



Policy and Procedure No: UM 31.5		Revision No: 5
Division: Care Management		
Department: Utilization Management		
Title: PHC-CA Post Stabilization		
Effective Date: 7/1/2011		
Supersedes Policy No: 93025, UM 31.0, UM 31.1, UM 31.2, UM 31.3, UM 31.4		
Reviewed/Revised by: Tiffany Jarrett		Review/Revision Date: 12/1/2025
Approving Committee: Utilization Management Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

To provide clear and consistent guidelines for response to acute hospital emergency departments for the provision authorizing post-stabilization care services pursuant PHC California’s (the Health Plan) state and Department of Health Care Services (DHCS) contractual obligations.

Policy:

1. Per Health and Safety Code section 1371.4 and Welfare and Institutions Code section 14454, The Health Plan is responsible for coverage and payment of Emergency Services and post-stabilization care services regardless of whether or not the provider that furnishes the services is a network provider, subcontractor, downstream subcontractor, or out-of-network provider.
 - a. This is further reiterated in the Health Plan’s Managed Care Contract and section 1300.71.4 of Title 28 of the California Code of Regulations (CCR), which sets forth the rules for emergency medical condition and post-stabilization responsibilities for medically necessary covered services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred.
2. The attending emergency physician or the provider treating the Member is responsible for determining when an enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the Health Plan.
3. In accordance with Title 28 CCR section 1300.71.4, when an enrollee is stabilized, but the health care provider believes that they require additional medically necessary covered services and may not be discharged safely, the Health Plan, “shall approve or disapprove a health care provider’s request for authorization to provide necessary poststabilization medical care within one half hour of the request.” To clarify, the “health care provider” as referenced herein refers to both out-of-network providers (i.e., non-contracting providers) and Network Providers. If the Health Plan fails to approve or disapprove a health care provider’s request for authorization to provide medically necessary post-stabilization care services within one-half hour or thirty (30) minutes of the request, the medically necessary post-stabilization care services are deemed as authorized.
 - a. The Health Plan responds to a Provider’s request for authorization for Post-Stabilization Care Services within thirty (30) minutes or the service is deemed approved in accordance with 22 CCR section 53855(a).
 - i. Title 28 CCR section 1300.71.4, and specifically the “one-half hour” requirement, must apply to all network provider agreements, as well as all applicable subcontractor and downstream subcontractor agreements.

4. The Health Plan is also financially responsible for post-stabilization care services obtained from out-of-network providers and network providers that are not pre-authorized by the Health Plan, but administered to maintain, improve, or resolve the enrollee's stabilized condition if:
 - a. The Health Plan does not respond to a request for pre-approval within the time allotted, which is one-half hour per Title 28 CCR section 1300.71.4;
 - b. The Health Plan cannot be contacted; or
 - c. The Health Plan and the treating provider cannot reach an agreement concerning the enrollee's care and a Health Plan physician is not available for consultation. In this situation, the Health Plan must give the treating provider the opportunity to consult with a Health Plan physician and the treating provider may continue with care of the enrollee until a Health Plan physician is reached or one of the following criteria is met:
 - i. A Health Plan physician with privileges at the treating provider's hospital assumes responsibility for the enrollee's care;
 - ii. A Health Plan physician assumes responsibility for the enrollee's care through transfer;
 - iii. The Health Plan and the treating provider reach an agreement concerning the enrollee's care; or
 - iv. The enrollee is discharged.
5. The Health Plan shall have access to a physician twenty-four (24) hours a day to coordinate the transfer to a Health Plan provider of an enrollee who is stabilized or authorizes medically necessary post-stabilization services.
6. All requests for authorization, and all responses to such requests for authorization, of medically necessary post-stabilization care services must be fully documented. Documentation must include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the Health Plan representative responding to the request.
7. The Health Plan maintains a twenty-four (24) hour multilingual telephone contact number for handling emergencies.
8. The Health Plan is responsible for ensuring that its subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.
 - a. These requirements must be communicated by the Health Plan to all subcontractors and network providers.
 - b. DHCS may impose Corrective Action Plans (CAPs), as well as administrative and/or monetary sanctions for non-compliance.

- c. For additional information regarding administrative and monetary sanctions, see DHCS All Plan Letter (APL) 22-015, and any subsequent iterations on this topic.
- d. Any failure to meet the requirements of the DHCS APL may result in a CAP and subsequent sanctions.

Procedure:

