# Emergency and Post-Stabilization Care—CCS309

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| **Subject:** Emergency and Post-Stabilization Care | **Revised Effective:** 5/1/20 |
| **Policy #:** CCS309 | **Review Schedule:** Annual or as needed |

**Applicability:**
Utilization Management
Claims Department
CHP+ (HMO and SMCN)
RAE

**Policy:** Colorado Access (COA) will maintain processes to ensure that members have direct access to emergency care and services on a twenty-four (24) hour, seven (7) day a week basis. Information about Emergent, Urgent, and Post-stabilization Services is available to members and providers. Members are notified through the member handbook(s). Providers are informed via the provider manual and COA website.

**Definitions:**

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| Emergency Medical Condition: | A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:<br>• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy<br>• Serious impairment to bodily functions<br>• Serious dysfunction of any bodily organ or part |
| Emergency Services: | Covered inpatient and outpatient services that are:<br>• Furnished by a qualified provider under 42 CFR 438<br>• Needed to evaluate or stabilize an Emergency Medical Condition |
| Post-Stabilization Care Services: | Covered services, related to an Emergency Medical Condition, which are furnished by a qualified provider after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition. |
| Prior Authorization: | Authorization obtained from COA prior to a covered service being delivered. Emergency Services do not require prior authorization. |
| Urgent Care Request (CHP+) | A request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination that:<br>• Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function; or for persons with physical or mental disability, create an imminent |

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| | and substantial limitation on their existing ability to live independently; or<br>• In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.<br>• Except as provided in paragraph (3) of this definition, in determining whether a request is to be treated as an Urgent Care Request, an individual acting on behalf of COA shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine.<br>• Any request that a physician with knowledge of the member's medical condition determines and states the request is an Urgent Care Request within the meaning of Paragraph (1) above shall be treated as an Urgent Care Request. |
| Urgently Needed Services (CHP+): | Covered services that are not Emergency Services, as defined above, which are provided when a member is temporarily absent from the service area or, under unusual and extraordinary circumstances, provided when the member is in the service area, but the COA provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required such as:<br>• As a result of an unforeseen illness, injury, or condition<br>• It was not reasonable, given the circumstances, to obtain the services through COA |

**Procedures:**

**1. Emergency and Urgently Needed Services**

A. COA does not deny payment for the treatment of emergency medical conditions.

B. Emergency Services and Urgently Needed Services do not require prior authorization.

C. Colorado Access covers emergency and urgently needed services, without prior authorization, regardless of whether the services are obtained within or outside COA's provider network and in accordance with the definitions listed above.

D. COA bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

E. COA may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms that are otherwise covered under its contracts. COA may not refuse to cover Emergency Services based on the emergency room provider, hospital, or agent not notifying the member's primary care provider, COA, or the applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

F. Stabilized condition: the physician treating the member shall decide when the member may be considered stabilized for transfer or discharge, and that determination is binding on COA for coverage and payment.

G. A member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

**2. Post-Stabilization Services**

A. COA maintains utilization management coverage for behavioral health services 24 hours per day, 7 days per week, 365 days per year in order to review request for post-stabilization care in the most expeditious manner possible. COA maintains utilization management coverage for CHP+ physical health requests Monday – Friday between 8am-5pm. Authorization is rendered as long as COA is notified by the admitting provider within one business day of the post-stabilization admission.

B. COA is financially responsible for Post-Stabilization Care Services if:

1. Post-Stabilization services have been pre-approved by COA staff, regardless of whether the services are obtained within or outside COA's provider network.

2. Post-Stabilization services have not been pre-approved by COA staff, but administered to maintain the member's stabilized condition within one (1) hour of a request to COA for pre-approval of further post-stabilization care services.

3. Post-stabilization services have not been pre-approved by COA staff, but administered to maintain, improve, or resolve the member's stabilized condition if:

a. COA does not respond to a request for pre-approval within one (1) hour;

b. COA cannot be contacted; or

c. The COA staff and the treating physician cannot reach an agreement concerning the member's care and the COA Medical Director or designee is not available for consultation. In this situation, COA must give the treating physician the opportunity to consult with the COA Medical Director or designee, and the treating physician may continue with care of the member until the COA Medical Director or designee is reached or one of the criteria in Section 2.B below is met. See CCS316 Peer Review process.

C. COA's financial responsibility for post-stabilization services it has not pre-approved ends when:

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care;

2. A plan physician assumes responsibility for the member's care through transfer;

3. A Colorado Access representative and the treating physician reach an agreement concerning the member's care; or

4. The member is discharged.

D. If the member receives post-stabilization services from a provider outside COA's network, COA does not charge the member more than he or she would be charged if he or she has obtained the services through an in-network provider (applicable for CHP+ members only, as Medicaid members have no co-pay and cannot be balance-billed by the provider).

**3. Claim Adjudication Procedures for Emergency and Post-Stabilization Services**

A. When an Urgent/ER occurrence results in an observation stay, the Claims Department pays the entire claim (i.e. both Urgent/ER post stabilization care portions of same visit) without regard to authorization.

B. When an Urgent/ER occurrence results in an inpatient stay, the Claims Department must verify authorization has been issued by the COA UM department in order to pay the entire claim. If COA UM has not issued authorization for the inpatient portion of the claim, the claims department will pay ER and Stabilization and the provider will need to present evidence to UM why authorization for inpatient stay was not obtained timely for reconsideration of entire inpatient claim (including any applicable circumstances in Sections 2B and/or 2C).

C. If submitted ER/Inpatient claim has issued authorization in place approving the actual number of inpatient days billed by provider, the claims department will pay the entire claim.

D. Any additional claims associated with the urgent/ER hospital service such as physician, physician interpretation services provided for pathology or radiology, are considered downstream from the urgent/ER admission claim and are paid without regard to authorization.

E. The Claims Department also reviews the denial report to verify no ER experiences have been denied in error. If incorrectly denied ER/Urgent Care claims are found the affected claims are corrected or placed in PEND status for later correction by the claims department.

**References:**
CCS316 Peer Review Process

**Attachments:**
N/A