

METHOD OF INDICATING CHANGES

This Accessible PDF version of the proposed regulation text includes the phrase **[begin underline]** at the beginning of each addition, **[end underline]** at the end of each addition, **[begin strikethrough]** at the beginning of each deletion, and **[end strikethrough]** at the end of each deletion.

A standard PDF version of this proposed regulation text is also available on the Department's Office of Regulations Internet site.

(1) Amend Division 3., Chapter 4., Article 3., Section 53216 as follows:

§ 53216. Care Under Emergency Circumstances.

(a) Each plan shall provide, directly or by subcontract, at least one physician and a nurse on duty 24 hours a day, 7 days a week, at each location designated as a location where members can obtain medical services in the event of emergency circumstances, as defined in Section 51056.

(b) Written procedures shall be developed and applied by the plan regarding care under emergency circumstances provided by nonplan providers in and outside the service area. These procedures shall include but not be limited to the following:

(1) Verification of membership.

(2) Transfer of the medical management of the member to a plan provider.

(3) Payment within 60 days of receipt of properly documented bills for the services rendered to the member. Bills for services rendered to the member shall be submitted not later than the second month following the month of service, except for good cause.

(4) Written notice of action within 60 days of receipt of bills which are denied or reduced for any reason by the plan. The notice shall include a statement, subject to prior approval by the Department, of the provider's right to:

(A) Dispute the plan's rejection or reduction of the bill.

(B) Submit the dispute to the Department pursuant to Article 7.

[begin underline](5) Reimbursement to nonplan emergency care providers shall be in accordance with Section 53623.[end underline]

(c) The plan shall provide or pay for medical transportation, as defined in Sections 51151 and 51323, to members needing care when such transportation is necessary due to the medical condition of the member.

(d) Each provider who agrees with a plan to provide emergency medical services shall furnish, when the course of treatment of a plan member under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs to last until the member can reasonably be expected to have a prescription filled.

NOTE: Authority cited: Section 20, Health and Safety Code and Sections 14312 and 14454, Welfare and Institutions Code.
Reference: Section s 14091.3 and 14454, Welfare and Institutions Code.

(2) Amend Division 3., Chapter 4., Article 7. title to read:

Emergency Services Claims Disputes and Payments for

Emergency and Post-Stabilization Services

(3) Adopt Division 3., Chapter 4., Article 7., Section 53623 as follows:

[begin underline]**§ 53623. Emergency Services Furnished by Nonplan**

Providers.

(a) This section shall apply to all hospitals that do not have in effect a contract establishing payment amounts for emergency services or inpatient hospital services furnished since January 1, 2007 to a beneficiary enrolled in a Medi-Cal managed care plan.

(b) Payments authorized by this section shall apply to all hospitals described in Subsection (a) even if the hospital contracts with the Department under the Medi-Cal Selective Provider Contracting Program (SPCP) described in Article 2.6, commencing with Section 14081, of the Welfare and Institutions Code.

(c) Emergency outpatient services shall be reimbursed at the Medi-Cal Fee-For-Service rate.

(d) Emergency inpatient services shall be reimbursed at the average SPCP regional contract rate for the type of facility providing the service in the managed care region in which the facility is located. These facilities shall include only:

(1) A Tertiary Hospital.

(A) A Children's Hospital as specified in Section 10727 of the Welfare and Institutions Code, or

(B) A hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(2) A Non Tertiary Hospital.

(e) The average SPCP regional contract rates for each year, which are derived from unweighted average contract rates that are publicly available on June 1 of each year and trended forward based on the annual increases in the average SPCP regional contract rates, shall be published by the Department prior to July 1 of each year.

(f) Pursuant to Section 6254(q) of the Government Code, rates set forth in the hospital contracts with the Department under SPCP shall be confidential for four years.

(g) Pursuant to Section 14091.3(d) of the Welfare and Institutions Code, health plans shall make reconciliations and adjustments for payments made to nonplan hospitals that were not based upon the Department's published emergency inpatient services rates.

NOTE: Authority Cited: Section 20, Health and Safety Code; and Sections 14312 and 14454, Welfare and Institutions Code. Reference: Sections 1317.2a, 1797.1 and 127800, Health and Safety Code; Sections 10727, 14091.3, 14166.245 and 14454, Welfare and Institutions Code; Section 6254(q), Government Code; and 42 USC 1396u-2(b)(2)(D).[end underline]

(4) Adopt Division 3., Chapter 4., Article 7, Section 53623.5 as follows:

[begin underline]53623.5. Payment for Post-Stabilization Services Following an Emergency Admission Furnished by Nonplan Providers.

