Emergency and Urgent Services

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➲ Instructions for Use

Table of Contents **Page**
Federal/State Mandated Regulations 1
State Market Plan Enhancements 7
Covered Benefits 8
Not Covered 9
Policy History/Revision Information 9
Instructions for Use 9

Related Benefit Interpretation Policy
- Ambulance Transportation

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

No Surprises Act - Federal Register: Requirements Related to Surprise Billing; Part I

See link below for information on the act.
- https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- Surprise Medical Bills: New Protections for Consumers Take Effect in 2022 | KFF

The above indicates that the Federal Register states the following to be covered.

Consumer Protections Under Federal Law

- Health plans must cover surprise bills at in-network rates.
- Balance billing is prohibited.
- Out-of-network providers cannot send patients bills for excess charges.
- Specific oversight and enforcement activities are required.

Resolving Payment Amount for Surprise Bills

Other Provisions

- Health plans must provide an advanced explanation of benefits.
- Health plans must provide transitional continuity of coverage when a provider leaves the network.
- Health plans must maintain accurate provider network directories.

42 Code of Federal Regulations (CFR) Section 489.24, Emergency Medical Treatment and Active Labor Act (EMTALA)

(Full text available at http://www.emtala.com/law/index.html)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-B/section-489.24
https://crsreports.congress.gov/product/pdf/IF/IF12355
42 USC 1395dd: Examination and treatment for emergency medical conditions and women in labor
"All hospitals, regardless of contractual relationship, must provide for an appropriate medical screening exam (MSE). The hospital's emergency room department is required to determine whether an emergency medical condition exists or whether the member is in active labor. The hospital may not delay the examination or treatment in order to inquire into the member's method of payment or insurance status. This law was enacted due to complaints that hospitals were refusing to treat indigent patients in their emergency rooms and referring (dumping) them to county facilities for care.

If an emergency medical condition exists (e.g., if the member's health is in serious jeopardy o if there is a reasonable likelihood of serious impairment to bodily functions or of serious dysfunction of any bodily organ or part) or if a pregnant woman is in labor, the hospital must either:

- Provide further medical examination and treatment as may be required to stabilize the member's medical condition or provide for treatment of the labor, or
- Transfer the individual to another medical facility if such a transfer is appropriate. If the member refuses to be treated or does not consent to an appropriate transfer, the hospital will be deemed to have met its obligations under its provider agreement. [SSA 1867(b)].

The transfer of an emergency room patient who has not been properly treated, as described above is not appropriate unless the member (or a person acting in his behalf) requests a transfer or a physician has certified that the medical benefits to be obtained from appropriate medical treatment outweigh the risks of transfer and the receiving hospital must agree to accept the member, and it must be provided with all relevant medical records from the transferring hospital. Participating hospitals with specialized facilities cannot refuse to accept a member who needs those facilities. The transfer must be effectuated by qualified personnel using appropriately equipped transportation. [SSA 1867(c)]"

California Code of Regulations Section 1300.71.4, Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services

https://regulations.justia.com/states/california/title-28/division-1/chapter-2/article-8/section-1300-71-4/

The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.

(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.

(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:
  (1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.
  (2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.
  (3) Notwithstanding the provisions of subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:
  (1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,
  (2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.

(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include but not be limited to the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

House of Representatives 3590, Section 2719A, Federal Regulation 37188

https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

(June 28, 2010) Non-grandfathered plans are required to afford members several patient protections, including)

- The ability to select any participating primary care provider (PCP) as their PCP;
- The ability for parents to select a participating pediatrician as their child's PCP; and
- For female members, direct access to a participating OB/GYN professional without the need to obtain a prior authorization or referral.

Non-grandfathered plans that provide benefits for services in the emergency department of a hospital also must comply with a number of rules, including:

- A prohibition on prior authorization requirements for emergency services, even if the services are rendered by an out-of-network provider;
- A requirement that cost-sharing requirements (i.e., copayment and coinsurance) for out-of-network emergency services not exceed cost-sharing requirements for in-network emergency services;
- A requirement to pay a "reasonable amount" to out-of-network providers before the member is subject to balance billing; and
- A prohibition on applying administrative requirements or benefit limitations to out-of-network emergency services that are more restrictive than requirements or limitations applied to in-network emergency services.

These provisions apply to fully insured and self-funded plans, group and individual insurance coverage. They are effective for plan years beginning on or after September 23, 2010.

