

October 26, 2009

**Subject: Alien Emergency Medical (AEM) program medical eligibility and benefit changes**

Dear Medicaid Provider:

Effective November 1, 2009, we are implementing eligibility and benefit changes in the Department of Social and Health Services Alien Emergency Medical Program. These changes are needed to comply with federal and state requirements.

Beginning November 1, coverage for these individuals will be available under three programs.

1. One program is provided under the federal regulation and is called the "Federal Funded Alien Emergency Medical (AEM) Program."
2. A second program covers nursing facility care and is called the "State Funded Nursing Facility Program."
3. The third program implements the state mandate and is called the "State Funded Alien Medical Program."

Criteria for coverage and the services available are different under each program. More information is available in the 09-68 AEM Billing Instruction posted on our Web site at <http://hrsa.dshs.wa.gov/News/aem.htm> and in WACs 388-438-0115, 0125, and 0120, which will be published soon.

We reviewed our claims history and prior authorization data and it appears you have provided services to non-citizens covered under the current AEM program. We want to assure you are aware of these changes and how these new programs, specifically 1 and 3 above, may effect you and your non-citizen patients.

**What has changed?**

In recent years, the federal Medicaid program has been changing the definition of "emergency conditions," and this change brings Washington State into compliance with the new definition. Essentially, the two new state programs cover conditions and pays for services that are no longer covered by the federal program.

**Who is eligible for the Federal Funded AEM program (WAC 288-438-0115)?**

This program is only available for categorically and financially eligible non-citizens who receive treatment for a qualifying emergency condition when that treatment is provided in one of the following hospital settings:

- Emergency room, which must include an Evaluation and Management (E&M) Service
- Emergency outpatient surgery
- Emergency inpatient admission, including Voluntary or Involuntary Treatment Act (ITA) psychiatric admissions authorized by DSHS's designee

Eligibility for this program will not be established prior to services. Most applications for coverage are submitted after the services are provided. Applications for lengthy inpatient admissions may be submitted during the admission. The date span for coverage is only for the dates the non-citizen is in the hospital receiving services.

**If the service received required prior authorization**, the medical necessity determination will be made after the coverage determination is made. The department may request additional information to complete this review. You will receive a letter regarding the authorization determination after the review is completed.

#### **What is different under the federal program?**

DSHS pays **only** for the medically necessary services provided in the hospital setting to treat the emergency condition as defined by WAC 388-500-0005. DSHS reviews the submitted documentation to determine if the primary condition requiring treatment meets the definition of an emergency medical condition.

DSHS pays for all related medically necessary health care services and professional services provided during this specific emergency room visit, emergency outpatient surgery or emergency inpatient admission. These services include, but are not limited to:

- Medications
- Laboratory, x-ray and other diagnostics and the professional interpretations
- Medical equipment and supplies
- Anesthesia, surgical and recovery services
- Physician consultation, treatment, surgery or evaluation services
- Therapy services
- Emergency medical transportation
- Non-emergency ambulance transportation to transfer the person from the hospital to a long-term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if DSHS prior authorizes that admission

DSHS will expand the coverage period to cover admissions to an LTAC facility or inpatient PM&R unit if:

- The initial admission to the community hospital meets the criteria above
- The client is transferred directly to this facility from the community hospital and
- The admission is prior authorized

DSHS also pays for one fill of prescribed medication(s) and retrospectively reimburses this service according to pharmacy program rules if the prescription is:

- Prescribed on the same day as the release from the hospital,
- Provided and billed by a hospital's outpatient pharmacy service or by a retail pharmacy, and

- Associated with the qualifying emergency condition and hospital-based service

Any services provided at the hospital that are not related to or consistent with best practices in treating the qualifying emergency medical condition will not be paid for.

