



Louisiana Department of Health and Hospitals BAYOU HEALTH Informational Bulletin 12-7 February 22, 2012

Issue: Reimbursement for Emergency Care in BAYOU HEALTH

BAYOU HEALTH Plans must cover emergency services as defined below. Coverage is required regardless of prior authorization, where services are rendered or whether the provider has a contract with the Health Plan.

An emergency medical condition manifests 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 impairment to body functions, or
- Serious dysfunction of any bodily organ or part.

An emergency medical condition can be treated in settings other than a hospital emergency room, for example:

1. A woman is in pediatrician's office with her daughter for routine vaccinations. She is 35 weeks pregnant with her next child. While in the waiting room her membranes rupture and she starts having abdominal pain and light vaginal bleeding suggestive of possible abruption. The pediatrician's office is in Grand Isle and the closest hospital is over 30 minutes away.
2. A woman is in her internal medicine physician's office for her diabetes checkup. Her 4 year old daughter is with her who has asthma. While there the daughter develops an acute asthmatic episode and is gasping for breath. She has no inhalers or medications with her.

(The person having the acute medical episode may or may not be enrolled in same Health Plan as the member with the original appointment).

As a result, Health Plans must base coverage of emergency services on presentation of symptoms consistent with the prudent layperson standard at the time the member seeks treatment. If a member seeks emergency services that could reasonably be expected to have the above effects, then the Health Plan must cover emergency services as outlined below.

The treating physician will make a clinical determination if an emergency medical condition is present. As noted in the definition of emergency services, the Health Plan is responsible as follows:

- Coverage of assessment services to determine if an emergency medical condition is present;
- If the medical assessment leads to a clinical determination that an emergency medical condition does not exist, then the provider should contact the Health Plan regarding coverage of treatment as it may not be covered.
- The Health Plan has the option to deny or permit payment for screening and assessment when the prudent layperson standard has not been met.
- If the medical assessment leads to a clinical determination that an emergency medical condition is present, the treating physician will provide further examination and treatment as necessary to stabilize the condition. The Health Plan is responsible for coverage of treatment until the patient is either stabilized or discharged, as determined by the treating physician.

If the medical assessment determines there is an emergency medical condition, then the Health Plan assumes financial responsibility for post-stabilization care services provided within or outside the Plan when the services are:

1. Pre-approved by a network provider or other representative from the Health Plan;
2. Not pre-approved, but were administered to maintain the member's stabilized condition within one hour of a request to the Plan for pre-approval of post-stabilization services;
3. Administered to maintain, improve or resolve the member's stabilized condition in the event the Health Plan:
 - Does not respond to a request for pre-approval within one hour,
 - Cannot be contacted, or
 - Cannot reach an agreement with the treating physician concerning the member's care and a network physician is not available for consultation. In this event, the Health Plan must give the treating physician the opportunity to consult with a network physician, and the treating physician may continue with care of the patient until a network physician is reached.

The Health Plan's financial responsibility for post-stabilization care services that are not pre-approved ends when a network physician assumes responsibility for the member's care, a representative of the Health Plan and the treating physician reach an agreement concerning the member's care, or the member is discharged.

As noted above Plans are responsible for payment for emergency services regardless of whether the provider has a contract. If emergency services are provided by an out-of-network provider that does not have a contract with the Health Plan, the provider will be reimbursed 100% of the Louisiana Medicaid payable amount, in effect on the date of service.

A Health Plan may not deny payment for emergency services when:

- Based on symptoms identified by the member and using the prudent layperson standard, the member appeared to have an emergency medical condition, but, upon examination, the condition turns out not to meet the emergent definition as listed above.
- The member does not provide the Plan notification either before or after receiving emergency services. The Plan may, however, enter into contracts with providers or facilities that require, as a condition of

payment, the provider or facility to provide notification to the Health Plan after members are present at the emergency room, assuming adequate provision is given for such notification.

- Emergency provider, hospital, or fiscal agent does not notify the member's PCP or Plan of the member's medical assessment and treatment within ten (10) calendar days of presentation for emergency services.
- The member obtained services based on instructions of a practitioner or other representative of the Plan, including the member's PCP.