



Title: Post-Stabilization Policy		Policy Number: UM - 005	
Primary Department: Utilization Management	LOB: Medicare Advantage and D-SNP	Author: J Murphy	
Effective Date: 11/1/2022	Original Date: 11/1/2022	Review Date(s): 4/26/2023, 12/7/2023, 11/07/2024, 11/11/2025	Archive Date:
Interactive Related Department(s)			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input checked="" type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other	

Disclaimer: Troy Medicare Utilization Management applies CMS criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Clinix Internal Review Guidelines, Troy Utilization Review Policies, and MCG (Milliman Criteria Guidelines) Criteria. This suite of guidelines covers the spectrum of inpatient, outpatient, and rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, Troy partners with vendors who provide clinical expertise for specific services.

POLICY PURPOSE

The purpose of this policy is to state Troy Medicare’s compliance with CMS post-stabilization requirements.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state laws, including health care fraud and identity theft laws..

SCOPE

The following policy applies to requests for authorization of post-stabilization care/services provided to a Troy Medicare plan member after emergency services have been rendered.

REFERENCES

- 42 CFR §§422.105(a), 422.113
- CMS Medicare Managed Care Manual, Chapter 4, Sections 20 and 160

RESPONSIBLE PARTIES

- Chief Clinical Officer
- Chief Medical Officer

DEFINITIONS

1. Post-stabilization care services: Covered services that are provided are:
 - a. Related to an emergency medical condition
 - b. Provided after a member is stabilized
 - c. Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the member's condition
2. Pre (Prior) Authorization: Authorization that was granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification.
3. Urgent and Emergency care/services: Hospital services necessary to prevent the death or serious impairment of the health of the recipient.

POLICY

Troy Medicare follows CMS post-stabilization requirements for all urgent and emergency hospital admissions.

PROCEDURE

Troy will cover all urgent and emergency care/services without prior authorization when a Troy member experiences a medical condition with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- b. Serious impairment to bodily function
- c. Serious dysfunction of any bodily organ or part
- d. Troy cannot be held responsible for coverage of care provided for an unrelated non-emergency problem during treatment of an emergent condition.

Once emergency care has been provided and the member's condition is stabilized, authorization for post-stabilization care is required. Post-stabilization care services are covered services that are:

- a. Related to an emergency medical condition
- b. Provided after a member is stabilized
- c. Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the member's condition.

Providers should submit an authorization request for post-stabilization care to Troy Medicare's Utilization Management department within 1 hour, but no later than 24 hours of stabilizing the member's condition. Prior authorizations cannot be submitted to Troy for review after the member has been discharged. Troy does not require out-of-network facilities to transfer members to in-network facilities. However, Troy will assist hospitals in making a transfer if the member or provider requests and if medically necessary.

Troy Health will cover post-stabilization services that are medically necessary when the services:

1. Are pre-approved by Troy Medicare
2. Although not pre-approved by Troy Medicare but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services
3. Although not pre-approved by Troy Medicare but services are administered to maintain, improve, or resolve the member's stabilized condition when:
 - a. Troy Medicare does not respond to a request for pre-approval within 1 hr
 - b. Troy Medicare cannot be contacted; or
 - c. Troy Medicare and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, Troy Medicare must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the following criteria in 5. is met; and;
4. Troy Medicare must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.
5. Troy Medicare's financial responsibility for post-stabilization care services it has not pre-approved ends when—
 - a. A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
 - b. A plan physician assumes responsibility for the enrollee's care through transfer;
 - c. An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or
 - d. The enrollee is discharged.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- n/a

APPROVALS

<u><i>Jennifer Murphy</i></u> <small>Jennifer Murphy (Nov 24, 2025 09:32:31 EST)</small>	<u><i>Sally Scott</i></u> <small>Sally Scott (Nov 23, 2025 22:39:03 EST)</small>
Chief Clinical Officer	UM Committee
11/24/2025	11/23/2025
Date	Date

Revision History

Revision Date	Revised by Whom	Revisions Made
10.31.2022	J Murphy	Initial policy
4.26.2023	J Murphy	Review by Policy Committee
12.7.2023	J Murphy	Annual review by Utilization Management Committee
11.7.2024	J Murphy	Annual review. Updates to definitions and procedure. Annual review by Utilization Management Committee.
11.11.2025	J Murphy	Revised purpose, Annual review by Utilization Management Committee