No. UM AER-001	Access to Emergency Services and Post Stabilization Requests to Authorize Continuing Care	
Effective Date: 1/1/2021	POLICY AND PROCEDURE	
Committee Approval: 1/18/22 Previous Versions: See revision history on last page		
DMHC TAG: Access to Emergency Services and Payment		

ACCESS TO EMERGENCY SERVICES POLICY

Canopy Health bears responsibility for emergency and post-stabilization services that are provided to our members in our defined service areas specific to each of our health plan products.

The Medical Group/IPA shall facilitate all needed emergency services without prior authorization in cases where an emergency medical condition exists. Coverage of emergency services is required to screen and stabilize the member without prior approval, when a member believed that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases. Emergency medical condition is defined as 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." HSC Section 1317.1(b).

The medical groups and IPAs do not deny payment for ER services and do not hold the member financially responsible for amounts beyond applicable co-payments.

"Emergency services" means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition

All emergency services that are provided to screen and stabilize members who present with an emergency medical condition are covered without prior authorization, do not require medical record review and are not denied. Emergency department services are never denied through an automated claims system. Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant, e.g., the member is unconscious and in need of immediate care at the time medical treatment is required [per California regulation 29 CFR 2560.503-1(b)(3)].

A physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services.

Behavioral health care practitioners are available to review psychiatric emergency conditions.

Urgent Care services do not require prior authorization.

The medical groups and IPAs cover all requests for emergency services if an authorized representative acting for the group authorized the provision of the emergency services. An "authorized representative" constitutes any employee or contractor (e.g., network practitioner, advice nurse, PA, or customer services representative) who directs the member to seek emergency services.

The medical groups and IPAs do not limit emergency medical conditions on the basis of lists of diagnoses or symptoms.

The medical groups and IPAs do not refuse to cover services because an emergency room provider, hospital or fiscal agent did not notify the member's PCP or Health Plan about the member's screening and treatment within 10 calendar days of presentation for emergency services.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

The emergency screening fee (Medical Screening Exam) is paid in timely fashion for all ER claims when clinical data that would support a higher level of payment is not available. The medical groups and IPAs have processes to review and address claims payment and provider disputes about emergency room claims that have been denied.

Services are covered by the member's health plan when a member is temporarily out of the service area for care that is medically necessary and immediately required because 1) the illness, injury, or condition was unforeseen; and 2) it was not

reasonable, for the member to obtain the services through Network providers, given the circumstances.

Emergency and urgent services are covered by the member's health plan when they are offered by a Canopy Health non-Network provider for a member who is temporarily located out of Canopy Health's service area. Emergency and urgent services are covered by Canopy Health when they are offered by providers within Canopy Health's service area, whether or not that provider is within Canopy Health's network. Emergency and urgent services are those which are immediately needed and medically necessary because:

1) the illness, injury, or condition was unforeseen and

2) it was not reasonable for the member to obtain the services through Network providers given the circumstances.

Members may never be balance-billed for emergency services by providers in network or non-network providers.

Non-contracted providers are paid for the treatment they provide for the emergency or urgent medical condition, including medical necessary services rendered to a member until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Retrospective Review of Emergency Services

Claims adjusters, utilization review staff and the medical director(s) work together to evaluate pre-certification and retrospective requests for emergency services.

Payment denials of emergency services are considered "medical necessity" denials and must be reviewed by a Medical Director.

Retrospective denials of emergency services must include consideration of presenting symptoms and will not be based solely on discharge diagnosis.

Ambulance services are covered when the member reasonably believed the condition was an emergency.

Behavioral health practitioners are available to the Medical Director for denial determinations as appropriate.

The Medical Director(s) may contact board certified specialists to assist in making determinations of medical necessity.

Care after Emergency Room Services:

If the medical staff at the hospital department determines that the condition is not an emergency, the member is responsible for arranging follow up care with the PCP, per CA HSC 1371.4.(d), applicable to Commercial and Medi-Cal only.

PCP Notification and Follow up care

The PCP is to be notified of their patient's accessing the ER for emergency care.

The PCP is required to provide timely follow-up care to members in the following circumstances:

- when emergency care is deemed not necessary in an emergency department after emergency services were sought or
- if follow-up care is indicated after treatment in the emergency department.

RESPONSIBILITY:

Utilization Management Medical Director, ER Physicians, Claims Department.

POST-STABILIZATION REQUESTS TO AUTHORIZE CONTINUING CARE POLICY

Prior authorization of ongoing care after initial stabilization:

Canopy Health, its participating providers and/or contracted health plan requires prior authorization for post-stabilization care. Canopy Health notifies all hospitals within its service area about how and whom to contact to obtain authorization for post stabilization care. Canopy Health's upstream health plans are responsible to authorize post stabilization care outside of Canopy Health's service area, and so those health plans are responsible to notify out-of-area hospitals about how and whom to contact within the health plan to obtain authorization for post stabilization care.

Providers requesting authorization for post stabilization care within Canopy Health's service area must document the following:

- Date and time of the provider's request;
- Name of the health care provider making the request;
- Name of the Network representative responding to the request.

Responses to authorization requests for post stabilization, medically necessary care are rendered by Canopy Health through its participating providers and/or contracted health plans to the requesting patient and provider (regardless of whether that provider is contracted with the Network or not). Responses must adhere to the following requirements:

- Access for patients and providers to timely authorization for medically necessary post -stabilization care, through a 24 hour, toll-free Member Services telephone line. This telephone number must be widely distributed to all hospitals to obtain authorization.
- Response to an initial single call from a hospital that is requesting post-stabilization authorization.
- If Canopy Health providers and/or contracted health plans do not respond to a post stabilization request within 30 minutes of the request, the Network will pay any claims submitted by the provider for the post stabilization care rendered.
- If post-stabilization requests are denied, that decision is communicated within 30 minutes of the request.

Addressing disagreements about medical necessity of ongoing care after initial stabilization:

After a member has been stabilized after received emergency services, if the treating provider believes that the enrollee may not be discharged safely from that treating institution but the member's primary medical group disagrees about the need for the member to get ongoing care at that institution, the medical group shall assume responsibility for the care of the patient. The medical group may assume responsibility in one of two ways:

- having providers contracted with the medical group personally take over the care of the patient, within a reasonable amount of time after the disagreement has been identified, or
- transferring the member to another general acute care hospital that 1) has agreed to accept the patient in transfer and 2) is contracted with the Canopy Health.

Revision History:

Version Date	Edited By	Reason for Change
1/29/16	M. Stevens	Creation date
7/27/16	M. Durbin	Consolidated sections of Exhibit J-9 pertaining to post-stabilization care authorization into a single, standalone policy.
7/25/17	M. Durbin	Updated sections in response to the Health Net UM audit re: ER services are never denied through automated claims systems
10/9/17	M. Durbin	Updates based on MWE DMHC P&P filing updates to align language re: emergency medical definition to regulations
9/30/18	M. Durbin	Clarified and improved readability of non-network coverage for members.
5/21/20	M. Durbin	Changed term "Network" to "Canopy Health".
1/1/2021	M. Durbin	Added wording to clarify coverage of emergency services in network, out of network, and out of area for Canopy Health.