
2.6 If the Plan fails to approve or disapprove the request within this timeframe, the care is deemed authorized?			

ER-001 - Key Element 3:

3. The Plan ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and the Plan shall not shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

CA Health and Safety Code section 1371.4(b)

Assessment Questions	Yes	No	N/A
3.1 Do the Plan policies and procedures specify that providers are reimbursed for emergency services and care provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee?			
3.2 Do the Plan policies and procedures specify that providers are not required to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee’s medical condition?			
3.3 Does the Plan reimburse providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee and does the Plan not require a prior authorization for that reimbursement?			

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ER-001 - Key Element 4:

- 4. The Plan may deny reimbursement to a provider for a medical screening examination in cases where the Plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.
CA Health and Safety Code section 1317.1; CA Health and Safety Code section 1371.4(c)**

Assessment Questions	Yes	No	N/A
4.1 Do the Plan policies and procedures specify that reimbursement to a provider for a medical screening examination may be denied only if the enrollee did not require emergency services and the enrollee reasonably should have known that an emergency did not exist using the Reasonable Person Standard?			
4.2 Does the Plan deny reimbursement to a provider for a medical screening examination only if the enrollee did not require emergency services and the enrollee reasonably should have known that an emergency did not exist using the Reasonable Person Standard?			

ER-001 - Key Element 5:

- 5. If the Plan and the provider disagree regarding the need for necessary medical care, following stabilization of the enrollee, the Plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer of the patient.
CA Health and Safety Code section 1371.4(d); CA Health and Safety Code sections 1317.4a.(a) and (d); CA Health and Safety Code sections 1317.4a.(b)(1) and (c)(1); 28 CCR 1300.71.4(c)**

Assessment Questions	Yes	No	N/A
5.1 Do the Plan's policies and procedures specify that, if the Plan and the provider disagree about the need for necessary medical care following stabilization of the enrollee, the Plan shall assume responsibility for the care of the patient by <i>either</i> of the following: Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement? -- Or -- Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient?			

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Assessment Questions	Yes	No	N/A
<p>5.2 If the Plan and the provider disagree regarding the need for necessary medical care following stabilization of the enrollee, does the Plan assume responsibility for the care of the patient by <i>either</i> of the following: Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement? -- Or -- Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient?</p>			
<p>5.3 Does the Plan provide all non-contracting hospitals in the state to which one of its members could be transferred the necessary Plan contact information to contact the health plan?</p>			
<p>5.4 Is this contact information updated on a periodic basis, at least annually?</p>			

End of Requirement ER-001: Emergency Services Authorizations