

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE**

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 06/20/2001		Next Review Date: 02/11/2027 Last Review Date: 02/11/2026	
Applies to:	<input type="checkbox"/> Employees	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Partnership Advantage
Reviewing Entities:	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 02/11/2026

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 person, the health of the Member and/or the unborn child) in serious jeopardy
 - 2. Serious impairment of bodily functions;
 - 3. Serious dysfunction of any bodily organ or part; or
 - 4. Death
- B. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
- C. Physician: Medical Doctor (MD) or Doctor of Osteopathy (DO)
- D. Provider: For the purposes of this policy, the provider is a physician, nurse practitioner or physician assistant.
- E. 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.
- F. Urgent Care Services: A type of medical service that provides immediate care for non-life-threatening conditions that require prompt attention. Urgent Care Services are designed to address acute illnesses or

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injuries that need to be treated within a short time frame but are not serious enough to warrant a visit to the emergency room. Common conditions treated in urgent care include:

1. Minor fractures and sprains
2. Cuts and lacerations
3. Minor burns
4. Ear Infections
5. Infections (e.g., urinary tract infections, bronchitis)

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the circumstances under which emergency services are covered.

VI. POLICY / PROCEDURE:

A. Authorization for Emergency Services

1. Partnership covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition as defined at III.A.

B. Referral of Triage 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 or neurosurgery 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

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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 M CCP2018 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 United States:
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.
- F. Coverage for Services Rendered Outside of the United States:
1. For members enrolled in Partnership Advantage or with Medicare Part A coverage, no prior authorization is required for emergency services that require hospitalization in Canada or Mexico which meet the following qualified circumstances:
 - a. An emergency occurs, and a Canadian or Mexican hospital is closer to, or more accessible from, the site of the emergency than the nearest adequately equipped United States hospital that can provide emergency services, or
 - b. The emergency occurred in Canada while the beneficiary is traveling between Alaska and another State without unreasonable delay and by the most direct route, and a Canadian hospital is closer to, or more accessible from, the site of the emergency than the nearest

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United States hospital. For this purpose, an emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

2. For members with full scope Medi-Cal or Emergency-Only services, no services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.
- 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 Sections [51056](#), [53855](#)
- D. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment 1, Definitions and Exhibit A, Attachment III Section 3.3.16 Emergency Services and Post-Stabilization Care Services
- 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](#) (Revised 10/14/2022)
- F. [Medicare Managed Care Manual 100-16: Chapter 4 Benefits and Beneficiary Protections](#), Section 20 Ambulance, Emergency, Urgently Needed and Post-Stabilization Services. Implementation date 01/01/2015 or any subsequent updates published by CMS.
- G. [Medicare Claims Processing Manual Chapter 1](#) (Rev. 12909, Issued: 10-24-24), Section 10.2.1 FI Payment for Emergency and Foreign Hospital Services (Rev. 1, 10-01-03)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027)
05/14/25; 08/13/25; 02/11/26

Medi-Cal

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; 05/14/25; 08/13/25; 02/11/26

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*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

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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