40-4603. Same; emergency services, prohibitions on health care plan; prior authorization after condition stabilized; post evaluation or post stabilization services. (a) A health benefit plan shall not deny coverage for emergency services if the symptoms presented by an insured and recorded by the attending provider indicate that an emergency medical condition exists, or for emergency services necessary to provide an insured with a medical examination and stabilizing treatment, regardless of whether prior authorization was obtained to provide those services.

(b) If a participating provider or other authorized representative of a health insurer authorizes emergency services, the health insurer shall not subsequently rescind or modify that authorization after the provider renders the authorized care in good faith and pursuant to the authorization except for:

(1) Payments made as a result of misrepresentation, fraud, omission or clerical error; and

(2) copayment, coinsurance or deductible amounts that are the responsibility of the insured.

(c) Once an insured is stabilized pursuant to subsection (a), a health benefit plan may require as a condition of further coverage that a hospital emergency facility shall promptly contact the health insurer for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other medically necessary and appropriate care for an insured.

(d) Coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.

(e) For required post evaluation or post stabilization services immediately following treatment of an emergency medical condition, a health insurer shall provide access to an authorized representative 24 hours a day, seven days a week.

History: L. 1997, ch. 190, § 18; July 1.