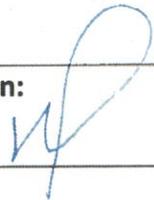


**Commonwealth of Puerto Rico  
Puerto Rico Health Insurance Administration  
Compliance & Clinical Affairs Office**

<b>Name: Payment rule for Out of Network Emergency Services rendered in Puerto Rico, and for emergency services rendered in USA, for beneficiaries enrolled in MI Salud.</b>		
<b>Apply to :</b> Manage Care Organization (MCO) / Third Party Administrator (TPA) / Mental Behavior Health Organization (MBHO)	<b>Approval by:</b> William Ruiz Alejandro	<b>Approval Date:</b> 4-29-13
<b>Created by :</b> Compliance & Clinical Affairs Office	<b>Sign:</b> 	<b>Effective Date:</b> 5-1-13
<p><b>Contractual Reference for MCO/TPA</b>  <i>"7.5.9.3 Emergency Services Within and Outside Puerto Rico</i></p> <p style="margin-left: 40px;"><i>7.5.9.3.1 The Contractor shall make Emergency Services available:</i></p> <p style="margin-left: 80px;"><i>7.5.9.3.1.1 For all Enrollees, throughout Puerto Rico, including outside the Contractor's service Regions, and notwithstanding whether the emergency room is a Network Provider; and</i></p> <p style="margin-left: 80px;"><i>7.5.9.3.1.2 For Federal Medicaid and CHIP Eligible Persons, in Puerto Rico or in the United States, when the services are Medically Necessary and could not be anticipated, notwithstanding that emergency rooms outside of Puerto Rico are not Network Providers. The Contractor shall be responsible for timely payment for Emergency Services in the United States. If, in an extenuating circumstance, a Medicaid or CHIP Eligible Enrollee incurs out-of-pocket expenses for Emergency Services provided in the United States, the Contractor shall timely reimburse the Enrollee for such expenses, and the reimbursement shall be considered a Covered Service.</i></p> <p style="margin-left: 40px;"><i>7.5.9.3.2 In covering Emergency Services provided by Puerto Rico Providers outside the Contractor's Network, or by Providers in the United States, the Contractor shall pay the Provider at least the average rate paid to Network Providers."</i></p> <p><b>Contractual Reference for MBHO</b>  <i>"7.4.5.3 Emergency Services Within and Outside Puerto Rico</i></p> <p style="margin-left: 40px;"><i>7.4.5.3.1 The Contractor shall make Emergency Services available:</i></p> <p style="margin-left: 80px;"><i>7.4.5.3.1.1 For all Enrollees, throughout Puerto Rico, including outside the Contractor's Service Region, and notwithstanding whether the emergency</i></p>		

*room is a Network Provider; and*

*7.4.5.3.1.2 For Federal Medicaid and CHIP Eligible Persons, in Puerto Rico or in the United States, when the services are Medically Necessary and required by Puerto Rico law or the Puerto Rico Medicaid State Plan and could not be anticipated, and notwithstanding that emergency rooms outside of Puerto Rico are not Network Providers. The Contractor shall be responsible for the timely payment for Emergency Services in the United States. If, in an extenuating circumstance, a Medicaid or CHIP Eligible Enrollee incurs out-of-pocket expenses for Emergency Services provided in the United States, the Contractor shall timely reimburse the Enrollee for such expenses, and the reimbursement shall be considered a Covered Service.*

*7.4.5.3.2 In covering Emergency Services provided by Puerto Rico Providers outside the Contractor's Network, or by Providers in the United States, the Contractor shall pay the Provider at least the average paid to Network Providers."*

Note: This Procedure must be review as necessary.

**Purpose:**

To defying the payment rule policy to covered Emergency services rendered by Out of network providers in Puerto Rico & within the USA to beneficiaries entitles under the Health Plan of the Commonwealth of Puerto Rico, MI Salud, including emergency ambulance transportation.

**Introduction**

**A) Emergency services received in a Non participant facility in the scope of Puerto Rico territory.**

The Health Plan of the Commonwealth of Puerto Rico, MI Salud establishes that any Emergency Service (ER) received by any beneficiary of Mi Salud on a non participant provider's facility within Puerto Rico area will be covered and paid according to the average established rate for the participant providers within the nearby area or region. The covered ER benefit is limited only to emergency room facility use, emergency ambulance, and medical services that are Medically Necessary and could not be anticipated or treated in the ambulatory setting. If the participant requires inpatient services, the Non Participant facility should coordinate with a participant facility for the appropriate transfer; meanwhile, the non participant facility must provide the necessary service to assure patient safety that may include temporary admission to inpatient services if medically mandatory.

**B) Emergency Services received in any state of the USA**

For any emergency service provided within the USA for a Medicaid Federal Categories Group 100, 110, and for CHIP's group 230 of Mi Salud, the service will be covered and paid according to the average rate established for participant's facilities and providers in Puerto Rico. The Benefit for

Emergency Services to the others Commonwealth Mi Salud participant's categories, will not be covered in any state outside the Puerto Rico territory.

The covered ER benefit is limited only to emergency room facility use, emergency ambulance, and medical services that are Medically Necessary and could not be anticipated or treated in the ambulatory setting. The billed services will be revised by the delegated insurance company to determine, in view of the presented diagnosis and therapeutic management, that such emergency was necessary.

All submitted ER billed services will be revised by the MI Salud delegated insurance company to determine, in view of the presented diagnosis and therapeutic management, that such emergency was necessary.

