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FEDERAL REQUIREMENT

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified noncitizens when these services are provided in a hospital emergency room or inpatient hospital setting.

VIRGINIA ADMINISTRATIVE CODE: EMERGENCY SERVICES FOR CERTAIN NON-CITIZENS INELIGIBLE DUE TO IMMIGRATION STATUS

Virginia Administrative Code describes the scope of emergency services furnished and reimbursed through Medicaid at *12VAC30-50-310. Emergency services for aliens.*

SERVICE LIMITATIONS

Services must meet emergency treatment criteria to qualify for coverage. Members in Aid Categories 112 (Expansion population/Modified adjusted gross income (MAGI) Adults), and 113 (Non-MAGI/ABD/Children) are eligible for the following services:

- Emergency room care (see additional information below)
- Physician services
- Routine outpatient dialysis services
- Labor and Delivery
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Emergency ambulance service to the emergency room or hospital (does not include non-emergency medical transportation services)
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Emergency room care may include coverage for medical conditions such as:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (for example, appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

ELIGIBILITY FOR EMERGENCY SERVICES BENEFITS

Please see Chapter 3 of this manual for information about eligibility for these services.

REQUESTING SERVICE AUTHORIZATION

Services delivered will be eligible for reimbursement when all the following conditions are met:

- The member is determined eligible for Emergency Services benefits by Virginia Department of Social Services (VDSS)
- The service delivered meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA)
- The service provided meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information.
- Services delivered meet all applicable state laws, regulations, and licensure requirements.

Requests for Inpatient Acute Hospital admissions will only be accepted electronically utilizing the Service Authorization Contractor's electronic provider portal, Atrezzo Connect. In order to successfully submit service authorization requests through KEPRO's web-based portal Atrezzo Connect (also known as Atrezzo), providers must be registered and obtain a passcode for Atrezzo. The registration process for providers happens immediately on-line at the time of registration. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com and click on the Training menu.

For inpatient acute hospital requests completion of the inpatient questionnaire is required. All providers will attest electronically that information submitted through the Service Authorization Contractor's portal is within the member's documented record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to the Fiscal Agent. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will follow the normal review process.

TIMELINESS OF SERVICE AUTHORIZATION REQUESTS

To be deemed timely, receipt of initial service authorization requests must meet the following criteria:

- Unplanned/urgent or emergency admissions: these admissions will be permitted before any Service Authorization procedures and must be authorized within 24 hours of admission or on the next business day after the admission.
- If received after this timeframe (acute stays are paid on a DRG methodology), the admission should be denied as untimely (3170) if the member is not retro-eligible.
- Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage.
- For those members who do not meet criteria on admission but do meet the criteria later in the hospitalization, the authorization must be obtained within one business day of the patient's meeting the criteria.

Inpatient Hospital Providers

Hospital claims for Emergency Services-eligible individuals must include an attachment with the case discharge summary. The discharge summary will identify the admission and discharge date to the facility and a clinical summary of the hospital stay.

Emergency Department Providers

For Emergency Services-eligible individuals receiving inpatient or outpatient services through the Emergency Department without a hospital admission, providers must include the following information in the attachment they submit with their claim: the date and time of entry and discharge, as well as the clinical summary of events during the Emergency Department stay.

TRANSMITTING TO THE FISCAL AGENT

- Medical/surgical services must have their own service authorization number and cannot be combined with a psychiatric authorization
- Inpatient Medical/Surgical Services are reimbursed using the DRG payment methodology. All requests will be approved/denied for one (1) unit, using the admit date as the "from" and "through" date
- If the member is not eligible on admission but is eligible later during the hospital stay, the Contractor will transmit the date that eligibility begins as the "from" and "through" date.

PROCESSING SERVICE AUTHORIZATION REQUESTS

The Service Authorization Contractor will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, the Service Authorization Contractor notifies the member and the provider in writing of the status of the request through the Fiscal Agent and/or the Service Authorization Contractor's letter generation process.