1. The Utilization Management team (Medical Director, National Director of Care Coordination and Utilization Management RN) approves or disapproves a health care provider's request for authorization to provide necessary post-stabilization medical care within thirty (30) minutes of the request. Denials are the responsibility of the Medical Director.
2. The Health Plan maintains a twenty-four (24) hour multilingual telephone contact number for handling emergencies.
3. The Health Plans notifies the service provider of its intent to authorize post stabilization care or transfer the enrollee to a Network Provider.
4. If the enrollee is unstable for transfer, based on the clinical information provided by the facility, the hospital stay is authorized by the Utilization Management Department for the continuation of necessary post-stabilization medical care.
5. If it is deemed the enrollee is stable based on the clinical information provided by the facility, the provider is informed within thirty (30) minutes of notification of the request of post-stabilization medical care of the Health Plan's intent to transfer the enrollee to a contracted, in-network facility by the Utilization Management Department.
6. The Health Plan is not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider within the thirty (30) minute timeframe except for care which is necessary to maintain the enrollee's stabilized condition up to the time of transfer or discharge.
7. The Utilization Management (UM) Nurse or the Nurse Triage After Hours Nurse, after informing the provider of the intent to transfer the enrollee, begins the transfer process to an in-network facility. If unable to facilitate a transfer by the end of the business day, the Utilization Management Nurse approves the admission and provides authorization to the provider.
8. The Utilization Management Nurse or After-Hours Nurse Triage documents all aspects of the communication to include, but not limited to the following:
 1. Date and time of the request;
 2. Name of the health care provider making the request;
 3. Diagnosis and medical condition of the member;
 4. Time the health care provider notified of the Plans decision;
 5. Approval to admit or;
 6. Transfer facility and receiving provider;

2. Notice to Non-Contracted Hospitals

Non-contracted hospitals are required to obtain prior authorization for post-stabilization care of the Health Plan's enrollees. The Health Plan is required to provide all non-contracting hospitals in the state of California with contact information needed to request authorization for post-stabilization care when a Health Plan's enrollee receives emergency medical care from a non-contracting hospital as set forth in the Health and Safety Code, Section 1262.8(j).

Authorization is not required to provide necessary emergency services and care to a patient who has an emergency medical condition.

The Health Plan requires non-contracted hospitals to obtain prior authorization prior to providing post stabilization care to enrollees. The Health Plan requests the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary to make a decision in authorizing post stabilization care or to assume management of the patient's care by prompt transfer.

The non-contracted hospital contacts the Health Plan by either following the instructions on the patient's health care service plan member card:

- Call the Utilization Management Department at (800) 474- 1434, Monday through Friday from 8:30 a.m. to 5:30 p.m., Pacific Standard Time (PST) to obtain timely authorization for post stabilization care; or
- Fax the request for timely authorization for post-stabilization care to (888) 238-7463;
- Call the After-hours Nurse Advice Line at (800) 797-1717.

When the Health Plan is contacted by a non-contracted hospital pursuant to Section 1262.8 shall, within thirty (30) minutes of the time the hospital makes the initial telephone call requesting information, either authorize post stabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

When the Health Plan is contacted by a non-contracted hospital pursuant to Section 1262.8, it reimburses the hospital for post-stabilization care rendered to the enrollee if any of the following occur:

- The Health Plan authorizes the hospital to provide post stabilization care.
- The Health Plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize post stabilization care or to promptly transfer the enrollee within the timeframe noted above.
- There is an unreasonable delay in the transfer of the enrollee, and the non-contracting Physician and Surgeon determines that the enrollee requires post-stabilization care.

The Health Plan does not require a non-contracted hospital representative or a non-contracting physician and surgeon to make more than one telephone call pursuant to Section 1317.4a (c)(2) to the number provided in advance by the Health Plan. The representative of the hospital that makes the

telephone call may be, but is not required to be, a physician and/or surgeon. An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the Health Plan and the Utilization Management Department. The Utilization Management Department forwards that report to the State Department of Public Health.

Definitions:

1. All Plan Letter (APL) or Policy Letter (PL): means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Health Plan’s contractual obligations, implementation instructions for Health Plan’s contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.
2. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children’s Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.
3. Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:
 - a. Placing the Member’s health in serious jeopardy;
 - b. Serious impairment to bodily functions;
 - c. Serious dysfunction to any bodily organ or part; or
 - d. Death.
4. Emergency Services: means inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).
5. Medically Necessary or Medical Necessity: means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member’s current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.
6. Member or Enrollee: means a Potential Member who has enrolled with the Health Plan.



7. Network Provider: means any Provider or entity that has a Network Provider Agreement with Health Plan, Health Plan’s Subcontractor, or Health Plan’s Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
8. Notice: means any formal or informal report, communication, correspondence, disclosure, or documentation transmitted by or on behalf of the Health Plan to a regulatory agency, member, provider, delegate, vendor, or other stakeholder, or received by the Health Plan from such parties. This includes, but is not limited to, reports, filings, attestations, submissions, audit responses, compliance notifications, corrective action plans, disclosures, data exchange communications, and other written or electronic transmissions that convey information, decisions, or updates regarding the Health Plan’s operations, compliance status, contractual performance, or regulatory obligations.
9. Prior Authorization: means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
10. Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member’s condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member’s condition.
11. Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Monitoring:

This policy is updated as often as necessary and reviewed and approved annually by the Utilization Management Committee.

Reference(s):

1. California Health and Safety Code § 1300.71_4 Emergency Medical Condition and Post – Stabilization Responsibilities for Medically Necessary Health Care Services.
2. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009, [Authorization for Post-Stabilization Care Services](#), Published May 3, 2023.
3. DHCS Managed Care Contract, Exhibit A, Attachment III, sections 2.3.2, 3.2.6

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
12/7/2023	31.2	Department of Health Care Services (DHCS)	2024 Operational Readiness R.0084	Approved
12/6/2023	31.2	DHCS	2024 Operational Readiness R.0095	AIR1
12/15/2023	31.3	DHCS	2024 Operational Readiness	Approved

