KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Emergency Services				POLICY #: 3.31-P	
DEPARTMENT: Utilization Management					
Effective Date: 04/2005	Review/Revised Date: 08/19/2014	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 8/19/14

Chief Medical Officer — Date 8/18/14

Chief Operating Officer — Date 8/13/14

Director of Claims — Date 8/11/14

Director of Quality Improvement, Health Education and Disease Management — Date

Director of Health Services — Date 8/6/14

POLICY[1]:
Emergency services may be provided by any qualified emergency provider.

Emergency services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code §1317; 1317.1; and 1371.4
- California Code of Regulations Title 28 §1300.67(g)
- California Code of Regulations Title 22 §§53216; and 53855
- 2004 DHCS Contract Exhibit A-Attachment 5(2) and (3); Exhibit A – Attachment 6 (5) and (9);

Exhibit A – Attachment 9 (6); and Exhibit E - Attachment 1, (31);

- DHCS Letter: Payment for Emergency Services to Non-Contracted Providers (October 1, 2001)

DEFINITIONS:

Emergency Medical Condition[2]	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such 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 any of the following: A. Placing the member's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, B. Serious impairment to bodily functions C. Serious dysfunction of any bodily organ or part; or D. With respect to a pregnant woman who is having contractions, inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may impose a threat to the health and safety of the woman or the unborn child.
Emergency Services and Care[3] [4]	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. This includes 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.
Stabilized[5]	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.

PROCEDURES:

1.0 ACCESS

Emergency services and care are available and accessible to members on a 24-hour a day, seven days a week basis within the KHS service area.[6] KHS members have access to all emergency service facilities in Kern County. All emergency services facilities in Kern County provide care on a 24-hour-a-day, 7-day-a-week basis with one or more Physicians and one Nurse on duty in the facility at all times.[7]

KHS does not require prior authorization for emergency services and care.[8] Members may receive emergency services and care from any qualified provider.

Members needing advice or triage to an emergent care center may contact the KHS 24-Hour Telephone Triage Service at 1-800-391-2000.

The KHS Chief Medical Officer or a designee who is licensed as a "physician or surgeon"[9], is available 24 hours per day, seven days per week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.[10]

1.1 Out-of-Area Services[11]

For the Medi-Cal Product, emergency services are covered if they are provided within the United States. In addition, emergency care services requiring hospitalization are covered if they are provided in Canada or Mexico. Emergency services provided in any other country are not covered.

2.0 COVERED SERVICES

Members presenting to an emergency department for treatment should be provided with a medical screening examination (MSE) to determine whether or not an emergency condition exists. An MSE may include ancillary services routinely available to the emergency department that are necessary to determine whether an emergency condition actually exists.

If, after completion of the MSE, an emergency medical condition is found to exist, the emergency department shall treat and stabilize the member up to and including admission to the hospital.

If, after the MSE, an emergency medical condition has been determined not to exist or the emergency condition has been stabilized, prior authorization for further services must be obtained via the verbal authorization process.[12] When submitted as outlined in *KHS Policy and Procedure #3.22-P Referral and Authorization Process,* decisions on such verbal authorization requests will be rendered within 30 minutes, or the request will be deemed approved.[13] Prior authorization for payment of non-emergent services after the MSE has been performed will not be given to a non-contracted provider except in cases when KHS determines that the member could not be transferred to a contracted facility. If there is a disagreement between KHS and the Provider regarding the need for necessary medical care following stabilization of the member, KHS shall assume responsibility for the care of the patient either by having medical personnel contracting with KHS 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 KHS agree to accept the transfer of the patient[14].

2.1 Emergency Psychiatric Conditions

For the Medi-Cal Product, emergency services and care for psychiatric conditions are covered by KHS, including initial history and physical within 24 hours after admission to a psychiatric facility. All other psychiatric services with the exception of initial consults occurring while admitted for other medical condition or other

outpatient mild to moderate mental health services are carved out of the Medi-Cal Product.

KHS covers all professional services, except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets specialty mental health medical necessity criteria.

KHS covers the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.

Members in need of urgent and emergency psychiatric care that are identified by KHS, including person-to-person telephone transfers, will to be referred to the county crisis program during their call center hours. A toll free telephone crisis hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available 24 hours a day.

2.2 Emergency Transportation

Coverage includes appropriate ambulance services as described in *KHS Policy and Procedure 3.50-P Ambulance Transportation Services.*[15]

2.3 Emergency Pharmaceuticals

Under emergent circumstances, Provider shall administer and/or dispense a sufficient quantity of medication to the member to last until the member can reasonably be expected to have a prescription filled.

3.0 DOCUMENTATION

Although emergency services do not require prior authorization, practitioners/providers must submit a *Referral/Prior Authorization Form* to KHS as soon as reasonably possible after care has been provided. (Form included as an attachment to *KHS Policy and Procedure #3.22-P Referral Process.*) This requirement does not apply to Emergency Room Physicians but only to other types of Providers who perform emergency services.

4.0 COORDINATION OF CARE, MONITORING, AND REPORTING

KHS monitors primary care practitioners for adequate follow-up care for those members who have been screened in the Emergency Room and require non-emergency care through the QI site review process and reporting.[16]

KHS uses *Referral/Prior Authorization Forms* received from practitioners/providers to conduct coordination of care, tracking, and case management activities.

5.0 REIMBURSEMENT

Claims must be submitted and are processed in accordance with *KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement.* Provider disputes regarding claims payment must be submitted and are processed in accordance with *KHS Policy and Procedure # 6.04-P*

Practitioner/Provider Disputes Regarding Claims Payment.

