# DEPARTMENT OF MANAGED HEALTH CARE
# OFFICE OF PLAN MONITORING
# 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 July 13, 2016 Technical Assistance Guide renders all other versions obsolete***

## ACCESS TO EMERGENCY SERVICES AND PAYMENT

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**BEHAVIORAL HEALTH TAG**

# Requirement ER-001: Emergency Services Authorizations

## 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
- 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

***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.**

***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).**

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| Assessment Questions | |
|---|---|
| 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 | |
|---|---|
| 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? |
| 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? |

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***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 | |
|---|---|
| 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? |

***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 | |
|---|---|
| 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, from his or her subjective viewpoint, reasonably should have known that an emergency did not exist? |
| 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, from his or her subjective viewpoint, reasonably should have known that an emergency did not exist? |

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|---|---|
| 4.3 | Does the Plan's policy and denials for reimbursement use the standard set forth in Section 1317.1(b)?<br><br>"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:<br>(1) Placing the patient's health in serious jeopardy.<br>(2) Serious impairment to bodily functions.<br>(3) Serious dysfunction of any bodily organ or part. |

***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 section 1317.4a.(a), (b)(1), (c)(1) and (d); 28 CCR 1300.71.4(c).**

| **Assessment Questions** | |
|---|---|
| 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 ***either*** of the following:<br>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?<br>**-- Or --**<br>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? |
| 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 ***either*** of the following:<br>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?<br>**-- Or --**<br>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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| 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? |
| 5.4 | Is this contact information updated on a periodic basis, at least annually? |

**End of Requirement ER-001: Emergency Services Authorizations**

**BEHAVIORAL HEALTH TAG**

# Requirement ER-002: Emergency Services Claims Payments

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

**Staff responsible for the activities described above, for example:**

- Medical Director
- Director of Claims

## DOCUMENTS TO BE REVIEWED

- Policies and procedures and training materials regarding ER claims processing
- Claims processing guidelines, policies or procedures for processing ER claims.
- Claims processing timeliness reports for ER claims
- Internal audit reports to monitor compliance with ER claims processing policies and procedures
- ER claim denial log, including all ER claim types (for example, including medical services, mental health services, involuntary admissions, etc.
- Sample of Out-of-Area denied ER claim files to be reviewed onsite

***ER-002 - Key Element 1:***

1. **The Plan shall ensure the timely and accurate processing of emergency service claims.**
   **CA Health and Safety Code section 1317.1; CA Health and Safety Code section 1367.01(h)(1) and (4); CA Health and Safety Code section 1371; CA Health and Safety Code section 1371.4.(c); 28 CCR 1300.71(a)(3).**

| Assessment Questions | |
|---|---|
| 1.1 | Do the Plan's policies and procedures specify that payment for emergency services must be processed utilizing a standard where an emergency medical condition exists from the enrollee's subjective point of view? |
| 1.2 | Are ER claims denials processed within 30 working days of receipt of complete data necessary to process the claim by a health care service plan or within 45 working days of receipt of complete data necessary to process the claim by an HMO? |
| 1.3 | Did the denial consider a standard where an emergency medical condition exists from the enrollee's subjective point of view? |

**End of Requirement ER-002: Emergency Services Claims Payments**

# 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 (Part1 (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.

(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 sections 1317.4a (a), (b)(1), (c)(1) 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).
(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 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 **...**
(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 section 1367.01(h)(1) and (4)**
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and

telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

**CA Health and Safety Code section 1371**

(a)(1) A health care service plan, including a specialized health care service plan, shall reimburse claims or a portion of a claim, whether in state or out of state, as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.
(2) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. A plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.
(3) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.
(4) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue

