blue california
Promise Health Plan

Policy Title: Emergency Care Services		POLICY #: 70.2.1 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable): PHP CMO		**Date: 3/21**	

PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to monitor, control, account for, and maintain a workflow process for member utilization of emergency medical and mental health care services.

DEFINITION:

Emergency Services and Care: means medical screening, examination, evaluation and treatment to relieve and eliminate the emergency medical condition by a physician, or other appropriate personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

It also means additional screening, examination and evaluation and treatment to relieve or eliminate the psychiatric emergency medical condition by a physician, or other appropriate personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

Emergency Medical Condition: means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain, such that a reasonable person would expect that the absence of immediate medical attention could result in imminent and serious threat to health including (1) placing the member's health in serious jeopardy due to potential loss of life, limb, or other bodily function, or serious dysfunction of any bodily organ or part; (2) with respect to a pregnant woman who is having contractions, an emergency medical condition is also a situation in which (a) there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) transfer may pose a threat to the health or safety of the woman or the unborn child; or (3) a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function, and does NOT require prior authorization.

Emergency Psychiatric Condition: California HSC 1317.1 defines "psychiatric emergency medical condition" as a mental disorder that manifests itself by acute symptoms of sufficient severity to render the patient either an immediate danger to himself or others, or immediately unable to provide for, or utilize food, shelter, or clothing, due to the mental disorder.

Blue Shield Promise will cover emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

Urgent care service is a covered benefit for members. Either Blue Shield Promise Health Plan or the delegated IPA/Medical Group/MBHO responsible for urgent care services will ensure that the member will be seen within 48 hours upon request.

POLICY

Blue Shield Promise does not require a provider to obtain authorization prior to the provision of the emergency services and care necessary to stabilize the enrollee's emergency medical condition.

When an enrollee is stabilized but requires additional medically-necessary health care services, Blue Shield Promise requires providers to notify Blue Shield Promise prior to, or at least during the time of rendering these services. Blue Shield Promise wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue. Inappropriate use of the emergency room is often attended by disproportionate charges for less seriously ill patients who may be treated definitively by providers unfamiliar with them.

Blue Shield Promise is responsible for coverage and payment of emergency services and post-stabilization care services and shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with Blue Shield Promise. Further, Blue Shield Promise may not deny payment for treatment obtained when a representative of Blue Shield Promise instructs the member to seek emergency services.

Blue Shield Promise shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or Blue Shield Promise.

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

Blue Shield Promise does not deny ER Claims. All ER Claims with CPT Codes of 99284 or less are automatically paid by the claims department. All ER Claims with CPT of 99285 are subject to retrospective review, to review the level of care given. The Claims Department shall request medical records for all 99285 claims and forward to the UM Department for review and adjudication. Claims with CPT Code 99285 are not denied, but, if after review they do not meet the severity of CPT Code 99285, they will be paid at CPT Code 99284.

Blue Shield Promise ensures reasonable reimbursement for covered emergency services as follows:

- Services obtained from both contracted and non-contracted providers up to the time the emergency condition of the member was stabilized.
- Services obtained from both contracted and non-contracted providers when the services were authorized by Blue Shield Promise
- Ambulance services dispatched through 911

PROCEDURE

LIFE THREATENING OR DISABLING EMERGENCY: Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization.

BUSINESS HOURS:
In a 911 situation, if a member is transported to an emergency department (ED), the (ED) physician will contact the member's PCP (printed on the member's enrollment card) as soon as possible in order to give him/her the opportunity to direct or participate in the management of care.

Medical Screening Exam:
Hospital emergency departments under Federal and State laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the ED. Emergency services include additional screening examination and evaluation needed to determine if an emergency medical condition exists. Blue Shield of California Promise will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably, would have believed that an emergency medical condition existed in compliance with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) EMTALA – The Emergency Medical Treatment and Active Labor Act and California Health and Safety Code Section 1317.

AFTER BUSINESS HOURS:
After regular Blue Shield Promise business hours member eligibility, and access to emergency health care services is obtained and notification is made by calling the 800 number on the member ID card. The 800 number connects to a 24 hour per day/7 days per week multilingual information service. The service is available to members as well as to providers. For information other than eligibility requests the call service cross connects the caller to a Blue Shield of California Promise licensed nurse.

THIS IS NOT A MEDICAL ADVICE SERVICE. It is for informational purposes and to coordinate member care.
In the event that a member calls for advice relating to a clinical condition that they are experiencing and believe based on their perception that it is urgent/emergent, they will be advised to go to the nearest emergency room or to call 911.

