

FILED

**Jane Dee Hull
Secretary of State**

State of Arizona
Senate
Forty-second Legislature
Second Regular Session
1996

CHAPTER 132

SENATE BILL 1286

AN ACT

AMENDING SECTIONS 20-821, 20-923 AND 20-1068, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1137; AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 16; RELATING TO INSURANCE PAYMENTS FOR EMERGENCY SERVICES.

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-821, Arizona Revised Statutes, is amended to
3 read:

4 20-821. Scope of article; rules; authority of director

5 A. Hospital service corporations, medical service corporations, dental
6 service corporations, optometric service corporations and hospital, medical,
7 dental and optometric service corporations incorporated in this state are
8 governed by this article and are exempt from all other provisions of this
9 title, except as expressly provided by this article and any rule adopted by
10 the director pursuant to section 20-143 relating to contracts of such service
11 corporations. No insurance law enacted after January 1, 1955 is deemed to
12 apply to such corporations unless they are specifically referred to therein.

13 B. Sections 20-1133, 20-1377, 20-1408, 20-1692, 20-1692.01, 20-1692.02
14 and 20-1692.03 AND CHAPTER 16 OF THIS TITLE apply to this article.

15 Sec. 2. Section 20-923, Arizona Revised Statutes, is amended to read:

16 20-923. Law applicable to benefit insurers

17 A. No other provisions of this title shall apply to benefit insurers
18 except as stated in this article.

19 B. CHAPTER 16 OF THIS TITLE APPLIES TO THIS ARTICLE.

1 4. "HEALTH CARE SERVICES PLAN" MEANS DISABILITY INSURER, GROUP
2 DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES
3 ORGANIZATION, HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION
4 THAT CONTRACTUALLY AGREES TO PAY OR MAKE REIMBURSEMENT FOR HEALTH CARE
5 EXPENSES FOR ONE OR MORE INDIVIDUALS RESIDING IN ARIZONA BUT DOES NOT APPLY
6 TO BENEFITS PROVIDED UNDER A LIMITED BENEFITS COVERAGE AS DEFINED IN SECTION
7 20-1137.

8 5. "PRIOR AUTHORIZATION" MEANS AUTHORIZATION BY TELEPHONE OR FACSIMILE
9 GIVEN IN ADVANCE OF THE PERFORMANCE OF AN EMERGENCY SERVICE ON AN ENROLLEE,
10 BY A HEALTH CARE SERVICES PLAN AFTER RECEIPT OF NECESSARY MEDICAL AND
11 ENROLLMENT INFORMATION ON THE ENROLLEE. PRIOR AUTHORIZATION SHALL NOT BE
12 CONSIDERED AS A GUARANTEE OF FULL PAYMENT.

13 6. "PROVIDER" MEANS ANY PHYSICIAN, HOSPITAL OR OTHER PERSON THAT IS
14 LICENSED OR OTHERWISE AUTHORIZED TO FURNISH EMERGENCY SERVICES IN THIS STATE.

15 20-2602. Scope of chapter

16 A. THIS CHAPTER DOES NOT APPLY TO:

17 1. A PROVIDER EMPLOYED BY OR UNDER CONTRACT WITH THE ENROLLEE'S HEALTH
18 CARE SERVICES PLAN.

19 2. HEALTH CARE SERVICES PLANS ADMINISTERED UNDER TITLE 36.

20 3. A HEALTH CARE SERVICES PLAN WHICH ONLY COVERS HEALTH CARE EXPENSES
21 INCURRED BY AN ENROLLEE WHO IS SUBSEQUENTLY ADMITTED TO A LICENSED HOSPITAL
22 AS PART OF THE TREATMENT.

23 B. NOTHING IN THIS CHAPTER IS INTENDED TO CREATE ANY PRIVATE RIGHT OR
24 CAUSE OF ACTION FOR OR ON BEHALF OF ANY ENROLLEE, PROVIDER OR OTHER PERSON,
25 WHETHER A RESIDENT OR NONRESIDENT OF THIS STATE. THIS CHAPTER PROVIDES
26 SOLELY AN ADMINISTRATIVE REMEDY TO THE DIRECTOR OF THE DEPARTMENT OF
27 INSURANCE FOR ANY VIOLATION OF THIS CHAPTER OR ANY RELATED RULE.

28 20-2603. Emergency services access; prior authorization;
29 requirements

30 A. A HEALTH CARE SERVICES PLAN SHALL PROVIDE COVERAGE FOR AN INITIAL
31 MEDICAL SCREENING EXAMINATION AND ANY IMMEDIATELY NECESSARY STABILIZING
32 TREATMENT REQUIRED BY THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT
33 (P.L. 99-272; 100 STAT. 164; 42 UNITED STATES CODE SECTION 1395dd) WITHOUT
34 PRIOR AUTHORIZATION BY THE PLAN, SUBJECT TO APPLICABLE COPAYMENTS,
35 COINSURANCE AND DEDUCTIBLES.