and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30-or 45-working-day period.
(b) Notwithstanding any other law, a specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to investigate suspected fraud and to recover overpayments made as a result of fraud only if the specialized health care service plan complies with this subdivision.
(1) A specialized health care service plan's statistically reliable method, and how the specialized health care service plan intends to utilize that method to determine recovery of overpayments made as a result of fraud, shall be submitted to, and approved by, the department as elements of the specialized health care service plan's antifraud plan established and approved pursuant to Section 1348. The specialized health care service plan's utilization of a statistically reliable method shall help protect and promote the interests of enrollees and shall help ensure a stable health care delivery system. The statistically reliable method shall be consistent with direction provided by the International Standards for the Professional Practice of Internal Auditing and the guidance provided by the International Professional Practices Framework guide, which are both produced by the Institute of Internal Auditors.
(2) Pursuant to its antifraud plan established and approved pursuant to Section 1348, a specialized health care service plan shall provide a written notice of suspected fraud to a provider that includes, at a minimum, all of the following:
(A) A clear description of the specialized health care service plan's statistically reliable methodology. The description shall include information that ensures that the sample size used to calculate the repayment amount is consistent with the professional guidance provided in the 2009 edition of the American Institute of Certified Public Accountants' Audit Sampling Considerations of Circular A-133 Compliance Audits.
(B) A clear description of the universe of claims from which the statistical random sample was drawn and, if different, the universe of claims upon which the statistical analysis was applied to generate the recovery amount.
(C) A clear explanation of how the specialized health care service plan's statistically reliable methodology was utilized in the specialized health care service plan's findings of suspected fraud.
(D) Notice that a provider may dispute the specialized health care service plan's findings within 45 working days from the date of receipt of the notice of suspected fraud.
(E) The following information for each of the claims in the statistical sample that was utilized in the specialized health care service plan's findings:
(i) The claim number.
(ii) The name of the patient.
(iii) The date of service.
(iv) The date of payment.
(v) A clear explanation of the basis upon which the specialized health care service plan suspects the claim is fraudulent.
(3) A specialized health care service plan that undertakes solely to arrange for the provision of vision care services may use a statistically reliable method to recover overpayments made as a result of suspected fraud only if the universe of claims upon

which the statistical analysis is performed consists only of those claims made between 365 days from the date of payment of the earliest in time claim and the date of payment of the latest in time claim. Notice shall be mailed to the provider no later than 60 days following the date of payment of the latest in time claim.
(4) If the provider contests the specialized health care service plan's notice of suspected fraud, the provider, within 45 working days of the date of receipt of the notice of suspected fraud, shall send written notice to the specialized health care service plan stating the basis upon which the provider believes that the claims are not fraudulent. The specialized health care service plan shall receive and process this contested notice of suspected fraud as a provider dispute pursuant to subdivision (a) of this section, paragraph (1) of subdivision (h) of Section 1367, and the regulations promulgated thereunder.
(5) A specialized health care service plan may offset the amount the specialized health care service plan disclosed as overpaid to the provider in an uncontested notice of suspected fraud against the provider's current claim submissions only if all of the following requirements are met:
(A) The provider fails to reimburse the specialized health care service plan within 45 working days from the date of receipt by the provider of the notice of suspected fraud.
(B) The specialized health care service plan sends written notice to the provider no less than 10 working days prior to withholding current claim payments in which the specialized health care service plan, at a minimum, states its intent to withhold current claim payments and identifies the claim payments that the specialized health care service plan intends to withhold.
(C) The withheld claim payments do not exceed the amount asserted by the specialized health care service plan to be owed to the specialized health care service plan in its notice of suspected fraud.
(6) This section does not limit or remove a specialized health care service plan's obligation to comply with its antifraud plan established pursuant to Section 1348, or to limit or remove the specialized health care service plan's obligation to comply with the requirements for claims subject to subdivision (a).
(7) This subdivision does not limit or remove a specialized health care service plan's ability to recover overpayments as long as recovery is consistent with applicable law, including subdivision (a) and the regulations promulgated thereunder.
(8) This subdivision does not apply to claims submitted by a physician and surgeon for medical or surgical services that are outside the scope of practice of an optometrist pursuant to the Optometry Practice Act (Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).
(c) The obligation of a plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

### CA Health and Safety Code section 1371.4(a)-(d)

(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.
(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.
(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 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.
(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 section 1374.72(g)(2)**
(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.

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**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.

**28 CCR 1300.71(a)(3)**
(a) Definitions.
**…**
(3) Except as required by section 1300.71.31, “Reimbursement of a Claim’’ means:
(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;
(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider’s training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider’s practice that are relevant; and (vi) any unusual circumstances in the case; and
(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee’s Evidence of Coverage.

## BEHAVIORAL HEALTH TAG

**28 CCR 1300.71.4.(a)(3)-(d)**

(a) Definitions.

**…**

(3) "Reimbursement of a Claim" means:

(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:(1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.

(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.

(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.

(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.
(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.

**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.