

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH SERVICES

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December 6, 1999

All Plan Letter 99015

- TO: Two-Plan Model Plans
- Geographic Managed Care Plans
- County Organized Health Systems Plans
- Prepaid Health Plans
- Primary Care Case Management Plans

SUBJECT: EMERGENCY SERVICES CLAIMS

The purpose of this letter is to advise Medi-Cal managed care plans of the Department of Health Services' (DHS) concerns regarding the continuing problem of complaints from providers and provider representatives about the untimely payment of out-of-plan emergency and other post-stabilization services claims by Medi-Cal plans. Also of concern, is the growing confusion of where providers should bill in the delegated claims payment model, which is standard for many Medi-Cal plans and alleged downcoding of claims without the required medical review. Emergency claim disputes filed with the Department underscore this problem.

The legislature has also acted in response to the general issue of managed care plans payment of emergency services claims by enacting Assembly Bill 1560 (Chapter 994, Statutes of 1998). As you may be aware, effective September 1, 1999, AB 1560 set forth additional requirements with respect to the reimbursement of claims for emergency services and care rendered by licensed health care service plans on or after July 1, 1999. Specifically, AB 1560 requires health care service plans to notify a claimant in writing within 30 days from the date of receipt if a complete emergency claim, or portion of the claim is contested or denied. AB 1560 also requires interest to accrue on an uncontested claim that is not paid by a health care service plan within 30 working days, or by a health maintenance organization within 45 working days. AB 1560 also added Section 1371.35 to the Health and Safety Code imposing financial penalties for nonpayment of uncontested claims by a managed care plan, its medical groups, Independent Physicians Associations, or other contracting entities.

DHS must ensure that its contracted health plans have the appropriate mechanisms in place to assure timely processing and appropriate payment of emergency services claims submitted by nonplan providers. To this end, Medi-Cal plans must demonstrate to the Department that emergency services claims processing and payment is accurately and timely performed and monitored by plans and their subcontractors. Specifically, within 30 days of receipt of this letter, each Medi-Cal plan must submit the following to the Medi-Cal Managed Care Division:

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- **A written description of each of your plan's policies, performance standards, procedures, management reports, and other written documentation that describes or governs the processing and payment of out-of-plan emergency and other plan-authorized, post-stabilization services claims.**

Submitted descriptive materials should include, but not be limited to, a description of plan billing requirements and procedures, payment delegation policy, internal and external claims monitoring and tracking systems, and overdue/outstanding claims status reports. Additionally, whether licensed by the Department of Corporations or not, each plan should describe how its claims payment program meets the requirements of AB 1560.

- **Copies of all written instructional materials provided to nonplan providers which explain the plan's arrangements for out-of-plan providers to:**
 - 1. Identify the correct location in the plan to obtain timely authorization of out-of-plan post-stabilization services.**
 - 2. Submit emergency and post-stabilization services claims to the correct location within the plan.**
 - 3. Identify the plan's required components of a complete claim for out-of-plan emergency or post-stabilization services.**
 - 4. Inquire and obtain timely and accurate information about claim status.**
 - 5. Obtain timely and specific written information from the plan about the need for additional documentation required by the plan to make a decision about a claim.**
 - 6. Appeal denied or down coded claims.**

In the event that your plan does not have out-of-plan emergency claims monitoring/tracking policies, procedures or systems, or written instructions for

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out-of-plan providers that cover all elements described above, new policies, procedures and instructions must be created and sent to DHS for review and approval in the time frame set forth below.

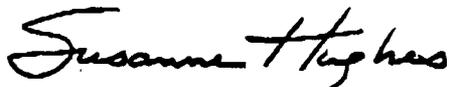
If your plan utilizes a billing contractor for or otherwise delegates the processing and payment of emergency services claims, you must also identify and provide materials that explain those administrative procedures in place to monitor the processing of claims by your contractor(s).

The submissions required in this letter are due to DHS 30 days from the date of this letter. All submissions should be sent to your contract manager.

DHS is committed to ensuring that emergency services providers are paid in an appropriate and timely manner for services rendered, pursuant to all Medi-Cal managed care plan contracts and state and federal requirements. Please be advised that DHS will be conducting both announced and unannounced on-site monitoring visits to plans and emergency providers. DHS will predominantly be examining whether there are policies and procedures in place, and if those policies and procedures are adequately communicated to emergency service providers. Additionally, if the results of DHS' review reveals that adequate access to policies and procedures are not in place, promulgation of regulations will be considered to strengthen or replace those already in effect. In developing these regulations, DHS will look closely at the efficacy of continuing to allow the decentralized delegation of emergency services claims processing by Medi-Cal plans.

If you have any questions or need any further information, please contact your contract manager.

Sincerely,



Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division