Court, Attorney, or Agency Requested Services

Policy Number: BIP031.L
Effective Date: January 1, 2024

Instructions for Use

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Related Benefit Interpretation Policies

- Emergency and Urgent Services
- Medical Necessity
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- Services While Confined/Incarcerated

Federal/State Mandated Regulations

California Health & Safety Code Section 1374.723: Community Assistance, Recovery, and Empowerment (CARE) Act

Bill Text - SB-1338 Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(a) A health care service plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code, regardless of whether the service is provided by an in-network or out-of-network provider.

(b) (1) A health care service plan shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) A health care service plan may conduct a post-claim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health care service plan may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The health plan's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) A health care service plan shall provide for reimbursement of prescription drugs provided to an enrollee pursuant to this section at the health care service plan's contracted rate.

(3) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

(e) No later than July 1, 2023, the department may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.
(f) This section does not excuse a health care service plan from complying with Section 1374.72.
(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.
(h) This section shall become operative on July 1, 2023.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

- Court/attorney or agency requested services and testing only when they are medically necessary and are preauthorized by UnitedHealthcare. (Refer to the Benefit Interpretation Policies titled Medical Necessity and Preventive Care Services)
- Emergency Services or urgently needed services (Refer to the Benefit Interpretation Policy titled Emergency and Urgent Services)

Note: For coverage of services required for injuries or illnesses while under arrest, detained, imprisoned, or incarcerated, refer to the Benefit Interpretation Policy titled Services While Confined/Incarcerated.

Not Covered

Examples include, but are not limited to:
- Evaluation and therapy orders by a court for accused sex offenders
- Attorney requesting a medical consultation in a civil liability case
- Paternity testing

Policy History/Revision Information

Date	Summary of Changes
01/01/2024	**Federal/State Mandated Regulations** • Added language pertaining to *California Health and Safety Code Section 1374.723* **Covered Benefits** • Added instruction to refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility **Supporting Information** • Archived previous policy version BIP031.K

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.