The Blue Shield Promise 800 number additionally serves as first response access for beneficiaries in need of behavioral health services. The Blue Shield Promise on-call nurse(s) can assist members in coordinating care Blue Shield Promise Managed Behavioral Health Organization (MBHO), the county Mental Health Plan, or emergency room personnel during a crisis.

The following are some of the key services that the on-call case managers provide:

- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for members post emergency care
- Facilitate patient transfers from emergency departments to contracted hospitals or California Children Services (CCS) paneled facilities when applicable.
- Arrange facility transfer ambulance transport services
- Assist members with non-emergent transportation services for weekend appointments when needed
- Provide network resource information to members and providers
- Assist in pharmacy issues

- Link Blue Shield Promise contracted physicians to Emergency Department physicians when necessary
- For additional support the on-call nurse has access to the Medical Director or an alternate covering physician to assist in physician related issues.

POST-STABILIZATION SERVICES:
Blue Shield Promise shall approve or disapprove a request for post-stabilization inpatient services made by a contracting or non-contracting provider on behalf of a member within 30 minutes of the request. If not done within the required timeframe, the authorization request will be deemed approved, in accordance with Title 28, Section 1300.7.1.4.

Post-stabilization care services are covered and paid for in accordance with provisions set forth in 42 CFR 422.113(c). Blue Shield Promise is financially responsible for post-stabilization services obtained within or outside its network that are pre-approved by plan provider or representative. Blue Shield Promise is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved but administered to maintain the enrollee's stabilized condition within one hour of a request to Blue Shield Promise for pre-approval of further post-stabilization care services.

Blue Shield Promise is financially responsible for post-stabilization care services obtained within or outside of its network that are not pre-approved by plan representative, but administered to maintain, improve or resolve the enrollee's stabilized condition under the following conditions:

- Blue Shield of California Promise does not respond to a request for pre-approval within **30 minutes** (in accordance with Title 28, Section 1300.71.4) or within **one hour** (consistent with 42 CFR §422.214)
- Blue Shield Promise cannot be contacted; or
- Blue Shield Promise representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, Blue Shield Promise shall give the treating physician may continue with care of the patient until a physician is reached or one of the criteria 422.133(c)(3) is met.

Blue Shield Promise's financial responsibility for post-stabilization care services it has not pre-approved ends when

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A plan representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

If assistance is needed in directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary, or under circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.

Blue Shield Promise's Chief Medical Officer or a covering physician is available 24 hrs per day 7 days per week to consult with the on-call case manager or emergency room personnel, or for resolving disputed requests for authorizations.

The on-call nurse's authorization of ER services is recorded on a Report of Emergency Treatment when the nurse is notified of a Blue Shield Promise member accessing ER care. The information from this form is entered into the Medhok Auth Accel system by a UM Coordinator and this information is faxed to the PCP's office the next business day to be retained in the member's medical record in order to maintain continuity of care. The Utilization Management (UM) Department will also assist in coordinating any post-ER follow-up services needed for the member.

If criteria are not clearly satisfied, the on-call nurse will advise the caller that the care will be subject to retrospective review, and that clinical records must accompany the claim (see Retrospective Utilization Review Policy and Procedure).

In the event that a Quality Management indicator has been identified by the Utilization Management (UM) Department staff during the emergent/urgent review process the on-call nurse will complete a Quality Management Referral Indicator form and forward the Case to the Quality Management department on the next business day.

RETROSPECTIVE REVIEW OF EMERGENCY ROOM SERVICES:
ER claims may be reviewed according to clinical criteria for medical necessity by the Utilization Management (UM) Department. Determinations made with consideration of the member's perception of what constitutes a medical emergency (i.e., severe pain, acute versus chronic, symptoms not recognized or experienced before), in compliance with health plan standards. Any claims that does not meet criteria for emergent services may be modified upon review and approval of a Blue Shield Promise Medical Director. Any claim reviewed retrospectively will be returned to the Claims Department for processing within 30 (thirty) - calendar days.

All ER visits authorized by the PCP or other authorized representatives will be automatically approved for payment. They may be subject to retrospective review if they are determined to contain non-emergent services.

NON-CONTRACTING PROVIDERS:
Blue Shield Promise shall pay for emergency services received by a member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition, including medically necessary inpatient services rendered to a member until the member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Blue Shield Promise, or the member is stabilized sufficiently to permit discharge. The attending ER physician, or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding with Blue Shield Promise. Emergency services shall not be subject to prior authorization by Blue Shield Promise.

REPORTING
Quarterly reports are generated for statistical purposes and reported to Medical Services Committee to trend ER utilization.

REFERENCES
Health & Safety Code Sections 1371.35 & 1371.4
Title 22 California Code of Regulations Section 51056
42 CFR §422.214