POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Emergency Services
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APPROVED DATE: 12/07	**RETIRED:**
EFFECTIVE DATE: 12/07	**REVIEWED/REVISED:** 6/08; 2/09; 12/09; 2/10; 2/11; 2/12; 2/13; 2/14; 11/14; 3/15: 7/16; 12/16; 7/17; 8/18
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** SC.UM.12

SCOPE:
Absolute Total Care Medical Management Departments.

PURPOSE:
The purpose is to promote timely Member access to needed emergency services and appropriate financial reimbursement to Providers of emergency services.

POLICY:
Members may access emergency services at any time without prior authorization or prior contact with Absolute Total Care.

Absolute Total Care will cover the medical screening to determine if an emergency exists.

A member may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Absolute Total Care will cover the transfer of a Member presenting for emergency care to another medical facility within Social Security Administration (SSA) Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations (See Definition for details).

Absolute Total Care will cover all emergency services to screen and stabilize a Member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

Absolute Total Care will cover emergency services if an authorized representative, acting for the organization, has authorized or directed the Member to access emergency services.

Absolute Total Care will cover emergency services if an authorized representative did not respond to the Provider of post-stabilization care services' request for pre-approval within one (1) hour after the request was made.

Absolute Total Care will cover emergency services if the Provider could not contact Absolute Total Care for pre-approval.

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Absolute Total Care will cover emergency services if Absolute Total Care and the treating Physician cannot reach an agreement concerning the Member's care and a network Physician is not available for consultation.

Absolute Total Care will limit Member cost sharing for post-stabilization Out of Network (OON) services to no more than cost sharing from a network Provider. For the purposes of cost sharing, post-stabilization services begin upon inpatient admission.

Plan shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under the Contract with SCDHHS.

PROCEDURE:

A. Accessing Emergency Medical Services

1. Absolute Total care utilizes the prudent layperson (PLP) definition of an emergency medical condition (see 'Definitions') as determined by the Balanced Budget Act (BBA) of 1997 and the appropriate South Carolina State Medicaid statutes. Lists of diagnoses or symptoms are not used as a basis for defining an Emergency Medical Condition.

2. Prior Authorization is not required for Emergency Medical Services**.**

3. If Members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or the 24 hr Nurse Triage Line (NurseWise) for assistance.

4. Once the Member's Emergency Medical Condition is stabilized, Absolute Total Care will require Authorization for hospital admission or Prior Authorization for follow-up care (See Associated Policy).

    a. Contracted facilities are required to notify Absolute Total Care of emergent and urgent admissions within one (1) business days following the admission.

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B. Coverage of Emergency Medical Services

1. Coverage decisions regarding Emergency Services are based on the severity of the symptoms at the time of presentation. Emergency Services will be covered when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.

2. Emergency Services are covered by Absolute Total Care when furnished by a qualified Provider, including non-network Providers, and will be covered until the Member is stabilized. Absolute Total Care shall pay non-contracted providers for emergency services no more than the amount that would have been paid if the service had been provided under the State's Fee For Service Medicaid Program. Any screening examination services conducted to determine whether an Emergency Medical Condition exists will also be covered by Absolute Total Care.

3. If an Absolute Total Care network Provider, or other authorized representative, instructs a Member to seek Emergency Services, Absolute Total Care will cover the medical screening examination and other medically necessary Emergency Services without regard to whether the condition meets the prudent layperson standard. Once the Member's Emergency Medical Condition is stabilized, Absolute Total Care will require Authorization for hospital admission or Prior Authorization for follow-up care.

4. Absolute Total Care shall not condition coverage for Emergency Services on the treating Provider notifying the member's PCP, the Plan or any applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

5. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge from emergency services, and that determination is binding on the Plan for coverage

and payment.

C. Coverage of Post-stabilization Services

Absolute Total Care shall cover and pay for post-stabilization care and services in accordance with the provisions of 42 CFR § 422.113(c). Post-stabilization care and services are covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Absolute Total Care is financially responsible for post-stabilization care services obtained within or outside the Plan that are pre-approved by a Plan provider or other Plan representative.