36 B. A PROVIDER SHALL NOT DENY, LIMIT OR OTHERWISE RESTRICT A PATIENT'S
37 ACCESS TO MEDICALLY NECESSARY EMERGENCY SERVICES BASED UPON THE PATIENT'S
38 ENROLLMENT IN A HEALTH CARE SERVICES PLAN.

39 C. A HEALTH CARE SERVICES PLAN MAY REQUIRE AS A CONDITION OF COVERAGE
40 PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES ARISING AFTER THE INITIAL
41 MEDICAL SCREENING EXAMINATION AND IMMEDIATELY NECESSARY STABILIZING
42 TREATMENT. PRIOR AUTHORIZATION IS GRANTED UNLESS DENIED OR DIRECTION OF THE
43 ENROLLEE'S CARE IS INITIATED BY THE PLAN WITHIN A REASONABLE PERIOD OF TIME
44 AFTER THE PLAN RECEIVES THE PRIOR AUTHORIZATION REQUEST. IF DIRECTION OF

1 CARE INSTRUCTIONS ARE RECEIVED FROM THE PLAN AFTER MORE THAN A REASONABLE
2 PERIOD OF TIME HAS ELAPSED, THE TREATING PROVIDER OR PROVIDERS SHALL COMPLY
3 WITH THE LATE INSTRUCTIONS TO THE EXTENT FEASIBLE, EXCEPT THAT A HEALTH CARE
4 SERVICES PLAN REMAINS RESPONSIBLE FOR COVERAGE OF MEDICALLY NECESSARY CARE
5 GIVEN AND SUBSTANTIALLY COMPLETED BEFORE THE LATE INSTRUCTIONS WERE RECEIVED.

6 D. A HEALTH CARE SERVICES PLAN THAT REQUIRES PRIOR AUTHORIZATION UNDER
7 SUBSECTION C SHALL PROVIDE TWENTY-FOUR HOUR ACCESS BY TELEPHONE OR FACSIMILE
8 FOR ENROLLEES AND PROVIDERS TO REQUEST PRIOR AUTHORIZATION FOR MEDICALLY
9 NECESSARY CARE AFTER THE INITIAL MEDICAL SCREENING EXAMINATION AND ANY
10 IMMEDIATELY NECESSARY STABILIZING TREATMENT. PLAN PERSONNEL SHALL HAVE
11 ACCESS TO A PHYSICIAN WHEN NECESSARY TO MAKE DETERMINATIONS REGARDING PRIOR
12 AUTHORIZATION.

13 E. A HEALTH CARE SERVICES PLAN THAT GIVES PRIOR AUTHORIZATION FOR
14 SPECIFIC CARE BY A PROVIDER SHALL NOT RESCIND OR MODIFY THE AUTHORIZATION
15 AFTER THE PROVIDER RENDERS THE AUTHORIZED CARE IN GOOD FAITH AND PURSUANT TO
16 THE AUTHORIZATION.

17 F. A HOSPITAL EMERGENCY DEPARTMENT SHALL MAKE REASONABLE EFFORTS TO
18 PROMPTLY CONTACT THE HEALTH CARE SERVICES PLAN FOR PRIOR AUTHORIZATION FOR
19 CONTINUING TREATMENT, SPECIALTY CONSULTATIONS, TRANSFER ARRANGEMENTS OR OTHER
20 APPROPRIATE CARE FOR AN ENROLLEE. A HEALTH CARE SERVICES PLAN SHALL NOT DENY
21 COVERAGE FOR EMERGENCY SERVICES PROVIDED TO THE PLAN'S ENROLLEE DUE TO A
22 PROVIDER'S FAILURE TO OBTAIN PRIOR AUTHORIZATION FROM THE PLAN IF THE
23 PROVIDER COULD NOT DETERMINE THE PATIENT'S ENROLLMENT IN A PARTICULAR PLAN
24 DUE TO THE PATIENT'S PHYSICAL CONDITION, OR IF THE PATIENT'S ENROLLMENT
25 INFORMATION WAS NOT AVAILABLE FROM THE PLAN AT THE TIME OF THE PROVIDER'S
26 CONTACT.