(a) This section shall apply to all general acute care hospitals as specified in Health and Safety Code Section 1250(a), including those that contract with the Department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 of the Welfare and Institutions Code, commencing with Section 14081, that do not have in effect a contract with a Medi-Cal managed care plan that establishes payment amounts for inpatient services following an emergency admission furnished since November 1, 2008 to a beneficiary enrolled in a Medi-Cal managed care plan.

(b) For post-stabilization services following an emergency admission, all general acute care hospitals shall accept as payment in full for inpatient hospital services the hospital's Medi-Cal Fee-For-Service rate set forth in Section 14166.245 of the Welfare and Institutions Code.

NOTE: Authority Cited: Section 20, Health and Safety Code; and Sections 14312 and 14454, Welfare and Institutions Code. Reference: Sections 10727, 14091.3, 14166.245 and 14454, Welfare and Institutions Code; Sections 1317.2a, 1797.1 and 127800, Health and Safety Code; and Section 6254(q), Government Code.[end underline]

(5) Amend Division 3., Chapter 4., Article 7., Section 53698 as follows:

§ 53698. Standard of Liability.

(a) The plan's financial liability to the provider, if any, shall ~~[begin~~
~~strikeout]~~not exceed the lower of the following rates applicable at the time the
services were rendered by the provider ~~[end strikeout]~~ ~~[begin underline]~~be as
follows~~[end underline]~~:

(1) ~~[begin strikeout]~~The usual charges made to the general public by the
provider.~~[end strikeout]~~~~[begin underline]~~For emergency outpatient services, in
accordance with the provisions in the contract between the plan and the provider,
or, where there is no contract, as specified in Section 53623(c).~~[end underline]~~

(2)~~[begin strikeout]~~The fee-for-service rates for similar services under the
Medi-Cal program. Upon determination of the plan's liability, if no final rate has
been established for a provider for the period and type of services in question,
then the applicable interim rate shall be used for final determination of plan
liability.~~[end strikeout]~~ ~~[begin underline]~~For emergency inpatient services, in
accordance with the provisions in the contract between the plan and the provider,
or, where there is no contract, pursuant to Section 53623(d).

(3) ~~[begin underline]~~For post-stabilization services following an emergency admission, in
accordance with the provisions in the contract between the plan and the provider,
or, where there is no contract, pursuant to Section 53623.5(b).~~[end underline]~~

(b) The amount demanded shall be presumed to be correct, and the
provider shall be entitled to the full amount demanded in its claim should it

prevail, unless the plan files a Notice of Defense, pursuant to Section 53632,
which places the amount of the provider's demand for payment in issue.

NOTE: Authority cited: [\[begin underline\]Section 20, Health and Safety Code; and](#)
[\[end underline\] Sections 14312 and 14454, Welfare and Institutions Code.](#)
Reference: Sections [\[begin underline\]14091.3 and](#)[\[end underline\] 14454, Welfare](#)
and Institutions Code.

(6) Amend Division 3., Chapter 4.1., Article 6., Section 53855 as follows:

§ 53855. Care Under Emergency Circumstances.

(a) Each plan in a designated region shall cover emergency medical services without prior authorization pursuant to Title 28, CCR, Section 1300.67(g) and Title 22, CCR, Section 53216. Each plan shall reimburse, without prior authorization, hospital emergency departments or emergency physicians for medical screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the plan member. If the medical screening examination indicates that the patient's condition does not constitute an emergency as defined in Section 51056, hospital emergency departments or emergency physicians shall obtain prior authorization from the plan to render treatment. If the hospital emergency department or emergency physician fails to obtain prior authorization the plan may deny reimbursement for any services rendered to the member beyond the medical screening examination. A request for prior authorization from an emergency services provider shall be deemed approved, unless a plan renders a decision upon the request within 30 minutes.

(b) Each plan shall maintain a 24-hour multilingual telephone contact number for handling emergencies. Each plan shall ensure that a physician is available 24 hours a day to coordinate the transfer to a plan provider of a member whose condition is stabilized or authorize medically necessary post-stabilization services. Each plan shall have a system to ensure continuity of care

and follow-up care for all plan members for whom the plan has denied authorization for emergency services.

(c) A plan may subject all hospital emergency department and emergency physician claims to post-service, prepayment review when the claims involve post-stabilization services; however, claims for medical screening examinations shall not be denied without review. Each plan shall pay emergency services claims at the appropriate level based on the documentation submitted. All properly documented claims for medical screening examinations and emergency services rendered by ~~noncontracted~~ nonplan providers shall be paid by the plan within 45 days of receipt of a valid invoice. Each plan shall pay all prior authorized claims involving medically necessary services to diagnose and treat nonemergency conditions.

