Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**		**SUBJECT (Document Title)** **Emergency Services - Core Process**	
Effective Date 05/20/2009	**Date of Last Review** 01/23/2020	**Date of Last Revision** 03/11/2020	**Dept. Approval Date** 03/11/2020
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☒ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

This Policy and Procedure is also applicable to Medicare. Please see exceptions section for Medicare exceptions to this policy.

To ensure the health plan provides coverage for Emergency Services and Care as appropriate.

DEFINITIONS:

Appropriate Practitioner: A representative who makes utilization management denial decisions. Depending on the type of case, the reviewer may be a health plan Medical Director, or a physician, pharmacist, chiropractor, clinical psychologist, dentist or other licensed practitioner type as appropriate. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

"Emergency Medical Condition" means a medical condition (or behavioral condition – GA, NY, TN) manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.
4) A medical condition manifesting itself by acute symptoms of sufficient severity
5) With respect to a pregnant woman having contractions
   a) That there is inadequate time to effect a safe transfer to another hospital before delivery, or
   b) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Refer to Exceptions for state-specific definitions

"Emergency Services" means covered inpatient and outpatient services that are as follows:

1) Furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act.
2) Needed to evaluate or stabilize an emergency medical condition that is found to exist under the prudent layperson standard.

"Emergency Transportation" means emergency medical transportation utilizing ground or air ambulance, as medically necessary, to transport a recipient with an emergency medical condition. A ground or air ambulance resulting from a "911" communication is considered emergency medical transportation.

Prudent Layperson: An individual who is without medical training, who draws on practical experience to decide if there is a need to seek emergency medical treatment.

PROCEDURE:

1) Emergency services shall be available twenty-four (24) hours and seven (7) days a week to treat an emergency medical or behavioral health (BH) condition.

2) The health plan will cover and pay for Emergency Services and Care, regardless of whether the entity furnishing the services is a participating provider. (All coverage and payment for services is contingent on member benefits and eligibility at the time services are rendered.)

3) The health plan will not deny payment for Emergency Services and Care if, on the basis of presenting symptoms identified by the member, a prudent layperson who possesses an average knowledge of health and medicine, believed that it was an Emergency Medical or BH Condition.

4) Likewise, the health plan will not deny payment if the member obtained Emergency Services and Care based on instructions of a practitioner or other representative of the health plan.

5) The health plan will not limit what constitutes an Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.

6) The health plan will not refuse to cover Emergency Services and Care due to a lack of notification to the health plan.

7) The health plan will provide coverage for pre-hospital and hospital-based trauma services and Emergency Services and Care to members.

8) When a member presents himself or herself to a hospital seeking Emergency Services and Care, the determination that an Emergency Medical Condition exists will be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate healthcare professional under the supervision of a physician of the hospital.
   a) The physician, or other appropriate healthcare professional, will indicate on the member's chart the results of all screenings, examinations and evaluations.
   b) The health plan will compensate the physician for all screenings, evaluations and examinations that are reasonably calculated to assist the physician, or other appropriate healthcare professional, in arriving at the determination as to whether the member's condition is an Emergency Medical Condition.
   c) The health plan will pay for all Emergency Services and Care in accordance with the contract or State-specific, non-par methodology. If the physician, or other appropriate healthcare professional where the member presents for care, determines that an Emergency Medical Condition does not exist, the health plan is not required to pay for services rendered subsequent to the provider's determination.

9) If the physician, or other appropriate healthcare professional, determines that an Emergency Medical Condition exists, and the member notifies the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a member of the health plan, the hospital must make a reasonable attempt to notify the member's Primary Care Provider (PCP), if known, or the health plan. If the health plan has previously requested in writing, that said notification be made directly to the health plan, of the existence of the Emergency Medical Condition.

10) If the hospital, any of its affiliated physicians, or other appropriate healthcare professional, do not know the member's PCP, or have been unable to contact the PCP, participating hospital must:
   a) Notify the health plan as soon as possible before discharging the member from the emergency care area; or
   b) Notify the health plan within twenty-four (24) hours or on the next business day after admission of the member as an inpatient to the hospital.

11) Once member is stabilized or once an elective inpatient admits, the hospital is required to notify the health plan of admission within one (1) business day.

12) If the hospital is unable to notify the health plan, the hospital must document its attempts to notify the health plan, or the circumstances that precluded the hospital's ability to notify the health plan. The health plan will not deny payment for Emergency Services and Care based on a hospital's failure to comply with the notification requirements of this section.

13) If the member's PCP responds to the hospital's notification, and the hospital physician, or other appropriate healthcare professional, and PCP discuss the appropriate care and treatment of the member, the health plan may have a member of the hospital staff, with whom it has a participating provider contract, participate in the treatment of the member within the scope of the physician's hospital staff privileges.