**Once the client is released or discharged from the hospital, he or she will no longer be covered for any services under this program. This includes any non-emergency- based hospital care. See the referenced WAC or Billing Instruction for more information about what services are no longer paid for.**

### **Who is eligible for the State Funded Alien Medical Program (WAC 388-438-0120)?**

This program is available only to categorically and financially eligible non-citizens who require:

- Surgery, chemotherapy, or radiation therapy to treat cancer
- Dialysis to treat acute renal failure or end stage renal disease (ESRD)
- Anti-rejection medication because the person has had a solid or non-solid organ transplant

Applications for coverage can be submitted once it is determined that dialysis is required or the diagnosis of cancer has been clinically established. The date span for coverage will range from one week to a year depending in the condition and the length of treatment anticipated.

Clients who require anti-rejection medications may submit requests anytime. The department will cover services related to managing or treating the organ transplant **after** the organ transplant is completed, including these medications. This coverage will continue as long as they remain eligible for the program.

### **What is different under this new state program?**

Once the non-citizen is deemed eligible for coverage, the department **will pay for** any medically necessary services to treat the non-citizens qualifying condition as described above.

This includes:

- Physician and ARNP services, except when providing a service that is not within the scope of this medical program
- Inpatient and outpatient hospital care
- Dialysis
- Surgical procedures and care
- Office- or clinic-based care
- Pharmacy services, including anti- rejection medications
- Laboratory, x-ray or other diagnostic studies
- Oxygen services
- Respiratory and Intravenous (IV) therapy
- Anesthesia services
- Hospice services
- Home health services, limited to two visits
- Durable and non durable medical equipment
- Non-emergency transportation
- Interpreter services

Providers must meet any prior authorization (PA) requirements to receive payment for services. All of the following require PA:

- Hospice
- Home health
- Durable and nondurable medical equipment
- Oxygen and respiratory therapy
- IV therapy
- Dialysis for acute renal disease services

Any prior authorization requirements applicable to the other covered services listed above must also be met according to specific program rules.

**Under the state program, DSHS will not pay for:**

- Cancer screening or work-ups to detect or diagnosis the presence of cancer
- Fistula placement while the client waits to see if dialysis will be required
- Services by any health-care professional provided to treat a condition not related to, or required to, treat the qualifying condition
- Organ transplants, except as described above
- Health department services
- School-based services
- Personal care services
- Physical, occupational, and speech therapy services
- Audiology services
- Neurodevelopmental services
- Waiver services
- Nursing facility services
- Home health services--more than two visits
- Vision services
- Hearing services
- Dental services, unless prior authorized and directly related to dialysis or cancer treatment
- Mental health services
- Podiatry services
- Substance abuse services
- Smoking cessation services

PLEASE NOTE: When a client covered under the state program requires care for an emergency condition not related to their qualifying condition for this program, they may apply for coverage under the federal program.

**What about the patients covered by the current AEM program?**

The department will continue to cover clients who have cancer, but will only pay for the services they require to treat their cancer. When their current certification period ends they must reapply. If the person continues to be categorically and financially eligible, DSHS will grant extensions until they no longer require treatment. Extensions for coverage cannot exceed one year increments.

The department will continue to cover clients who have acute or end stage renal disease, but will only pay for services related to treating their renal disease. When the person's current certification period ends they must reapply. If the non-citizen continues to be categorically and financially eligible, DSHS will grant extensions until they no longer require dialysis. Extensions for coverage cannot exceed one-year increments.

The department will continue to cover current clients who require anti-rejection medications, but will pay only for services related to post organ transplant care as described above. When their current certification period ends they must reapply. If the person continues to be categorically and financially eligible, DSHS will grant extensions until they no longer require anti-rejection medications. Extensions for coverage cannot exceed one-year increments.

**Can I bill the client for services not in the scope of coverage under these programs?**

Yes, you can bill the person for any service that doesn't meet the criteria described in the WACs referenced. See WAC 388-502-0160 for rules related to billing the client.

**Please note:**

Providers should not bill the department for any service not covered according to the WACs referenced. The department will recoup any payment made in error under this program.