The following criterion needs to be met in order to be considered as legitimate for possible payment by the Insurer or the MBHO for those ER services rendered in the USA:

- Beneficiary that required emergency services during a trip or stay in the United States (U.S.), within the first 45 days or less of that stay.
- The Insurer or the MBHO who received the submitted claim will validate that such claim has not being paid in any other moment.
- Any ER services paid by the beneficiary must be submitted with an evidence of such payment.
- The Beneficiary needs to present evidence that his fly to the USA occurred during the first forty five (45) days or less. Must submit evidence such as airline ticket.

If the participant requires inpatient services, the USA Non Participant facility must provide the necessary service to assure patient safety that may include any surgery or hospital admission, if medically necessary. In such circumstances, Mi Salud Health Insurance Plan will cover such services at the average rate established in Puerto Rico for the Medicaid population. If the patient needs to stay in the mainland for further ambulatory treatment, the facility and member should coordinate with the local state Medicaid office to assure local state Medicaid coverage.

#### **Procedure for services billing and payment:**

- A) Emergency services received in a Non participant facility in the scope of Puerto Rico territory.**

The Hospital Institution or health provider must comply with the following required process to bill any emergency service for any "Mi Salud" beneficiaries. The bill must be address to the responsible Insurer or Mental Health Organization.

- 1- The Hospital or Provider rendering the emergency services has the responsibility to verify patient's eligibility. The provider must contact the responsible insurer (Telephone number provided in Plan ID) to determine final eligibility as a Federal Medicaid or CHIP participant. If the claim belongs to a non Federal Medicaid or CHIP member, the services will be automatically denied by the Insurer or the MBHO
- 2- Must corroborate the beneficiary identity with an insurance and identification card.
- 3- Claims submitted by the beneficiary, the medical provider or any Institutional provider for an emergency service will be reviewed by the insurer to determine if medically necessary.
- 4- The claim has to be submitted in the format that the Insurance or Mental Health Organization required according with their payment process for emergency services. The claim must include and comply as minimum but not limited to the following items:
  - i. Beneficiary contract number
  - ii. Service and/or procedure codes
  - iii. Primary and secondary Diagnosis
  - iv. Necessary services codes Modifiers
  - v. Expected Payment amount per service
  - vi. Date of service
  - vii. Place of services
  - viii. Benefits Coordination, if any
  - ix. Rendering physician & NPI
  - x. Facility name & NPI
  - xi. Any other information required by the Mi Salud contracted Insurance or MBHO.
- 5- Any suspicious of fraudulent action for rendered or billed services by the beneficiary, any rendering provider or perceived by the Insurer / MBHO, must be reported with the necessary documentation immediately to ASES.

#### **B) Emergency Services received in any state of the USA**

The Hospital Institution or health provider must comply with the following required process to bill any emergency service for any "Mi Salud" beneficiaries. The bill must be address to the responsible Insurer or Mental Health Organization.

- 6- The Hospital or Provider rendering the emergency services has the responsibility to verify patient's eligibility. The provider must contact the responsible insurer

(Telephone number provided in Plan ID) to determine final eligibility as a Federal Medicaid or CHIP participant. If the claim belongs to a non Federal Medicaid or CHIP member, the services will be automatically denied by the Insurer or the MBHO

- 7- The provider must validate, as possible, that the beneficiary do not exceed forty five (45) days of his/her arrive to the State, the limited time to be apply to cover the payment of any emergency services.
- 8- On all claims, submitted by the beneficiary, the medical provider or an Institutional provider for an emergency service the payers will validate the emergency medical necessity of provided services. If the patient needs to be admitted as inpatient, the services will be denied as non covered benefits.
- 9- The claim has to be submitted in the format that the Insurance or Mental Health Organization required according with their payment process to off island emergency services of the Insurer or the MBHO. Claim must be submitted before 90 days after such services were provided, to be considered a valid claim for payment. All services received after 90 days of being given will be denied.
- 10- The Insurer or MBHO will process the submitted claims. The claim must include and comply with the following minimum information field:
  - i. Beneficiary contract number,
  - ii. Service and/or procedure codes, including any necessary emergency transportation
  - iii. Principal and secondary Diagnosis
  - iv. Necessary services codes Modifiers
  - v. Expected Payment amount per service
  - vi. Date of service
  - vii. Place of services
  - viii. Benefits Coordination, if any
  - ix. Rendering physician & NPI
  - x. Facility name & NPI
  - xi. Any other information required by the Mi Salud contracted Insurance or MBHO.
- 11- Any suspicious of fraudulent action for rendered or billed services by the beneficiary, any rendering provider or perceived by the Insurer / MBHO, must be reported with the necessary documentation immediately to ASES.

**C) Reimbursement for Emergency Services in a non participant facility and paid by the insured member**

Any enrollees that received and paid for emergency services in a non participant provider in Puerto Rico or in any ER facility in the USA can submit payment evidence of the services received to the Insurance or Mental Health Organization. The member will submit a Request for reimbursement completing the Form with the following information;

- a- Original receipt
- b- Name and telephone numbers of the provider
- c- Diagnosis (ICD 9-10)
- d- Procedures (CPT, HCPCS or Revenue Codes)
- e- Any information regarding the existence of other health plan, a copy of the CBO with the explanation of benefits paid, and charges for copayments or deductibles.
- f- The request for reimbursement must not exceed 90 days after services were rendered.

Payment for valid services will be reimbursed based on the current payment average for the "Mi Salud" contracted provider's network.

MMC/Rev. August 05, 2013

**\*\*This policy is under review\*\***