14) The health plan may transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member's Emergency Medical Condition. The attending emergency physician, or other appropriate healthcare professional, actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

15) Notwithstanding any other State law, a hospital may request and collect any insurance or financial information necessary to determine if the patient is a member of the health plan, in accordance with federal law, from a member, so long as Emergency Services and Care are not delayed in the process.

16) When included in the member's benefit plan, the health plan is responsible for covering emergency transportation without the need for precertification. Emergency transportation providers have one hundred eighty (180) days from the date of service to submit a claim for reimbursement or such other time frame to submit claims as included in their provider agreement.

17) Notwithstanding the requirements set forth in this section, the health plan will make payment on all claims for Emergency Services and Care by non-participating providers.

REFERENCES:

42 CFR Ch. IV (10-14-06 Edition)
42 USC 1395dd (e) Definitions
§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.
§ 422.214 Special rules for services furnished by non-contract providers.
42 CFR 438.114; 42 CFR 422.113(c); Federal Requirement letter dated 04.05.2000 ("SMD Letter - Managed Care Provisions Regarding Coverage of Emergency Services by MCOs – 04.05.2000")
Colorado Community Health Alliance Regional Accountable Entity Contract, Amendment 1, Section 14.5.6.2
405 Indiana Administrative Code §§ 5-2-9, 5-3-12; 5-4-2; and 5-5-2
Florida Healthy Kids Medical Services Contract
Indiana HHW, Exhibit 1.C, Sections 3.2 and 3.6; HIP, Exhibit 2.C, Sections 6.1, 6.2 and 6.6; and HCC, Exhibit 1.G, Sections 3.0 and 3.3

Indiana Code §§ 12-15-12-0.3 and 12-15-12-0.5
Iowa Health Link Contract § 3.2.5.1.
Kentucky Medicaid Managed Care Contract Sections 1, 33.3, 33.4
Kentucky Revised Statute 304.17A-603, 304.17A-607
Maryland COMAR 10.67.05.08
Minnesota Contract PMAP, MinnesotaCare, MSC+, and MSHO. January 2018
Second Amendment to the Iowa Health Link Contract § 3.2.5
Virginia Commonwealth Coordinated Care Plus Contract § 4.6.
Virginia Medallion 4.0 §8.2.Q; 42 CFR §422.113(c)
West Virginia Contract Article II, Section I; Article III, Sections 1.2.2; 1.2.3; 1.3.1; 2.7.3; 2.7.4; 2.7.5; 7.6.3

Related Policies and Procedures:
Behavioral Health Emergency Care
Coverage for Post Stabilization Care Services
Emergency Care - TX
Emergency Room Services - VA
Emergency and Post-Stabilization Services – LA
Reimbursement Policy: Transportation Services – Ambulance
Timely Claims Payment - AR

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department:
The GBD Intake teams within GBD OPC team – Clinical (formally known as the NCC)

EXCEPTIONS:

Medicare
In accordance with the prudent laypersons definition of emergency medical condition, regardless of diagnosis, for which a plan provider or other Medicare representative instructs a member to seek emergency services within or outside the plan.

For Emergency Services Out of the Country:
1) Refer to Benefit Summary to verify if **the World Wide Coverage** Benefit exists and to review benefit exclusions.
2) If member does have World Wide coverage, advise of limited annual benefit as identified in the Benefit Summary for all services related to an emergency.
3) **For Blue and Green Plan Members:**

World Wide Coverage Benefit is a supplemental benefit and not a benefit covered under the Federal Medicare program. This benefit applies to travel outside the United States and its territories for less than six months

a) Benefit is limited and covers emergency services related to stabilize the medical condition.

4) **For Blue Plan members:** Direct member/provider to contact the Blue Card World Wide Service Center at 1-800-810-2583 or collect at 1-804-673-1177 for more information or to verify provider participation.
5) **For Green Plan members**:
   a) Customer service representative is to review benefit summary to verify if coverage exists and explain benefit payment limits to member.
   b) The member may request that the provider submit a bill to the Company for the services rendered. The maximum allowable amount noted in the benefit summary and all other costs will be the member's responsibility.
   c) The member may submit a bill for reimbursement. The member must include the bill and receipt of payment for the services when submitting the information to us via the following address:

AMERIVANTAGE
P.O. Box 61010
Virginia Beach, VA 23466

Stabilization of the Member:

The physician treating the member must decide when the member is considered stable for transfer or discharge, which is binding to Medicare. During this period, maintenance and post-stabilization care services will be coordinated. The Plan assumes financial responsibility for:

1) The member's post-stabilization care services obtained within or outside the Medicare network that are pre-approved by the plan/plan provider or a Medicare representative,
2) Post-stabilization services that are not pre-approved by a plan provider or Medicare representative, but administered to maintain, improve or resolve the member's stabilized condition if:
   a) The plan does not respond to a request for further pre-approval of additional post-stabilization care services within one (1) hour of a request,
   b) The plan is unable to be reached,
   c) An agreement between the plan and the treating physician cannot be reached concerning the member's care, and a plan physician is not available for consultation. In this situation, Medicare 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 § 422.113 (c)(3) is met. That is, when the financial responsibility ends with the following:
      i) A plan physician with privileges at the treating hospital assumes responsibility for the member's care,
      ii) A plan physician assumes responsibility for the member's care through transfer,

iii) A Medicare representative and treating physician reach an agreement concerning the member's care, or
iv) The member is discharged.