KHS reimburses all medically necessary emergency claims according to the eligibility of the member at the time of service and the level of care received by the member. At a minimum, reimbursement for a MSE is made to all emergency room practitioners/providers, (professional and facility component and hospital based urgent care facilities).

5.1 Contracted Practitioners/Providers

Claims are reimbursed at the appropriate contract rates. Contracted practitioners/providers are paid as outlined in the following table.

Claim Type	Reimbursement Guidelines
Emergency Room	Paid at the appropriate case or MSE rate.
Emergency Room Physician	Physician is only reimbursed separately from the emergency room claim if the hospital does not have a composite rate for reimbursement of ER services. If the hospital has an all-inclusive composite rate, the physician's claims are denied "D74-Included in Hospital ER Reimbursement". In such cases, the physician should seek reimbursement from the hospital. **Contracted Physician:** Paid at the contracted case rate. **Non-Contract Physician:** Paid at Medi-Cal rates.
Pathology	Pathology services pertaining to emergency services are only reimbursed separately from the emergency room claim if the hospital does not have a composite rate for reimbursement of ER services. If the hospital has an all-inclusive composite rate, the pathologist's claims are denied "D74-Included in Hospital ER Reimbursement". In such cases, the pathologist should seek reimbursement from the hospital.
Radiology	Radiology services pertaining to emergency services are only reimbursed separately from the emergency room claim if the hospital does not have a composite rate for reimbursement of ER services. If the hospital has an all-inclusive composite rate, the radiologist's claims are denied "D74-Included in Hospital ER Reimbursement". In such cases, the radiologist should seek reimbursement from the hospital.

5.2 Non-Contracted Practitioners/Providers.

Claims are reimbursed at the lessor of the following for properly documented claims for emergency department, emergency practitioner, and emergency transportation services[17]:

A. Usual charges made to the general public
B. Maximum Medi-Cal fee-for-service (FFS) rates
C. Negotiated rates

For emergency inpatient services, in the absence of a negotiated rate, claims are reimbursed in accordance with the following guidelines: Applicable Diagnostic Related Group (DRG) reimbursement rates for out-of-network emergency and post-stabilization acute inpatient services provided to MCP beneficiaries by general acute care hospitals.

Non-contracted practitioners/providers are paid as outlined in the following table.

Claim Type	Reimbursement Guidelines
Emergency Room	Any billed service which does not seem appropriate for the diagnosis listed is subject to medical review.
Emergency Room Physician	99284-99285 require medical review and should be submitted with an emergency room report. Those claims submitted without supporting documentation are reimbursed at the 99283 level.
Pathology	Paid at the appropriate rate.
Radiology	Flat plate x-rays paid at the appropriate rate. MRIs, CT scans, etc. require prior authorization unless necessary to determine whether an emergency condition exists.

6.0 PROVIDER REQUIREMENTS

All non-contract and out-of-area Emergency Departments must follow applicable laws and regulations when KHS members present for care.

REFERENCE:

[1] **Revision 2014-08:** Revised by Director of Health Services to comply with All Plan Letter 13-004. Revised per DMHC comments dated 9/7/06. Added contract language for dispensing medication in emergency cases. Revised per DMHC Comments dated 09/06/06. **2005-10:** Revised per DHS Workplan Comments 6d (9/1/05) and 6h (9/1/05). Revised to reflect the deletion of external policy 3.15 – Urgent Care/Emergent Care 24 Hour Telephone Triage. **Revision 2005-08:** Revised per DHS Comments (7/12/05). **Revision 2005-04:** Policy reviewed against DHS Contract 03-76165. No revision needed per Lacey Campbell. **Revision 2004-05:** Created as part of routine revision of emergency services policies. Contains elements of the following policies that will be deleted upon the release of 3.23: *#3.12 – Prior Authorization for Urgent Care and Non-Emergent ER Services (2000-05); #6.24 – Emergency/Urgent Care Reimbursement Guidelines (2002-02).* **Formerly #3.23.**

[2] HSC §1317.1(b) and (c) and 2004 DHS Contract Exhibit E – Attachment 1(31). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.

[3] HSC §1317.1(a). Definition from DHS Contract Exhibit E-Attachment 1(32) is not included because it is less restrictive.

[4] " For the purposes of Section 1371.4 emergency services and care as defined in this paragraph shall not apply to services provided under managed care contracts with the Medi-Cal program to the extent that those services are excluded from coverage under the contract." HSC §1317.1(a)(2)

[5] HSC §1317.1(j)

[6] CCR Title 28 §1300.67(g)(1); DHS Contract A-6 (5) and A-9 (6)

[7] DHS Contract A-6 (5)

[8] CCR Title 22 §53855(a); DHS Contract Exhibit A-Attachment 5(2)(F) and (3)(A); DHS Contract A-9 (6)(A)

[9] "physician and surgeon" added per DMHC comment 9/6/06.
[10] DHS Contract A-6 (9) and A-9 (6)(C)
[11] CCR Title 22§51006

[12] HSC 1371.4(c); CCR Title 22 §53855(a)
[13] CCR Title 22§53855(a); 2004 DHS Contract Exhibit A-Attachment 5(3)(C). Language is currently (7/25/05) in policy 3.22. Added to this policy per DHS request (07/12/05).
[14] DMHC comment letter dated 9/6/2006
[15] CCR Title 28 §1300.67(g)(1)
[16] DHS Contract A-9 (6)(B)
[17] CCR Title 22 §53855(d); DHS Letter: Payment for Emergency Services to Non-Contracted Providers (October 1, 2001)