VENTURA COUNTY HEALTH CARE PLAN

Utilization Management Policy & Procedure:
Retrospective Review Process Emergency Care and/or Urgently Needed Services
Requirement: UM 002
Revised/Reviewed: 8/2009, 5/2011, 1/2012, 2/2013, 2/2014, 2/2015, 2/2016, 5/2016, 11/2016, 2/2017, 2/2018, 2/2019, 2/2020, 2/2021, 2/2022, 8/2022, 2/2023, 2/2024, 2/2025

POLICY FOR RETROSPECTIVE REVIEW PROCESS EMERGENCY CARE AND/OR URGENTLY NEEDED SERVICES

Policy

VCHCP and its contracted providers comply with California and Federal Legislation. NCQA Standards, and the DMHC regulations regarding emergency care and post stabilization services. As is described in the two previous sections of this document, VCHCP will cover emergency or urgent services necessary to screen and stabilize members, without prior authorization, based on a person who reasonably believed that an emergency/urgent medical condition existed including acute symptoms of sufficient severity (including severe pain) reasonably believed that the absence of immediate medical attention (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Purpose

To establish and describe procedures for handling emergency room and urgent care facility claims, to ensure that the retrospective review of claims follows the Plan's policies for Emergency Services and Urgently Needed Services. In addition, these procedures are intended to include consideration of presenting symptoms as one of the items for review, assuring that the review is not based solely on discharge diagnoses.

Further, the policies and procedures herein are intended to ensure, through retrospective claim review, that claims are reviewed and paid correctly and in a timely manner, whenever a Plan member requires or uses emergency or urgent services. Such services are generally provided without prior authorization, as the patient believed that a true emergency existed and/ or the patient believed that needed care was necessary on an urgent or emergency basis.

Evaluation of claims for Emergency or Urgent Care Services, as herein defined, based on a person who reasonably believed that an emergency/urgent medical condition existed

Payment of Claims:

1. For the purpose of retrospective claim review, emergency or urgently needed services are covered.

2. For the purpose of retrospective claim review, reimbursement for emergency care may be denied only if, upon retrospective medical review by a Plan UR Physician and/ or the Plan Medical Director, it is determined that:

    a. The emergency services and care were never performed;
    Or,

    b. The screening examination revealed that the member did not require emergency care beyond the Basic Screening Exam and stabilization;

    However,

    c. The Plan shall **always** reimburse the facility/provider for a Basic Screening Examination.
3. Payment for emergency services must be processed utilizing a standard where an emergency medical condition exists from the enrollee subjective point of view.
4. Payment denials consider a standard where an emergency medical condition exists from the enrollee's subjective point of view.

Emergency Services 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.

Emergency Services 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. Examples of emergency situations include uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones, or severe pain.

Retrospective Review

Retrospective Review occurs after the care has been received and the member has been discharged from the ER and/or Urgent Care Facility.

Claims for services that appear to fall outside of the Plan's established basic screening examination and stabilization guidelines are presented to the Plan's UR Physician and/or Medical Director, for retrospective review Examples of services that fall outside of the Plan's established basic screening examination and stabilization include but are not limited to the following:

- Excessive charges. For example, the member obtained a head injury, and the facility is submitting a claim for a whole-body scan. Another example is when a member possibly dislocated his/her right arm, and the facility is submitting a claim for an x-ray of the right leg.
- Duplicated services such as inappropriately unbundled codes.
- Non-Covered charges

Procedure

1. ER claims received by VCHCP are number/date stamped, logged, and routed to the Claims Department to be keyed into the Claims system.
2. All ER claims are first queued to a Senior Claims Processor for the following actions:
    a. Confirmation of member eligibility
    b. Confirmation of potential third-party liability
    c. Confirmation of contract and pricing, and
    d. Request for:
        i. Medical Records (If necessary, for UR Physician/Medical Director review for those services falling outside of the basic screening examination and stabilization.)

        ii. Physician Notes, and (If necessary, for UR Physician/Medical Director review for those services falling outside of the basic screening examination and stabilization.)

        iii. All applicable records necessary for review of the care which was received. (If necessary, for UR Physician/Medical Director review for those services falling outside of the basic screening examination and stabilization.)

3. All such claims are then reviewed against the accompanying itemized statement of charges and ER reports. The Claims Reviewer, using the documentation, verifies the services rendered and level of service, and checks for excessive, duplicated, or non-covered charges.

    The Plan's Claims Department tracks each claim for processing within the regulated guidelines. All ER claims must be processed for payment or denial within 45 working days of receipt.