California Health and Safety Code (HSC), Division 2, Chapter 2, Article 7, Section 1317

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1317.

(a) Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

(c) Neither the health facility, its employees, nor any physician and surgeon, dentist, clinical psychologist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility that can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(f) A general acute care hospital or acute psychiatric hospital shall not require a person who voluntarily seeks care to be in custody pursuant to Section 5150 of the Welfare and Institutions Code as a condition of accepting a transfer of that person after his or her written consent for treatment and transfer is documented or in the absence of evidence of probable cause for detention, as defined in Section 5150.05 of the Welfare and Institutions Code.

(g) An act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised.

(h) "Rescue team," as used in this section, means a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.

(i) This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team.

HSC Section 1317.1

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1317.1.

Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

(D) This paragraph does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:
(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Public Health.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.

(g) "Board" means the Medical Board of California.

(h) "Within the capability of the facility" means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be medically necessary, jointly by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure, under the supervision of a physician and surgeon, and the consulting physician and surgeon, "consultation" includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician and surgeon, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon. The treating physician and surgeon may request to communicate directly with the consulting physician and surgeon, and when determined to be medically necessary, jointly by the treating physician and surgeon

and the consulting physician and surgeon, the consulting physician and surgeon shall examine and treat the patient in person. The consulting physician and surgeon is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

(k) (1) "Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
(A) An immediate danger to himself or herself or to others.
(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

(l) This section shall not be construed to expand the scope of licensure for licensed persons providing services pursuant to this section.

HSC Section 1317.2

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1317.2.

A person needing emergency services and care shall not be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician and surgeon, including, if necessary, consultation, prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician and surgeon at the transferring hospital has notified and has obtained the consent to the transfer by a physician and surgeon at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate personnel and equipment that a reasonable and prudent physician and surgeon in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All of the person's pertinent medical records and copies of all the appropriate diagnostic test results that are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician and surgeon that contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring physician and surgeon or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician and surgeon at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician and surgeon nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the state department. These regulations may prescribe minimum protocols for patient transfers.

(h) The patient shall be asked if there is a preferred contact person to be notified and, prior to the transfer, the hospital shall make a reasonable attempt to contact that person and alert him or her about the proposed transfer, in accordance with subdivision (b) of Section 56.1007 of the Civil Code. If the patient is not able to respond, the hospital shall make a reasonable effort to ascertain the identity of the preferred contact person or the next of kin and alert him or her about the transfer, in accordance with subdivision (b) of Section 56.1007 of the Civil Code. The hospital shall document in the patient's medical record any attempts to contact a preferred contact person or next of kin.

(i) This section shall not apply to a transfer of a patient for medical reasons.

(j) This section shall not prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

HSC Section 1371.4

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1371.4.&lawCode=HSC

(a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including but not limited to noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received

emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j) (1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

HSC Section 1345 (b), (h)

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1345.

(b) "Basic health care services" means all of the following:
  (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(h) "Out of Area Coverage, "for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

California Code of Regulations, Title 28, Section 1300.67 (g)

https://govt.westlaw.com/calregs/Document/I944154734C8A11ECA45D000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad7140a000001877b792417cd21406f%3fppcid%3d9e3105b422a84d87bb536fbcec168a35%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI944154734C8A11ECA45D000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T2=1300.67&t_S1=CA+ADC+s

(g) (1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the member to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.
  (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

State Market Plan Enhancements

- As defined in the *Federal/State Mandated Regulations* section**, emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be **expected by the member**, to result in any of the following:
  - Placing the **member's** health in serious jeopardy;
  - Serious impairment to bodily functions;
  - Serious dysfunction of any bodily organ or part; or
  - Active labor, meaning labor at a time that either of the following would occur:
    - There is inadequate time to affect a safe transfer to another hospital prior to delivery; or
    - A transfer poses a threat to the health and safety of the **member** or unborn child.
- Psychiatric emergency medical condition is a mental disorder where there are acute symptoms of sufficient severity to render the member as being either of the following:
  - An immediate danger to himself or herself or others; or
  - Unable to provide for, or use, food, shelter, or clothing, due to the mental disorder.
- If an accident/illness occurred within the network service area and the member is transported by emergency personnel (e.g., police) outside the network for treatment, the services are not considered out-of-area and must be handled in the same manner as in-area services.
- Additional covered benefits:
  - Initial emergency health care, post-stabilization and urgent out-of-area services such that the member would recognize them as urgent or emergent conditions and seek medical care. This includes the treatment and stabilization of psychiatric medical emergencies.