27 G. IF THE HEALTH CARE SERVICES PLAN AND THE PROVIDER DISAGREE ON THE
28 MEDICAL NECESSITY OF SPECIFIC EMERGENCY SERVICES FOR AN ENROLLEE, EXCEPT FOR
29 EMERGENCY SERVICES PROVIDED OUTSIDE THE GEOGRAPHIC SERVICE AREA OF THE PLAN,
30 MEDICAL PERSONNEL REPRESENTING THE PLAN SHALL MAKE NECESSARY ARRANGEMENTS TO
31 ASSUME THE CARE OF THE ENROLLEE WITHIN A REASONABLE PERIOD OF TIME AFTER THE
32 DISAGREEMENT ARISES. IF THE HEALTH CARE SERVICES PLAN FAILS TO ASSUME THE
33 CARE OF THE ENROLLEE AS PROVIDED BY THIS SUBSECTION, THE PLAN SHALL NOT DENY
34 COVERAGE FOR MEDICALLY NECESSARY EMERGENCY SERVICES PROVIDED TO THE ENROLLEE
35 DUE TO LACK OF PRIOR AUTHORIZATION.

36 H. IF WITHIN A REASONABLE PERIOD OF TIME AFTER RECEIVING A REQUEST
37 FROM A HOSPITAL EMERGENCY DEPARTMENT FOR A SPECIALTY CONSULTATION A HEALTH
38 CARE SERVICES PLAN FAILS TO IDENTIFY AN APPROPRIATE SPECIALIST WHO IS
39 AVAILABLE AND WILLING TO ASSUME THE CARE OF THE ENROLLEE, THE EMERGENCY
40 DEPARTMENT MAY ARRANGE FOR MEDICALLY NECESSARY EMERGENCY SERVICES BY ANY
41 APPROPRIATE SPECIALIST, AND THE PLAN SHALL NOT DENY COVERAGE FOR THESE
42 SERVICES DUE TO LACK OF PRIOR AUTHORIZATION. A HEALTH CARE SERVICES PLAN
43 SHALL NOT REQUIRE PRIOR AUTHORIZATION FOR SPECIALTY CARE EMERGENCY SERVICES
44 FOR TREATMENT OF ANY IMMEDIATELY LIFE THREATENING MEDICAL CONDITION.

1 20-2604. Utilization review: medically necessary emergency
2 services

3 A. A HEALTH CARE SERVICES PLAN ENGAGING IN UTILIZATION REVIEW TO
4 DETERMINE WHETHER ANY EMERGENCY SERVICES RENDERED BY A PROVIDER WERE
5 MEDICALLY NECESSARY AND IN ACCORDANCE WITH THIS CHAPTER SHALL CONSIDER THE
6 FOLLOWING FACTORS:

7 1. CURRENT EMERGENCY MEDICAL LITERATURE AND STANDARDS OF CARE.

8 2. CLINICAL INFORMATION REASONABLY AVAILABLE TO THE PROVIDER AT THE
9 TIME OF THE SERVICES.

10 B. A HEALTH CARE SERVICES PLAN SHALL NOT DENY A CLAIM FOR EMERGENCY
11 SERVICES ON THE BASIS THAT THE SERVICES WERE NOT MEDICALLY NECESSARY WITHOUT
12 REVIEW BY A PHYSICIAN OF THE PLAN'S CHOOSING.

13 C. FOR THE PURPOSE OF CLAIMS PAYMENT AND UTILIZATION REVIEW OF
14 EMERGENCY SERVICES, A HEALTH CARE SERVICES PLAN SHALL HAVE THE RIGHT TO
15 REQUIRE AS A CONDITION OF PAYMENT THAT EACH TREATING PROVIDER PRODUCE ALL OF
16 THE FOLLOWING:

17 1. COPIES OF ALL MEDICAL RECORDS PERTAINING TO THE EMERGENCY SERVICES
18 PROVIDED TO THE ENROLLEE.

19 2. COPIES OF RECORDS PERTAINING TO ANY PRIOR AUTHORIZATION AND
20 SPECIALTY CONSULTATION REQUESTS MADE BY THE PROVIDER.

21 3. A DETAILED AND ITEMIZED BILLING STATEMENT.

22 D. IF A HEALTH CARE SERVICES PLAN PAYS ANY PORTION OF A PROVIDER'S
23 CLAIM FOR SERVICES RENDERED TO AN ENROLLEE, THE PLAN SHALL NOT BE PERMITTED
24 TO RECOVER ALL OR PART OF THAT PAYMENT FROM THE ENROLLEE, EXCEPT FOR:

25 1. THE COST OF AN INITIAL MEDICAL SCREENING EXAMINATION AND RELATED
26 CHARGES WHERE THE EXAMINATION DETERMINED THAT EMERGENCY SERVICES WERE NOT
27 MEDICALLY NECESSARY.

28 2. PAYMENTS MADE AS A RESULT OF MISREPRESENTATION, FRAUD OR CLERICAL
29 ERROR.

30 3. COPAYMENT, COINSURANCE OR DEDUCTIBLE AMOUNTS THAT ARE THE
31 RESPONSIBILITY OF THE ENROLLEE.

32 Sec. 6. Applicability

33 The provisions of this act apply to health care services plans that are
34 offered, issued or renewed from and after December 31, 1996.

APPROVED BY THE GOVERNOR APRIL 9, 1996.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 10, 1996