[Ariz. Rev. Stat. §§ 20-2801 through 20-2804.]

§§ 20-2801 through 2804: Access to Emergency Health Care

§ 20-2801. Definitions.

In this chapter, unless the context otherwise requires:

1. "Coverage" means the contractual obligation of a health care services plan to pay its enrollee or a contracted or noncontracted provider for medically necessary emergency services rendered by the provider to an enrollee, as specified in the governing agreement, contract or policy between the plan and the enrollee, subject to applicable copayments, coinsurance and deductibles.

2. "Emergency ambulance services" means services provided by an ambulance service authorized to operate pursuant to title 36, chapter 21.1 following the onset of a medical condition that manifests itself by symptoms of pain, illness or injury that the absence of accessing an ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.

(b) Serious impairment to bodily functions.

(c) Serious dysfunction of any bodily organ or part.

3. "Emergency services" means health care services that are provided to an enrollee in a licensed hospital emergency facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Serious jeopardy to the patient's health.

(b) Serious impairment to bodily functions.

(c) Serious dysfunction of any bodily organ or part.

4. "Enrollee" means an individual, or a dependent of that individual, who is currently enrolled with and covered by a health care services plan.

5. "Health care services plan" means a plan offered by a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation or medical service corporation

that contractually agrees to pay or make reimbursement for health care expenses for one or more individuals residing in Arizona but does not apply to benefits provided under limited benefit coverage as defined in section 20-1137.

6. "Prior authorization" means authorization by telephone or telefacsimile given in advance of the performance of an emergency service on an enrollee, by a health care services plan after receipt of necessary medical and enrollment information on the enrollee. Prior authorization shall not be considered as a guarantee of full payment.

7. "Provider" means any physician, hospital or other person that is licensed or otherwise authorized to furnish emergency services in this state.

§ 20-2802. Scope of chapter.

A. This chapter does not apply to:

1. A provider employed by or under contract with the enrollee's health care services plan.

2. A health care services plan administered under title 36.

3. A health care services plan that only covers health care expenses incurred by an enrollee who is subsequently admitted to a licensed hospital as part of the treatment.

B. This chapter does not create any private right or cause of action for or on behalf of any enrollee, provider or other person, whether a resident or nonresident of this state. This chapter provides solely an administrative remedy to the director for any violation of this chapter or any related rule.

§ 20-2803. Emergency services access; prior authorization; requirements.

A. A health care services plan shall provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required by the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat. 164; 42 United States Code section 1395dd) without prior authorization by the plan, subject to applicable copayments, coinsurance and deductibles.

B. A health care services plan shall provide coverage for emergency ambulance services without prior authorization, subject to applicable copayment, coinsurance and deductibles.

C. A provider shall not deny, limit or otherwise restrict a patient's access to medically necessary emergency services based on the patient's enrollment in a health care services plan.

D. A health care services plan may require as a condition of coverage prior authorization for health care services arising after the initial medical screening examination and immediately necessary stabilizing treatment. Prior authorization is granted unless denied or direction of the enrollee's care is initiated by the plan within a reasonable period of time after the plan receives the prior authorization request. If direction of

care instructions are received from the plan after more than a reasonable period of time has elapsed, the treating provider or providers shall comply with the late instructions to the extent feasible, except that a health care services plan remains responsible for coverage of medically necessary care given and substantially completed before the late instructions were received.

E. A health care services plan that requires prior authorization under subsection C shall provide twenty-four hour access by telephone or facsimile for enrollees and providers to request prior authorization for medically necessary care after the initial medical screening examination and any immediately necessary stabilizing treatment. Plan personnel shall have access to a physician when necessary to make determinations regarding prior authorization.

F. A health care services plan that gives prior authorization for specific care by a provider shall not rescind or modify the authorization after the provider renders the authorized care in good faith and pursuant to the authorization.

G. A hospital emergency department shall make reasonable efforts to promptly contact the health care services plan for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other appropriate care for an enrollee. A health care services plan shall not deny coverage for emergency services provided to the plan's enrollee due to a provider's failure to obtain prior authorization from the plan if the provider could not determine the patient's enrollment in a particular plan due to the patient's physical condition, or if the patient's enrollment information was not available from the plan at the time of the provider's contact.

H. If the health care services plan and the provider disagree on the medical necessity of specific emergency services for an enrollee, except for emergency services provided outside the geographic service area of the plan, medical personnel representing the plan shall make necessary arrangements to assume the care of the enrollee within a reasonable period of time after the disagreement arises. If the health care services plan fails to assume the care of the enrollee as provided by this subsection, the plan shall not deny coverage for medically necessary emergency services provided to the enrollee due to lack of prior authorization.

I. If within a reasonable period of time after receiving a request from a hospital emergency department for a specialty consultation a health care services plan fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for medically necessary emergency services by any appropriate specialist, and the plan shall not deny coverage for these services due to lack of prior authorization. A health care services plan shall not require prior authorization for specialty care emergency services for treatment of any immediately life threatening medical condition.

§ 20-2804. Utilization review; medically necessary emergency services.

A. A health care services plan engaging in utilization review to determine whether any emergency services rendered by a provider were medically necessary and in accordance with this chapter shall consider the following factors:

1. Current emergency medical literature and standards of care.

2. Clinical information reasonably available to the provider at the time of the services.

B. A health care services plan shall not deny a claim for emergency services on the basis that the services were not medically necessary without review by a physician of the plan's choosing.

C. For the purpose of claims payment and utilization review of emergency services, a health care services plan shall have the right to require as a condition of payment that each treating provider produce all of the following:

1. Copies of all medical records pertaining to the emergency services provided to the enrollee.

2. Copies of records pertaining to any prior authorization and specialty consultation requests made by the provider.

3. A detailed and itemized billing statement.

D. If a health care services plan pays any portion of a provider's claim for services rendered to an enrollee, the plan shall not be permitted to recover all or part of that payment from the enrollee, except for:

1. The cost of an initial medical screening examination and related charges where the examination determined that emergency services were not medically necessary.

2. Payments made as a result of misrepresentation, fraud or clerical error.

3. Copayment, coinsurance or deductible amounts that are the responsibility of the enrollee.