

# **AB 1203:**

## **How to ensure your hospital is paid for non-contracted post-stabilization services**

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## **Purpose and Effect**

- **AB 1203 prevents a hospital from billing HMO members for amounts, other than co-pays and deductibles, owed for post-stabilization inpatient services in almost every circumstance**
- ***It requires non-contracting hospitals to contact HMOs before providing post-stabilization inpatient services***
- ***IF A HOSPITAL DOES NOT CONTACT THE NON-CONTRACTING PLAN PRIOR TO PROVIDING POST-STABILIZATION SERVICES, IT MAY NOT GET PAID!***

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## Exceptions to Ban on Balance Billing

- 📁 Where the hospital is unable to obtain the patient's insurance information
- 📄 Where the patient refuses to be transferred

## Scope

- **Which provider types does it apply to?**
  - General Acute Care Hospitals
  - Does not apply to ED doctors or other emergency service providers
- **Which plan types does it apply to?**
  - Knox-Keene Act licensed health care services plans (i.e. HMOs)
  - Does not apply to PPOs, indemnity plans
  - Does not apply to capitated medical groups or Risk Bearing Organizations so long as the hospital is contracted with the health care service plan
- **What services does it apply to?**
  - Post-stabilization services
- **When is it effective?**
  - January 1, 2009

## Overview of Hospital Requirements

- Prior to providing post-stabilization inpatient services, a ***non-contracted*** hospital must:
  - 📞 Upon stabilization, seek to obtain the name and contact information of the patient's health care service plan
  - 📞 Call the health plan
  - 📖 Upon request, provide the patient's diagnosis and other information needed for the plan to make a decision to authorize post-stabilization care or transfer the patient
  - 📄 Request the patient's medical record from the health care service plan

## Overview of Health Plan Requirements

- A non-contracted health plan that requires prior authorization for post-stabilization care must:
  - Be available 24 hours a day, 7 days a week to respond to either authorize post-stabilization care or arrange to transfer its member
  - Respond to calls within 30 minutes
  - Arrange for and effectuate transfer promptly, if it chooses to transfer the patient rather than authorize care
  - Pay for all authorized services and for all services provided prior to transfer

# HOSPITAL REQUIREMENTS AND GOOD PRACTICES

## Elements of a good plan

- **Determine which staff will contact the plan**
- **Set procedure for clinicians to communicate stability**
  - ED Staff before admission
  - Case Managers after admission
- **Determine when staff will contact plan**
  - At time of admission if HMO known, regardless of stability
  - Upon stability, if insurance info is not volunteered
- **Determine how and where to document notification and plan response**
  - Medical record, patient flow sheet, separate form/log
- **Establish protocols if patient refuses to be transferred**

## When to notify

- Not required to notify the plan for “minor services” provided to “treat and release” patients
- For inpatients, within a reasonable time *after* the patient is stabilized, and *prior* to providing post-stabilization services
- Practical Tip: For inpatients, as soon as insurance information is voluntarily provided (*i.e.* without any request) even before stabilization
- Must notify on nights and weekends

## Determining stability

- Legal standard: A patient is stable when, “in the opinion of the treating provider, 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, a transfer of the patient . . .” Health & Safety Code section 1317.1(j)
- “Stabilized to transfer” is not a clinically significant event
- Difficult to change physician practices to record “stability to transfer”
  - If possible, establish protocols for documenting when patient became stable in medical record
- Establish protocols so staff responsible for notifying HMOs knows when patient is stable

## How to notify the plan

- **Follow the instructions on the patient's member card or call the number provided by plan (on DMHC website and sent to each individual hospital)**
  - DMHC website:  
[www.dmhc.ca.gov/providers/gen/gen\\_247contact.aspx](http://www.dmhc.ca.gov/providers/gen/gen_247contact.aspx)
- **The hospital is only required to call once**
- **If the member card identifies an IPA or other delegated entity, it is probably best to contact the delegated entity**

## Recommended Documentation

- **By Clinical Staff:**
  - Time of stabilization
  - Attempts to obtain patient's plan information (required)
- **By Registration/Admitting, Financial Counselors, or other designated staff:**
  - Date and time non-contracting plan notified (minimum)
  - Phone number called (minimum)
  - Plan's response (time of response, authorization number, name of person responding)
  - Date and time of response

## Plan Requirements

## Plan's Response

- **A plan must respond within 30 minutes**
- **Plan must either authorize post-stabilization services or notify hospital that it will promptly transfer the member to another hospital**
- **If a plan fails to respond within 30 minutes, medically necessary post-stabilization services are deemed authorized**
- **Plan must pay charges for post-stabilization services**

## Time to effectuate transfer

- No specific time period set forth by statute, but transfer must be “prompt”
- If there is an “unreasonable delay” in transfer and the physician determines that post-stabilization services are necessary, plan must pay for post-stabilization services (Health & Safety Code section 1371.4(j))

## Patient refuses to be transferred

- The hospital must promptly provide a written notice to patient, in the patient’s primary language, that patient will be financially responsible for services
  - The notice, in all Medi-Cal threshold languages, are published on the DMHC website.
  - The hospital shall obtain signed acceptance of the written notice, and any other documents the hospital requires for further post-stabilization care (i.e. Conditions of Admission form). If patient refuses to sign, refusal should be documented in patient’s medical record.
  - Hospital shall provide plan with confirmation of the patient’s receipt of the written notice.
  - Hospital should retain copy of notice in patient’s medical record.
  - ***If the hospital fails to comply with these notice provisions, it cannot bill the patient!!!***

## **Disagreement regarding need for post-stabilization services**

- **If plan disagrees with the need for post-stabilization care, it shall assume responsibility for the care by either having medical personnel contracting with the plan take over care within a reasonable time after the disagreement, or having a contracted hospital agree to accept a transfer. (Health & Safety Code section 1371.4(d))**

## **REIMBURSEMENT RATES**

## Rate when plan fails to respond

- Where plan (1) fails to notify hospital of its decision to authorize or notify of transfer within 30 minutes, or (2) plan elects to transfer but fails to do so within a reasonable time:
  - Plan “shall pay charges for the care” in accordance with the Knox-Keene Act and regulations.

## Rate when plan transfers the member

- Where Plan transfers member:
  - Plan “shall pay for all of the immediately required medically necessary care rendered to the patient prior to transfer to maintain patient’s clinical stability.”

## **Rate when plan authorizes post-stabilization services**

- Plan “shall be responsible to pay for the authorized care”
- Provider may attempt to establish an agreement for plan to pay billed charges if it authorizes care

## **Medicare Advantage and Medi-Cal Managed Care**

- What if the plan is a Medicare Advantage Plan?
  - Reimbursement is Medicare Allowable
- What if the plan is a Medi-Cal managed care plan?
  - Reimbursement is “Medi-Cal Allowable”

# Questions?

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