Kentucky
Emergency Services or Emergency Care means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Emergency Behavioral Health Disorder Services or Care means an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition rendering the member unmanageable and unable to cooperate in treatment.

The health plan shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the health plan of the Member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A Member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The health plan is responsible for coverage and payment of services until the attending Provider determines that the Member is sufficiently stabilized for transfer or discharge.

Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid Fee-For-Service rate as required by Section 6085 of the Deficit Reduction Act of 2005. For services provided by non-contracting hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in Fee-For-Service payments.

Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts.

Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment. Continued hospital NICU stays require authorization.

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Health Care Management	**Emergency Services - Core Process**

REVISION HISTORY:

Review Date	Changes
03/11/2020	• Off cycle addition of contractual requirements for the Florida Healthy Kids contract. • Update to FL references and FL exception language
01/23/2020	• Annual Review • Removed KS as an applicable market and the exception • Remove Louisiana as an applicable market. Refer to LA-specific policy. • Added SC as an applicable market • Revised Definitions • Updated Procedure • Updated References • Updated Related Policies and Procedures • Updated Secondary Department to reflect NCC's new Department name of GBD OPC Team • Revised Medicare, CO, GA, KY, MN, NV, NY, NYW, VA, WA and WV exceptions and placed in alphabetical order
08/28/2019	• Off-cycle Review • Revised WV Reference
06/25/2019	• Off-cycle Review • Revised WV Exception per Contract Amendment
01/24/2019	• Off-cycle edits to add AR as an applicable market; added AR reference
12/12/2018	• Annual review • Added CO & DC as applicable markets • Revised References section • Added GBD Intake as a secondary department • Added exceptions for CO & WV, revised exceptions for FL, MN & WA, removed VA MMP exception. • Modifications required for AHCA Contract No. FP068 signed 08/01/2018 that becomes effective 12/01/2018 • Adopted for all Florida Simply Healthcare Medicaid Plans
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to

	notate market go-live of 12/1/18.
07/30/2018	• Off-cycle edits to VA References and exception for VA 4.0 Medallion project
07/26/2018	• Off-cycle edit to add Reference and modify KY exception language
06/07/2018	• FL Only - 2/1/18 - Off-cycle edits to add FL Medicaid definition exceptions • 2/16/18 - Adopted by FL Medicare Plan with no changes to the policy language
02/15/2018	• Off-cycle edits to IA exception language
12/29/2017	• Annual review • Revised definition of Emergency Medical Condition • Revised #3 & #8c of Procedure section • Revised References section • Revised IN, KS, NV, WA & VA exception language; added exception language for New York - Western
05/23/2017	• Off-cycle edits to add Medicaid-Medicare as an applicable product for CA & TX only and add exception language for Medicaid-Medicare
03/13/2017	• Off-cycle edits to add Iowa references and exception language per Second Amendment to the Iowa Health Link Contract § 3. 2. 5
10/27/2016	• Annual review – will go to MOC • Added IN and NY-Western as applicable markets; WV removed; • Added #11 under Procedure section - hospital notification to health plan • Added related policies and procedures • Added IN exception language; revised IA; MD; Medicare exception language
09/16/2016	• Off-cycle edits to add Iowa references and exception language
03/23/2016	• Off-cycle edit to WA exception language
02/10/2016	• Off-cycle edit to remove NM from the definition of “Emergency Medical Condition”
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016. • Added Iowa exception language
09/27/2015	• Off-cycle edits to New York exception
08/27/2015	• Annual review by PPOC and MOC. • Revisions to definitions, procedures and exceptions sections
05/28/2015	• Remove LA as applicable market. Added Emergency Services – Core Process – LA as a Related Policies and Procedures
12/10/2014	• Off- cycle edits to VA and NJ exceptions.
06/24/2014	• Annual Review

04/01/2014	• Added Wisconsin as applicable health plan and removed New Mexico. Deleted NM exception language
11/11/2013	• Added Kentucky health plan
11/01/2013	• Off-cycle review to add Virginia as an applicable market. Add VA exception, remove OH exception and move to MBU template.