765 The City Drive South, Orange Ca 92868

P&P #: 014	*Emergency Services and Emergent Worldwide Coverage*	**Page** 1 of 6
TITLE:	Astiva Health Utilization Management Policy for Emergency Services and Emergent Worldwide Coverage	
APPROVED:	**12/6/2023**	
APPROVED:	Jason Chung, MD, Chief Medical Officer	
APPROVED:	UM Committee Meeting	
DEPARTMENT:	Utilization Management	

POLICY:

The Health Plan or MSO/IPA do not require a provider to obtain authorization prior to the provision of emergency services and care that is necessary to stabilize the enrollee's emergency medical condition.

Stakeholder(s)	Line(s) of Business
X Workforce Member	X Medicare
X Contractor/Vendor	❑ Medi-Cal
X Delegate	X Dual
❑ Other	❑ Commercial
	❑ Other

PURPOSE:

This policy will establish and define mechanisms for the Health Plan and MSO/IPA Utilization Management (UM) Departments to monitor, control, account for and maintain a workflow process for member utilization of emergency medical and mental health care services.

DEFINITIONS:

Emergency Medical Condition

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 be expected that the absence of immediate medical

attention could result in imminent and serious threat to health including 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 bodily part.

Emergency care

Emergency care refers to services that are:

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

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

CMS The Centers for Medicare & Medicaid Services oversees the federally and state funded insurance programs for seniors, persons with disabilities (Medicare) and low income (Medicaid) who are deemed eligible for these benefits.

NCQA National Committee for Quality Assurance is an accreditation body that is highly respected in the industry and has been appointed by Congress to aid in developing standards for Special Needs Plans (SNPs) including but not limited to the SNP Model of Care requirements. Additionally, health plans and providers who voluntarily request NCQA Accreditation undergo an in-depth review and survey of their operations and quality improvement processes and results to prove their value to consumers and other purchasers of insurance. Accreditation may or may not be granted. When granted the accreditation is for specified functional areas and is for a specified timeframe.

FWA FWA is Fraud, Waste, and Abuse (a term used to reference the entire gamut of inappropriate behavior, activities, practices, etc. related to perpetrating crimes against members or related to government funding)

HHS The United States Department of Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services. Its motto is "Improving the health, safety, and well-being of America. Various States also have a Health & Human Services Department for the citizens of their State.

PROCEDURES

Emergent Stabilization

1. When an enrollee is stabilized but continues to require additional medically necessary health care services the servicing provider is required to notify the payor Health Plan or MSO/IPA within 24 hours during the stabilization period.
2. The Health Plan or MSO/IPA 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 the Health Plan, IPA.
3. The Health Plan, MSO/IPA 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 Health Plan, MSO/IPA
4. 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 patient.
5. The Health Plan, MSO/IPA ensures reasonable reimbursement for covered emergency services as follows:
   5.1 Services obtained from both contracted and non-contracted providers up to the time the emergency condition of the member was stabilized,
   5.2 Services obtained from both contracted and non-contracted providers when the services were authorized by the Health Plan, MSO/IPA
   5.3 Ambulance services dispatched through 911.
   5.4 Retrospective review of ER service will include review of ER summary including presenting symptoms and discharge diagnosis.

6. Life Threatening or Disabling Emergency:

   1. Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purpose of determining eligibility or obtaining prior authorization.

7. Business Hours:

1. In a 911 situation, if a member is transported to an emergency department (ED), the ED physician will contact the member's Primary Care Physician, Health Plan, or IPA in order to give the opportunity to direct of participate in the management of the care.

Post Stabilization Services

1. The Medicare member post stabilization care services are covered and paid for in accordance with provisions set for the in 42 CFR 422.113 ©. The Health Plan is financially responsible for post stabilization services obtained within or outside its network as follows:

1.1 In the event that an emergency department provider contacts the Health Plan/IPA for post stabilization authorization the Health Plan, IPA shall approve or deny the request for post stabilization inpatient services on behalf of a member within 60 minutes of the request. The decision to deny the request is solely made under the direction of the Physician on call after receiving full clinical report by the ER attending physician.

1.2 If the Health Plan, IPA does not respond within the required timeframe, the authorization request will be deemed approved.

1.2.1 If the Health Plan, IPA on call representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultations the post stabilization services will be deemed approved up to the time that the Health Plan, IPA is able to give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a physician is available.

1.2.2 The Health Plan, IPA financial responsibility for post stabilization care services that have not been pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the members care, or

1.2.2.1 A plan physician assumes responsibility for the member's care through transfer, or

1.2.2.2 A plan representative and the treating physician reach an agreement concerning the member's care, or

1.2.2.3 The member discharges.

1.2.3 The Health Plan, IPA maintains physician coverage availability 24 hours per seven (7) days per week to consult with the on-call case manager or emergency room personnel, or for resolving disputed request for authorization.

Non-Contracted Providers:

1. The Health Plan, IPA 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 instruction from the Health Plan, IPA, 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, or transfer or discharge and that determination is binding with the Health Plan, IPA. Emergency services shall not be subject to prior authorization of the Health Plan, IPA.

Emergency Care- Worldwide Coverage

1. We reimburse up to $50,000 per year, after a $75 copayment, for emergency and urgent care received outside the United States and its territories. This copayment is waived if you are admitted to the hospital as an inpatient or under observation within 48 hours for the same condition. Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States and its territories.

   If you have an emergency outside of the U.S. and its territories, you will be responsible for paying the services rendered upfront. You must submit a discharge summary or equivalent medical documentation and proof of payment in English and U.S. dollars for reimbursement to Astiva Health. We will review the documentation for medical necessity and appropriateness before reimbursement is made. We may not reimburse you for all out- of- pocket expenses.

   If clinical notes are not in English, you will need to provide a certified translation. If payment invoice is not in U.S. dollars, reimbursement will be calculated using the exchange rate at the time the check is processed. Payments are tendered in U.S. dollars only. Monetary exchange rate fees, translation costs, postage, return travel to the U.S., and other nonmedical fees are not reimbursable.

   See "Services we do not cover (exclusions)" section later in this chapter for more information. *This benefit does not apply to your maximum out-of-pocket amount.

Quarterly reports

1. Reporting is generated for statistical purposes and reported to the Health Plan, IPA Utilization Management Committee to trend ER Utilization and meet Health Plan requirements when requested.

REFERENCES / CITATIONS:

California Health and Safety Code Section 1317.1, 1371.35, 1371.4, 1367.01
42 CFR 422.113 ©, 422.214
Medicare Managed Care Manual, Chapter 4, 20.4, 20.5
Title 28, Section 1300 71.4

HISTORY:

Date	Summary of Significant Changes to P&P
10/19/2021	• Approved
11/6/2023	• Updated
12/6/2023	• Approved by UM Committee