

**From:** DMHC Licensing eFiling

**Subject:** APL17-017 (OPL) – Knox-Keene Act Standard For Determining Whether An “Emergency” Existed For Purposed Of Provider Reimbursement

**Date:** Tuesday, December 19, 2017 4:55:00 PM

**Attachments:** APL17-017 (OPL) – Standard for Determining Emergency.pdf

Dear Health Plan Representative,

Please find the attached All Plan Letter regarding the appropriate standard under the Knox-Keene Act for when a plan must reimburse for emergency services provided to an enrollee..

If you have any questions regarding the letter, please contact the Office of Plan Licensing through your assigned counsel.

Thank you.

## ALL PLAN LETTER

**DATE:** December 19, 2017

**TO:** All Full-Service Commercial Health Plans and Specialized Behavioral Health Plans (not including EAP-only plans)

**FROM:** Sarah Ream, Deputy Director  
Office of Plan Licensing

**SUBJECT:** APL 17-017 (OPL) Knox-Keene Act Standard For Determining Whether An "Emergency" Existed For Purposes Of Provider Reimbursement

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Health plans periodically ask the Department of Managed Health Care (DMHC) for guidance regarding the appropriate standard under the Knox-Keene Act for when a plan must reimburse for emergency services provided to an enrollee. This All Plan Letter (APL) reiterates the appropriate standard as set forth in the Knox-Keene Act for determining whether reimbursement is required in such circumstances. This APL does not apply to specialized health plan products (other than non-EAP behavioral health plans products) or to Medi-Cal or Medicare health plan products.

Health and Safety Code section 1371.4, subdivision (c), allows health plans to deny payment for emergency services and care only if "the health care service plan, or its contracting medical providers, 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 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."* [Emphasis added.]

Health and Safety Code section 1371.5 reiterates the standard set forth in section 1371.4 for determining whether a health plan must authorize or pay for ambulance or ambulance transportation services provided to an enrollee due to a "911" call for assistance. Section 1371.5 requires coverage of ambulance services if *either*

1. there was a medical emergency and the enrollee required ambulance services; or,
2. the *"enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services."* [Emphasis added.]

The standard articulated by the Knox-Keene Act in section 1371.4 and 1371.5 turns on whether the enrollee him/herself reasonably believed he/she had an emergency medical condition. This standard *is not* the objective “reasonable person” or “prudent layperson” standard that asks whether a reasonable person would have believed a medical emergency existed. Rather, the Knox-Keene Act’s standard is subjective and takes into consideration whether the enrollee’s belief was reasonable given the enrollee’s age, personality, education, background, and other similar factors.

Please note that whether the enrollee believed he/she was experiencing a medical emergency may not always be evident from the the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

If you have questions about the notice requirements outlined in this APL, please contact the Office of Plan Licensing through your assigned reviewer.