

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE**

Policy/Procedure Number: CLPM-26			Lead Department: Claims	
Policy/Procedure Title: Emergency Services			<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 9/1/25		Next Review Date: 01/01/2026 Last Review Date:		
Applies to:	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> Employees	
Reviewing Entities:	<input type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input type="checkbox"/> QUAC	
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE	<input checked="" type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING	<input checked="" type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: <i>Lisa Malvo</i>			Approval Date: 9/1/25	

I. RELATED POLICIES:

A. MCUP3014 – Emergency Services, Health Services

II. IMPACTED DEPTS:

A. Claims
B. Health 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.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide, for the provider, general guidelines and requirements relating to Emergency Services.

VI. POLICY / PROCEDURE:

- A. Partnership covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition.
- B. 95% of clean claims submitted by contracted or non-contracted providers, for which no further written documentation or substantiation is required, are processed and paid or denied within 45 working days after receipt.
- C. Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of \$15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.

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Penalty for failure to automatically include the interest due on a late claims payment. A plan or a plan's capitated provider that fails to automatically include the interest due on a late claim payment shall pay the provider \$10 for that late claim in addition to interest owed for late payment.

If the interest is not sent in the same envelope as the claim payment, Partnership or the subcontractor shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim and document the specific interest payment made for each claim within five (5) working days of payment.

- D. Effective for dates of service on and after 7/1/2014, Partnership will identify and deny claims that exceed the one-year billing limit. The one-year billing limit will be calculated from the date of service on the claim to the date the claim is received by Partnership. The system will deny claims received on and after the 366th day from the date of service.

VII. REFERENCES:

A.

VIII. DISTRIBUTION:

A. PARTNERSHIP4ME PowerDMS Policies & Procedures

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

X. REVISION DATES: 9/1/25