    Note: Emergency health care treatments for the diagnoses listed under the mental health parity must immediately be reported to UnitedHealthcare of California or designee. Refer to the Benefit Interpretation Policy titled Inpatient and Outpatient Mental Health.

- Services verbally authorized and/or directed by the network or referring on-call physician.
- Emergency health care or urgently needed services when a written referral or authorization by the network accompanies the claims for such.

Note: Members are not financially responsible for payment of emergency health care services beyond the co-payments and deductibles.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Explanation of Benefits (EOB)/Schedule of Benefits (SOB) for additional information.

- Emergency health care services and urgently needed services when the member is in his or her service area
  Notes:
  - Refer to *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for market-specific definitions of emergency health care services and urgent services.
  - When a member is in his or her service area, they must seek medical attention at an in-network hospital, unless otherwise noted in the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections.
- Coverage of emergency health care services and urgently needed services, transportation, and patient management when the member is out-of-area will be based on the following (**Note**: Refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for market-specific definitions of emergency health care services and urgent services):
  - Emergency health care/Urgently needed services:
    - Requested services are medically necessary.
    - Requested services are considered covered benefits by UnitedHealthcare.
    - Requested services are necessary to enable the member to return to the service area, or to prevent serious deterioration of the member's condition.
    - For members who are hospitalized, determine a coordination plan. The treating physician must be in agreement with the plan's proposed coordination plan before the member is clinically stable to return to the service area. If not, a network physician, ideally with privileges at the hospital, will assume care of that member and authorize transfer of the member back to the service area. If not, the plan must attempt to reach an agreement with the treating physician concerning appropriateness of discharge or transfer for the member. Until such agreement is reached, the plan, in the majority of cases, may be financially responsible for such services until an agreement is reached.
  - Transportation:
    - Determine transportation method for member transfer. A consensus among the treating physician, the primary care physician or plan specialist, and the plan's medical director is required regarding the member's medical stability for transfer and the proposed transportation method. Refer to the Benefit Interpretation Policy titled Ambulance Transportation.
  - Patient management:
    - Management of the patient should be based on the following:
      - Post-stabilization care cannot be limited except when there is a network physician who will assume appropriate care of the member who remains out-of-area.
      - All medically necessary covered benefits requested and ordered by the treating physician are covered without distinction that the member is out-of-area.
      - Denial of coverage may be issued if:
        - The care or services requested are not a plan covered benefit.
        - The services were not medically necessary.
        - Services could await the member's return to the service area without putting the member in danger of serious deterioration or bodily functional loss.
        - The treating physician is in agreement with the transfer; there is a physician willing to accept the member's care, but the member refuses. If the member can reasonably return to the service area, but the member refuses, the plan must explain the denial of continued out-of-area coverage and give the member a written notice and a reasonable time in which to return to the service area.

- The plan is responsible for medically necessary nurse-companion or other medical or health care services that are ordered by a treating physician and/or are a condition of the member's discharge (At UnitedHealthcare's discretion and only if cost effective).
- Return transportation to the service area if the member can return safely by common carrier, including medically necessary special accommodations that are not health services (e.g., first class airline ticket seat or two or three economy seats for the member to elevate extremity) are the responsibility of the member.
- The members' coverage may be further mandated by the individual state laws governing basic healthcare and out-of-area coverage.

Not Covered

- Services that do not qualify as urgent or emergent as defined in the *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and/or *Covered Benefits* sections.
- The **out-of-area services** that are not covered include but are not limited to:
  - Routine follow-up care to emergency health care or urgently needed services, such as treatments, procedures, X-rays, lab work and doctor visits, rehabilitation services, skilled nursing care or home health care.
  - Maintenance therapy and DME, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to help you while traveling outside the geographic area served by your network medical group.
  - Medical care for a known or long-term condition without acute symptoms as defined under "emergency health care services" or "urgently needed services."
  - Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition in or out of the area.

Policy History/Revision Information

Date	Summary of Changes
02/01/2025	**Federal/State Mandated Regulations** • Added language pertaining to *California Assembly Bill 2843* • Removed language pertaining to *California Code of Regulations, Title 28, Section 1300.67.01* **Supporting Information** • Archived previous policy version BIP057.M

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.