

HB 2225 -- EMERGENCY SERVICES HEALTH BENEFIT DETERMINATIONS

SPONSOR: Henderson

This bill specifies that necessity of emergency services to screen and stabilize a patient shall be determined by the treating physician.

Before a health carrier retrospectively denies payment for an emergency service, a qualified physician shall review the enrollee's medical records regarding the emergency condition at issue. Carriers shall not deny payment based predominantly on current procedural terminology or International Classification of Diseases (ICD) codes.

Health carriers are allowed to recapture from enrollee's payments made to health care providers for emergency services if it is determined the enrollee did not have an emergency condition.

Payments shall be paid directly to the health care provider by the health carrier regardless of whether the provider participates in the carrier's network.

The bill prohibits carriers from reducing payments for evaluation and management services that are otherwise eligible for reimbursement when reported by the same provider on the same day as a procedure, and specifies that contract provisions to the contrary shall be void.

Payment for all services shall be made directly to providers when the carrier has authorized the patient to seek such services from a provider outside the carrier's network.

This bill is the same as SB 928 (2018).