

CHELAN-DOUGLAS CDRSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	1.15
Title:	INTRODUCTION AND ADMINISTRATIVE POLICIES	Page:	1 of 6
		Date Effective:	July 1, 2004
Subject:	Emergency and Post- Stabilization Services	Date Revised:	July 1, 2004
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AUTHORITY: Guiding Principle(s): Effectively Managed
WAC 388-865-0340
DSHS/MHD – CDRSN/PIHP contract
42 CFR 438.114(a)(1)(2)(3);(b)(1);(c)(1);(d)(1)(2)(3);(e);(f)
State MHD Quality Strategy Doc Sec IV; V
State MHD Access to Care and Level of Care Guidelines Document

SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Health Plan (CDRSN/PIHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: This policy describes that CDRSN/PIHP is responsible for coverage and payment of emergency services, and post-stabilization care services, which qualify under the State Plan as covered mental health services.

DEFINITIONS: “Access to service” means: Enrollees can access medically necessary mental health services upon request that do not exceed the access standards

“A Request for Mental Health Services” means: A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, referral, walk-in, or written request for mental health services. The determination of eligibility for authorization to service shall be based on the Access to Care standards. Authorization shall not take more than fourteen calendar days, unless the enrollee or the CMHA requests an extension. An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA if: a) the Contractor provides written justification to the MHD regarding the need for additional information; and b) the Contractor indicates how the extension is in the enrollee’s best interest. Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.

“Access Standards” refers to: The Subcontractor ensures:

- a) An intake assessment is initiated within 10 working days of the request for mental health services;
- b) Routine mental health services are offered to occur within 14 calendar days of a determination of eligibility. An extension is possible upon request by the enrollee. A total of 28 calendar days from request for services to first routine appointment will be the normal time period expected;
- c) The CDRSN/PIHP provides written justification to the MHD regarding the need for additional information; and
- d) The CDRSN/PIHP indicates how the extension is in the enrollees' best interest.
- e) Emergent mental health services occur within 2 hours of the request for mental health services from any source;
- f) Urgent care occurs within 24 hours of the request for mental health service from any source.

“Emergency Medical Condition”: Emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. 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.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

“Emergency Services”: Emergency services means covered inpatient or outpatient services that are:

1. Furnished by a provider that is qualified to furnish these services under this title.
2. Needed to evaluate or stabilize an emergency medical condition.

“Emergent Care” means: Services provided for a person, that, if not provided, would likely result in the need for emergency crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

“Post-stabilization Care Services”: Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in paragraph (c) of this section, to improve or resolve the enrollee’s condition.

“Prudent layperson” is a phrase which refers to BBA language regarding the legitimacy of a person’s decision to seek emergency treatment and have it be covered as part of their benefits. It is based on the following excerpt from Public Law 105-33: "Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person’s bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

POLICY: Payment for emergency and/or post-stabilization services delivered within a facility setting by an entity under contract direct with the State of Washington MHD is the responsibility in Washington of the State. Emergency and/or other types of crisis type mental health services delivered in an outpatient setting by an entity which contracts directly with the CDRSN/PIHP are the responsibility of the CDRSN/PIHP and paid by the CDRSN/PIHP. The CDRSN/PIHP is responsible for providing emergent medically necessary mental health services, such as crisis services, stabilization services, etc. Emergent mental health services are provided within 2 hours of request for service.

Payment for inpatient services and for emergency and post-stabilization services that might be delivered within State contracted facilities remain the responsibility of the State of Washington, who holds the contract and processes the payments. The CDRSN/PIHP retains responsibility for maintaining well functioning authorization systems for facility based services.

Coverage and Payment include:

1. Covers and pays for emergency services regardless of whether the entity that furnishes the services has a contract with the CDRSN/PIHP; and
2. Does not deny payment for treatment obtained under either of the following circumstances;
 - o An enrollee having had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of “emergency medical condition.”
 - o A representative of the CDRSN/PIHP instructs the enrollee to seek emergency services.

Additional Rules for Emergency Services include: The CDRSN/PIHP does not:

1. Limit what constitutes an emergency medical condition as defined in this P&P, on the basis of lists of diagnoses or symptoms; and
2. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, CDRSN/PIHP, or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
3. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
4. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

Coverage and Payment for Post-Stabilization Services: Post-stabilization care services are covered and paid for in accordance with provisions set forth at 422.113 (c). In applying this provision, references to "M+C organization" must be read as reference to the entities responsible for Medicaid payment, the CDRSN/PIHP.

Applicability to CDRSN/PIHPs: To the extent that service required to treat an emergency medical condition fall within the scope of the services for which the CDRSN/PIHP is responsible, these rules apply. Refer to MHD contract for scope of services.

PROCEDURE: The CDRSN/PIHP contracted provider shall ensure appropriate use of inpatient services in adherence to WACDMHP Protocols (see MHD contract). In the event no hospital admission occurs the CDMHD shall ensure an appropriate evaluation for outpatient stabilization services as determined necessary to meet medical necessity. In the event inpatient hospitalization services are determined to be necessary, residency and funding source will effect the choice of hospital for psychiatric inpatient care. CDMHPs will ensure the authorization process is as follows.

1. Client presents as described in Timely Access (1.10.3)
2. CDMHP evaluation occurs as described in WACDMHP Protocols
3. Determine county of origin
 - a. If a Western Washington resident
 - i. Contracted provider determines Medical Necessity exists for inpatient care and authorizes admission

- ii. Contact any Western Washington RSN for confirmation and final determination for appropriate hospital
- b. If an Eastern Washington resident
 - i. Contracted provider determines Medical Necessity exists for inpatient care and authorizes admission
 - ii. If not a CDRSN/PIHP covered life, contact any Eastern Washington RSN for confirmation and final determination for appropriate hospital
 - iii. If client is a CDRSN/PIHP resident determine finding source
 - 1. For Medicare, private insurance, and children, ITA and voluntary admit to community hospitals
 - 2. For Chronic (multiple admits), TXIX and no access to community hospitals, ITA admit to Eastern State Hospital
 - iv. Contracted Crisis Services provider FAX demographic and clinical information to CDRSN/PIHP next business day
 - v. CDRSN/PIHP provide Certification for payment to Psychiatric hospital within three (3) business days

The authorization process is described in section 5.6 of the CDRSN/PIHP Policy and Procedures.

The oversight of inpatient care and utilization is described in sections 5.7, 5.8, and 5.9 of the CDRSN/PIHP Policy and Procedures.

Data tracking on the performance of the care management of emergency and post-stabilization services will be collected, analyzed and submitted to the Quality Management Oversight Committee for review and decision making.

The CDRSN/PIHP contracted provided, must have policies and procedures which cover at least the following elements:

1. The CDRSN/PIHP covers and pays for emergency services regardless of whether the entity that furnished the services has a contract with the CDRSN/PIHP, and regardless of whether or not the claim contains the primary care provider's authorization number.
2. The CDRSN/PIHP pays for treatment obtained under either of the following circumstances:
 - An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of 'emergency medical conditions.'
 - A representative of the CDRSN/PIHP instructs the enrollee to seek emergency services.

- The CDRSN/PIHP does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- The attending emergency physician, or the provider actually treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the CDRSN/PIHP.

SEE ALSO: Glossary of Terms and Acronyms