Absolute Total Care is financially responsible for post-stabilization care services obtained within or outside the Plan that are not pre-approved by a Plan provider or other Plan representative, but administered to maintain, improve or resolve the member's stabilized condition within one hour of a request to Absolute Total Care for pre-approval of further post-stabilization care services.

Absolute Total Care is financially responsible for post-stabilization care services obtained within or outside the Plan that are not pre-approved by a Plan provider or other Plan representative, but administered to maintain, improve or resolve the member's stabilized condition if:

1. Absolute Total Care does not respond to a request for pre-approval within one (1) hour;
2. Absolute Total Care cannot be contacted; or
3. An Absolute Total Care representative and the treating physician cannot reach an agreement concerning the member's care and a Plan physician is not available for consultation. The Plan must give the treating physician the opportunity to consult with a Plan physician and the treating physician may continue with care of the patient until a Plan physician is reached.

Absolute Total Care's financial responsiblity for post-stabilization care services that are not pre-approved ends when:

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- A Plan physician with privileges at the treating hospital assumes responsibility of the member's care;
- A Plan physician assumes responsibility of the member's care through transfer;
- A Plan representative and the treating physician reach agreement concerning the member's care; or
- The member is discharged.

REFERENCES:
SC.UM.05 Timeliness of UM Decisions and Notifications
NCQA Standard
SCDHHS Contract
42 CFR § 438.114, 42 CFR § 422.113(c)

ATTACHMENTS:

DEFINITIONS:
Authorized Representative: an employee or contractor of Absolute Total Care who directs the Member to seek services. For example, an advice nurse, network Physician, Physician Assistant or Customer Service Representative may act as Absolute Total Care's authorized representative.

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 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, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition.

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Post-stabilization Care Services: Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition. Maintenance Care is considered post-stabilization care services.

Social Security Administration (SSA): Section 1867 (42 U.S.C. 1395 dd) guidelines –
Necessary stabilizing treatment for emergency medical conditions and labor —
(1) in general.— If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either —
(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
(B) for transfer of the individual to another medical facility in accordance with subsection(c).

Prudent Layperson: a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

REVISION LOG

REVISION	DATE
South Carolina 4.3	11/06/06
Minor grammar corrections- spacing and punctuation	6/3/08
Approval Titles changed- Director of Care Manager- to Manager of UM and CM; Vice President of Medical Affairs- to Medical Director; Total Carolina Care President- to Vice President of Medical Management	6/3/08
Name change from Total Carolina Care to Absolute Total Care NCQA NHP standard added to references SCHIP contract added to SCHIP	2/09
Changed product type from all to Medicaid & SCHIP	12/09
No revisions, no updates	2/10

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SCHIP removed from Product Type SCDHHS SCHIP Contract removed from References Formatting changes #3 changed physician to provider.	2/10/11
Minor grammatical corrections; A4 and B3 "Pre-Certification" and "Certification" replaced with "Authorization"; added Sr. Director Medical Management signature	2/9/12
Updated references to NCQA standard and State contract. Under Accessing Emergency Medical Services changed timeframe from 2 business days to 1 business day # 4 .a.	2/9/13
Deleted Manager Medical Management and Date under Policy and Procedure Approval, deleted references to SC UM 08, 12.01 and 16.01, changed to 2014 NCQA.	2/28/14
Updated reference section.	11/17/14
Updated Definition Section, "**Social Security Administration (SSA)**: Section 1867 (42 U.S.C. 1395 dd) guidelines"	3/23/15
Revisions for 42 CFR § 438.114, 42 CFR § 422.113(c).	7/7/2016
Corrected 42 CFR § 422.133(c) to 42 CFR § 422.113(c). Changed NCQA Standard from UM 12 to UM 11 per changes to NCQA 2016 Health Plan Standards and Guidelines. Added State Contract language re payment to non-contracted providers to page 3, B. #2.	12/8/16
Added "from emergency services" to B.5	7/11/17
Annual review-added (-) to the word poststabilization to read post-stabilization.	8/1/18

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director, Utilization Management: _____ Date: _____