PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3044 (previously UP100344)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Urgent Care Services</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/03/1995</td><td colspan="4">Next Review Date: 08/13/2026
Last Review Date: 08/13/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/13/2025</td></tr>
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I. RELATED POLICIES:

A. MPUP3014 - Emergency Services
B. MCUP3039 - Direct Members

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims
D. Configuration
E. Provider Relations

III. DEFINITIONS:

Direct Member: Direct Members are those whose service needs are such that inclusion in the Partnership HealthPlan of California (Partnership) capitation system would be inappropriate. Assignment to Direct Member status may be based on the Member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe urgent care facility standards for Partnership HealthPlan of California (Partnership) contractors.

VI. POLICY / PROCEDURE:

A. The following standards must be met for Partnership to contract with a facility to provide urgent care services. These standards are based on criteria developed by the Accreditation Association for Ambulatory Health Care for urgent care services.
    1. The range of services offered by the urgent care facility and its hours of operation must be clearly defined and communicated to the public and relevant organizations.
    2. Such facilities, unless they also provide emergency services, must not solicit patients with life-threatening conditions.
    3. The urgent care facility must be prepared to evaluate and transfer patients with medical emergencies that may present as such, or which may arise in conjunction with services provided by the facility.
    4. Patients seeking immediate/urgent services may be seen without prior appointments or the provider

may require patients to be seen by appointment.

5. Immediate/urgent care services must be performed only by health care practitioners who are licensed to perform such procedures and who have been granted privileges to perform those procedures by the credentialing body of the urgent care facility, after medical review of the practitioner's documented education, training, experience, and current competence.
6. During hours of operation, a qualified physician must be available for consultation.
7. Health care practitioners who maintain skills in basic life support (BLS) must be present in the facility at all times.
8. Arrangements must be made to assure that adequate specialty consultation services are available.
9. Equipment, drugs, and other agents necessary to provide immediate/urgent care services must be available.
10. Laboratory and radiology services should be available on site. If this is not feasible, the urgent care facility must arrange for safe transport of the patient to another site for laboratory or radiology services. A written policy must be in place regarding transport procedures, which includes a statement that financial responsibility for transport services rests with the urgent care facility.
11. Ability to communicate with local police departments, fire departments, community social service agencies, ambulance services, and hospitals is needed to ensure high-quality patient care.

B. Claims issues:
   1. Direct Members
      a. Initial urgent care visits for Direct Members may be billed at the urgent care rate.
      b. Follow-up visits after an urgent care contact or treatment of non-urgent conditions must be billed as an office visit.
   2. Members Assigned to a Primary Care Provider (PCP)
      a. Members who are assigned to a PCP other than the urgent care provider may be seen for urgent care visits after hours, on weekends, and on holidays. Partnership reimburses for these visits at the urgent care rates. Claims should be submitted to Partnership for these services. Follow-up of urgent problems and treatment of non-urgent conditions must be referred to the assigned PCP. The urgent care provider must forward (preferably FAX) a copy of the urgent care record to the PCP.
      b. Members assigned to another PCP who contact the urgent care facility during business hours must be referred to the assigned PCP during business hours.
      c. The urgent care facility cannot bill the urgent care rate for Members capitated to their practice, as extended service hours are part of the PCP's scope of practice.
   3. Partnership reserves the right to audit records related to urgent care claims.

VII. REFERENCES:

Accreditation Association for Ambulatory Health Care, Inc. criteria

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES:

Medi-Cal

03/18/96; 10/10/97 (name change only); 05/04/00; 10/17/01, 05/21/03, 10/20/04; 10/19/05, 10/18/06; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 11/11/20; 02/10/21; 05/11/22; 05/10/23; 08/13/25

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Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.