If the Plan cannot process the claim within 45 working days of receiving all the required documentation, the provider and/or the facility involved shall be notified, stating what further steps are necessary, requesting any other information, (if such is required), and stating a date by which the Plan expects to complete the evaluation of the particular claim.

4. The Claims Department reviews the ER claim(s) which may have the ER reports and medical records attached.

5. The Claims Department completes the first level of review based on a person who reasonably believed that an emergency/urgent medical condition existed.

6. When indicated, the review is routed to VCHCP UR Physician/Medical Director reviewer for evaluation of services beyond the basic screening examination and stabilization such as excessive charges and inappropriately unbundled codes.

The role of UR Physician Reviewer/Medical Director

1. When the claims department staff have claims, which relate to services beyond the basic exam and stabilization of the patient, then the claim, with all available records and reports pertaining to the case, is presented to the Plan UR Physician/Medical Director.
2. The UR Physician/Medical Director makes the final determination of medical necessity and quality and appropriateness of medical services, including presenting symptoms and the level of care provided.
3. The UR Physician/Medical Director completes a review of the ER claim(s) to confirm or deny coverage for each medical service rendered.
4. The UR Physician documents the determinations and returns the claim back to the Claims Department.

Procedure: Claims Department

1. Upon receipt of approval of determination for the claim for coverage of services, the Plan Claims Department processes the claim for payment or

   denial and sends an Explanation of Benefits (EOB) to the Plan Member, Facility and rendering Physician. If coverage for some services has been denied, denial codes denote the reason(s) for denial specific to service(s) rendered. The EOB also notifies the Plan Member, Facility and the rendering Physician of the right to appeal, and the DMHC notification of process for appeal (Provider Dispute Resolution Mechanism – PDRM). (Copy of ER Claim following).

4. So-called "balance billing", where claims are sent to members for the "balance" of the account after the Plan has paid the claim pursuant to the above, is not permitted. Plan members are to be reassured that they are not to be billed by providers for any remainder, and that it is against contractual requirements for a Plan network provider to present such bills for the balance of the account.

A. Attachments: none

B. References:

C. Reviewers: Utilization Management Committee; Medical Director; QA Manager; Health Services Director
Reviewed/Revised by: Lita Catapang, RN & Albert Reeves, MD
Committee Review: UM: August 2009; QAC: August 2009
Reviewed/No Changes by: Faustine Dela Cruz, RN & Albert Reeves, MD
Committee Review: UM: August 11, 2011; QAC: August 23, 2011
Reviewed/No Changes by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD
Committee Review: UM: February 9, 2012; QAC: February 28, 2012
Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD
Committee Review: UM: February 14, 2013; QAC: February 26, 2013
Reviewed/No Updates by: Linda Baker, RN & Catherine Sanders, MD
Committee Review: UM: February 13, 2014; QAC: February 25, 2014
Reviewed/No Updates by: Faustine Dela Cruz, RN & Catherine Sanders, MD
Committee Review: UM: February 12, 2015; QAC: February 24, 2015
Reviewed/No Updates by: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 11, 2016; QAC: February 23, 2016
Reviewed/Updated by: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: May 12, 2016; QAC: May 24, 2016
Reviewed/Updated by: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: November 10, 2016; QAC: November 22, 2016
Reviewed/No Updates: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 9, 2017; QAC: February 28, 2017
Reviewed/Updated by: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 8, 2018; QAC: February 27, 2018
Reviewed/No Updates by: Faustine Dela Cruz, RN, Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 14, 2019; QAC: February 26, 2019
Reviewed/No Updates by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 13, 2020; QAC: February 25, 2020
Reviewed/No Updates by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 11, 2021; QAC: February 23, 2021
Reviewed/ Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 17, 2022; QAC: February 22, 2022
Reviewed/ Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: August 11, 2022; QAC: August 23, 2022
Reviewed/No Updates by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 2, 2023; QAC: February 7, 2023
Reviewed/No Updates by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 8, 2024; QAC: February 27, 2024

Reviewed/No Updates by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 20, 2025; QAC: February 25, 2025

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
11/29/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Changed "prudent layperson" to "reasonable person" language as required by DMHC
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/13/20	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/11/21	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/17/22	Yes	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review; Updated with DMHC's definition of Emergency Care and Reasonable Person Standard
8/11/22	Yes	Faustine Dela Cruz, RN, Meriza Ducay, RN Howard Taekman, MD, Robert Sterling, MD	Updated with DMHC's language regarding Emergency services where a person reasonably believed that an emergency medical condition existed.
2/2/23	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/8/24	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/20/25	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review