Specific Information for Out-of-State Providers

Refer to the Physician-Practitioner Manual subsection, 'Specific Information for Out-of-State Providers' for details.

Review Criteria to be Used

Refer to the Physician-Practitioner Manual, Appendix D subsection, 'Review Criteria to be Used' for details.

Provider Requirements
All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply.

RETROSPECTIVE REVIEW

Services may be eligible for a retrospective review for service authorization on or after July 1, 2022 if:

- A provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage; or
- A patient receives maternity/newborn inpatient care that goes beyond the allowed length of stay (see section under Service Authorization Requirements)

Hospital to Hospital Transfers
Documentation for transfers will include initial hospital ED records and inpatient admission certification, as well as a discharge note/transfer summary to support that emergent care is still necessary. Transfers must occur only for treatment that the initial hospital cannot provide, such as a higher level of care.

BILLING: CLAIMS SUBMISSION

All Emergency Services claims are processed by the DMAS fiscal agent. Claims must pass all system edits prior to payment.

Billing instructions are available in Chapter 5 of the Medicaid Provider Manuals at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library

Services Provided Prior to July 1, 2022
Individuals are not eligible for ongoing Emergency Services Medicaid coverage for emergency admissions and dates of service prior to July 1, 2022. Emergency Medicaid eligibility for individuals who were admitted to the hospital *prior to* July 1, 2022, will only

be for the approved outpatient or inpatient time periods when service was provided. Providers must submit Emergency Medical Certification forms for admissions that began prior to July 1, 2022 to DMAS using the prior paper or electronic e-mailbox process. All requests for review must contain:

- Submission of the completed Emergency Medical Certification form
- Medical record to accompany the specific time period requested
- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
    - Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and therefore, does not need to be duplicated with this claim.
    - Submit the claim to Medicaid to the:

Department of Medical Assistance Services
PO Box 27443
Richmond, Virginia 23261-7443

Note: The same procedures apply for adjusted or voided claims. All claims for Emergency Services-eligible individuals will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. Claims may be submitted electronically or by paper.

For services Provided On or After July 1, 2022

Effective July 1, 2022, DMAS's Medicaid Enterprise System (MES) is assigning the following aid categories applicable to populations eligible for Emergency Services coverage. Covered services have not changed. These aid categories are eligible for emergency services only:

1. Aid Category 112 Expansion population/Modified adjusted gross income (MAGI) Adults
2. Aid Category 113 Non-MAGI/ABD/Children

Effective July 1, 2022, the new Aid Categories 112 and 113 are applicable for admissions that began *on or after July 1, 2022* for services rendered on or after July 1, 2022.

For services provided on or after July 1, 2022, DMAS no longer requires review of medical records and Emergency Medical Certification forms. Providers must submit claims for individuals enrolled with Aid Categories 112 and 113 directly to the:

DMAS Fiscal Agent
PO Box 27443
Richmond, Virginia 23261-7443

DOCUMENTATION REQUIREMENTS FOR CLAIMS

Inpatient Hospital Providers
Hospital claims for Emergency Services-eligible individuals must include an attachment with the case discharge summary. The discharge summary will identify the admission and discharge dates and a clinical summary of the hospital stay.

Emergency Department Providers
For Emergency Services-eligible individuals receiving inpatient or outpatient services through the Emergency Department without a hospital admission, providers must include the following information in the attachment they submit with their claim: the date and time of entry and discharge, as well as the clinical summary of events during the Emergency Department stay.

Professional Providers
Professional claim adjudication is contingent upon the receipt, adjudication and payment of the hospital or emergency department claims.

Additional information pertaining to paper claims submission documentation requirements is located in the October 4, 2022 DMAS Memo New Automated Claims Processing for Emergency Medical Certifications (EMC) for Undocumented Individuals | MES (virginia.gov)