PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3014 (previously UP100314)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Emergency Services</td><td colspan="3">☒External Policy
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 05/08/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Emergency Medical Condition is defined as a condition which is manifested 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 could result in:
   1. Placing the health of the member (or, in the case of a pregnant woman, the health of the member and/or her unborn child) in serious jeopardy
   2. Serious impairment to bodily functions; or
   3. Serious dysfunction of any bodily organ or part
B. Urgent conditions are defined as a sudden onset of a medical condition or the worsening of an existing medical condition such that the patient is in mild distress, but without severe pain, significant loss of function or threatened by loss of life and where urgent therapeutic intervention within 48 hours is needed to minimize the possibility of patient morbidity.
C. Triage evaluation is defined as a screening examination performed on a member where emergency or urgent services are not required in order to determine the appropriate location and time for the definitive evaluation of that member's problem.
D. Provider: For the purposes of this policy, the provider is a physician, nurse practitioner or physician assistant.
E. Physician: Medical Doctor (MD) or Doctor of Osteopathy (DO)

IV. ATTACHMENTS:

ADDENDA (*See pages 5 -7*)

A. Non-Urgent Medical Conditions
B. Urgent Medical Conditions
C. Emergency Medical Conditions

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V. PURPOSE:

To define the circumstances under which emergency services are covered.

VI. POLICY / PROCEDURE:

A. Payment for Services and Prior Authorization
   1. Partnership HealthPlan of California may review claims submitted by facilities and practitioners to determine the appropriate payment level. Partnership reserves the right to monitor claims submitted to determine that the billing accurately reflects the level of services provided.
   2. Partnership covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition.

B. Referral of Triaged Members and Follow-up
   1. Under Federal and State laws, a screening examination (triage services) is required to be performed on every patient presenting to the emergency department (24 hours a day). This will be reimbursed by Partnership. If a plan member is determined to not require emergency or urgent services, the facility will communicate with the Primary Care Provider (PCP) to determine the need for further medical attention.
   2. Partnership members may generally be referred by the treating Emergency Department (ED) provider for care to their PCP's office or an urgent care facility under the following circumstances:
      a. The member is willing to be seen in the PCP's office or urgent care facility.
      b. The member has transportation to the alternative site.
      c. The Emergency Department staff arranges an appointment for the member at a time suitable and medically appropriate for the member.
      d. The PCP or urgent care facility agrees to see the member at the appointed time.
   3. The emergency department or urgent care facility is expected to notify the PCP if follow-up care is required. The emergency department should send a copy of the ED record to the PCP or responsible provider within 48 hours of the ED visit. The emergency department provider should notify the PCP or the responsible provider at the time of the ED visit if urgent follow-up care by the PCP or responsible physician is required. Follow-up care by a specialist after an ED visit must have a Referral Authorization Form (RAF) from the PCP to be considered for payment (exception to this is for initial orthopedic consult after ED referral and for certain capitated specialist services).
   4. Emergency department staff will determine if the patient also must be evaluated by an emergency department physician prior to referral to the PCP for treatment. For more information on post stabilization services, please refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
   5. Partnership has a dedicated after-hours local phone number (707) 430-4808 or toll free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

C. Section 1882(c)(3) of the federal Social Security Act (as enacted by Section 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA):
   1. Pursuant to APL 21-015, OBRA services shall be billed and reimbursed through Medi-Cal FFS.
      a. Every person who presents to an emergency department must receive a medical screening evaluation by a physician or provider under the supervision of a physician without prior authorization.
      b. Medical screening must be performed prior to asking about the individual's ability to pay or before verifying Medicaid (Medi-Cal) eligibility.

c. Each person who presents to the ED must be stabilized by medical treatment, as needed.
d. The ED provider has the obligation to treat a patient in the emergency department if, in the provider's judgment, adequate care will not be obtained at another facility.
e. Transfers between emergency departments are appropriate only if the emergency physician at the second hospital accepts the transfer.

D. Advice Nurse Program
1. Partnership maintains 24-hour emergency telephone availability with physician backup for Members through the Partnership Advice Nurse Line at (866) 778-8873. (See policy MCCP2018 Advice Nurse Program). If the Partnership Advice Nurse directs a member to the ED, Partnership will pay for the visit. The advice nurse faxes a copy of the Triage Call Documentation Report to the ED. This report is to be attached to the claim when it is submitted for payment.

E. Coverage for Services Rendered Outside of the State of California, but within the U.S.
1. Medically necessary medical care outside of the State of California, within the limits of benefits as outlined in Title 22, is covered only when one of the following conditions is met:
   a. An emergency arises from accident, injury or illness; or
   b. The health of the individual would be endangered if care and services are postponed until it is feasible that the member return to California; or
   c. The health of the individual would be endangered if travel were undertaken to return to California; or
   d. It is customary practice in border communities for residents to use medical resources in adjacent areas outside California; or
   e. The out-of-state treatment plan has been proposed by the member's attending provider, and the plan has been received, reviewed and authorized by Partnership before the services are provided AND the proposed treatment is not available from resources and facilities within the State of California.
   f. Prior authorization is required for ALL out-of-state services, except:
      1) Emergency services as defined in Section 51056 – California Code of Regulations
      2) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.
      3) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

F. Emergency Department Contracts
1. Certain in-plan Emergency Departments have voluntarily entered into contractual relationships with Partnership. Addenda A, B and C are samples of non-urgent, urgent & emergency medical conditions applicable to these contracted Emergency Departments.