(d) Each plan shall ~~arrange and~~ make payment for ~~emergency department, emergency physician and emergency transportation services,~~ emergency outpatient services in accordance with the provisions in the contract between the plan and the provider, or, where there is no contract, as specified in Section 53623(c).

~~at the lesser of:~~

(1) ~~The usual charges made to the general public by the emergency services provider,~~

(2) ~~The maximum Medi-Cal fee-for-service rate, as specified in sections 51503 and 51509, or~~

(3) ~~The rate negotiated between the plan and the provider of services for emergency services as defined in section 51056.~~~~[end strikeout]~~

(e) For emergency inpatient ~~[begin strikeout] hospital~~~~[end strikeout]~~ services, payment shall be made in accordance with the provisions in the contract between the plan and the ~~[begin strikeout] department~~~~[end strikeout]~~[begin underline] provider, or, where there is no contract, pursuant to Section 53623(d)~~[end underline]~~.

(f) If disputes arise over claims submitted by providers seeking reimbursement for the provision of emergency services to plan members, the parties shall adhere to the procedures and requirements prescribed in ~~[begin strikeout]s~~~~[end strikeout]~~[begin underline]S~~[end underline]~~ection 53875 for the resolution of such disputes.

(g) In the event the provision of emergency services to plan members is delegated to an entity, such entity, and any further delegates, shall assume all obligations and responsibilities required under this section. The contractor shall assure compliance with the requirements of this section regardless of the entity providing the emergency services.

NOTE: Authority cited: [begin underline]Section 20, Health and Safety Code; and~~[end underline]~~ Sections 10725, 14105, 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14087.3, 14087.4 [begin underline] 14091.3~~[end underline]~~ and 14454, Welfare and Institutions Code.

(7) Amend Division 3., Chapter 4.5., Article 2., Section 53912.5 as follows:

§ 53912.5. Care Under Emergency Circumstances.

(a) Each GMC plan shall meet the requirements specified in Section ~~53216~~53855.

(b) Each GMC plan shall ~~arrange for and make payment, at the lowest of the Medi-Cal fee-for-service rate or the plan negotiated rate for emergency services as defined in Section 51056.~~ for emergency outpatient services in accordance with the provisions in the contract between the plan and the provider, or, where there is no contract, as specified in Section 53623(c).

(c) For emergency inpatient services, payment shall be made in accordance with the provisions in the contract between the plan and the provider, or, where there is no contract, pursuant to Section 53623(d).

~~(e)~~(d) Each GMC plan shall make payment, ~~at the lowest of the Medi-Cal fee-for-service rate or the plan negotiated rate,~~ for the diagnostic portion of any emergency room or urgent care visit as specified in Section 53623(c). Specifically, each plan shall reimburse and shall not require prior authorization for the following:

(1) Emergency room services required to determine whether a member's condition requires emergency services.

(2) All other capitated services, such as radiology or pathology, necessary to diagnose the possible emergency condition.

~~(d)~~(e) A GMC plan may authorize and reimburse services provided beyond those required to determine whether the condition is an emergency.

NOTE: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14089.7, 14105, 14124.5, 14203 and 14312, Welfare and Institutions Code. Reference: Sections 14088.4, 14089 ~~and~~ 14091.3 and 14454, Welfare and Institutions Code.

(8) Amend Division 3., Chapter 6., Article 3., Section 56216 as follows:

§ 56216. Care Under Emergency Circumstances.

(a) Each PCCM plan shall provide information to members on obtaining medical services on a 24-hour-a-day, seven-days-a-week basis in the event of an emergency as defined in ~~s~~Section 51056(a).

(b) Written procedures shall be developed and followed by the PCCM plan regarding care under emergency circumstances provided by nonplan providers in and outside the service area. These procedures shall include but shall not be limited to the following:

(1) Verification of membership.

(2) Transfer of medical management of the member to the PCCM plan.

(3) Payment for PCCM plan authorized services that are included in the PCCM contract as a covered service.

(4) Notice to nonplan providers of the right to:

(A) Dispute the PCCM plan's rejection or reduction of the claim.

(B) Submit the dispute to the Department for resolution in accordance with

~~s~~Section 56262.

(5) Reimbursements to nonplan emergency care providers shall be in accordance with Section 53623(c).

(c) When the course of treatment of a PCCM plan member under emergency services requires the use of drugs, the PCCM plan shall authorize the

provider to furnish a sufficient quantity of drugs to last until the member can reasonably be expected to have a prescription filled.

NOTE: Authority cited: [begin underline]Section 20, Health and Safety Code; and [end underline] Sections 14105 and 14124.5, Welfare and Institutions Code.
Reference: Sections 14088, 14088.16, 14088.2 ~~[begin strikeout]and[end strikeout]~~ 14088.4 [begin underline]and 14091.3[end underline], Welfare and Institutions Code.