G. Decisions Made on Medical Appropriateness
1. On an annual basis, Partnership distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement, which affirms that Utilization Management (UM) decision making is based only on the appropriateness of care and service. Furthermore, Partnership does not reward practitioners, or other individuals conducting utilization reviews, for issuing denials of coverage for services. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization, and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

H. Prescribed Medications Under Emergency Circumstances
1. When the course of treatment provided to a member under emergency circumstances requires the use of medication, a sufficient quantity shall be provided to the member to last until the member can

reasonably be expected to have a prescription filled.

VII. REFERENCES:

A. Omnibus Reconciliation Act (OBRA) regulations: Section 1882(c)(3) of the federal Social Security Act (SSA) as enacted by Section 4081(b)(2)(C) of OBRA, Public Law 100-203
B. Title 22 California Code of Regulations (CCR)
C. Title 22 CCR Section 51056
D. Department of Health Care Services (DHCS) Contract Exhibit E, Attachment 1, Definitions
E. DHCS All Plan Letter (APL) 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (10/18/2021) Attachment 1: Mandatory Managed Care Enrollment (MMCE) Requirements

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 05/09/95; 10/10/97 (name change only); 06/21/00; 10/18/00; 08/15/01; 09/18/02; 10/20/04; 02/16/05, 10/18/06; 10/17/07, 08/20/08; 11/18/09; 05/18/11; 05/15/13; 01/20/16; 08/17/16; 08/16/17; *09/12/18; 09/11/19; 08/12/20; 08/11/21; 05/11/22; 04/12/23; 05/08/24

*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.

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ADDENDUM A

NON-URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires non-urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate urgent or emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record.

* Rash - minimally symptomatic
* External parasites
* First degree burns (small)
* Insect bites (no systemic symptoms)
* Minor puncture wounds (no evidence of infection or foreign object)
* Uncomplicated diarrhea (no blood in stool, no vomiting or symptoms of dehydration)
* Non-active but prior history of nausea/vomiting/diarrhea
* Hemorrhoids – minimally symptomatic
* Uncomplicated constipation
* URI symptoms with no shortness of breath
* Simple UTI – minimally symptomatic
* Urethral or vaginal discharge without bleeding
* Routine tetanus immunization
* Suture removal
* Routine dressing changes
* Missed physician appointments
* Prescription refills
* Follow-up visits
* Pre-employment physical examinations
* Exposures to communicable diseases (e.g. hepatitis, TB, STD, except accidental exposure to blood)
* Any other condition which appears uncomplicated and stable per judgment of ED staff.

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ADDENDUM B

URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record.

* Chickenpox
* Localized cellulitis
* Abscess requiring I & D
* Insect bites with systemic symptoms
* Small second degree burns
* Otitis media/Ear ache
* Otitis externa
* URI, complicated by abnormal vital signs
* Bronchitis
* Conjunctivitis
* Pharyngitis
* Sinusitis
* Back pain not requiring parenteral analgesics
* Stable Angina – not requiring diagnostic evaluation or parenteral therapy
* Asthma without SOB and/not requiring nebulizer treatment and 80% or greater of predicted peak flow measurement
* UTI-symptomatic
* Vaginitis
* Urethritis
* Menstrual cramps
* Dysfunctional Uterine Bleeding (DUB) without hemorrhage
* Acute gastroenteritis
* Hemorrhoids with bleeding
* Mild abdominal pain
* Minor contusion
* Minor laceration - no suturing
* Mild sprain/strain
* Headache not requiring diagnostic evaluation or parenteral analgesic
* Accidental Exposure to Blood with HIV risk
* Chronic arthritis
* Minor joint pain
* Localized tooth pain (mild)

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ADDENDUM C

EMERGENCY MEDICAL CONDITIONS

Treatment for the following conditions requires emergency services with regard to contracted facilities. This list is not intended to be all inclusive, and the ED physician may determine that emergency services were indicated for conditions other than those listed below. In these cases, Partnership reserves the right to review the record.

*Chest pain - R/O cardiac problem
*Angina - unstable
*Myocardial Infarction
*Congestive heart failure
*Stroke
*Significant abdominal pain with diagnostic work-up
*Pyelonephritis
*Acute GI bleed
*Asthma requiring nebulizer treatment or peak flow less than 80% of expected measurement.
*Pneumonia
*Acute back pain requiring parenteral analgesics
*Fractures or joint injury requiring splinting or reduction
*Lacerations requiring suturing
*Traumatic amputation
*Pyrexia - R/O sepsis in children with diagnostic work-up
*Hypovolemia/dehydration with IV treatment
*Acute psychiatric conditions
*Intoxication
*Delirium
*Hemorrhage in early pregnancy
*PID
*Genital tract hemorrhage
*Rape/sexual assault
*Labor/pre-term labor (to L & D)
*Acute allergic reaction with therapeutic injection of medication
*Acute seizure
*Severe headache requiring therapeutic injection for pain or diagnostic evaluation (CT)
*Uncontrolled epistaxis
*Meningitis
*Sepsis
*Significant acute change in vision
*Foreign body in eye
*Corneal abrasion
*Large first or second degree burn
*Third degree burns
*MVA
*Gunshot/stabbing
*Loss of consciousness
*Poisoning
*Overdose