Alien Medical Program Emergency Assistance

Billing Guide

April 1, 2016

About this guide*

This publication takes effect April 1, 2016.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

How can I get agency provider documents?

To download and print agency provider notices and billing guides, go to the agency's Provider Publications website.

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*This guide is a billing instruction.

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Resources Available

Topic	Resource
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	See the agency's Resources Available web page.
Electronic or paper billing	
Accessing agency publications, including Medicaid Billing Guides, provider notices, and fee schedules	
Private insurance or third-party liability	
How do I obtain prior authorization?	Requests for prior authorization must include: • A completed, typed General Information for Authorization form (HCA 13-835), which must be the first page of your request packet. • A completed Authorization Request form HCA 13-756 and all the documentation listed on that form and any other medical justification. Fax your request to: 866-668-1214.

About the Program

(WAC 182-507-0110)

What is Alien Medical Program (AMP) emergency assistance?

Alien Medical Program (AMP) emergency assistance provides medical care to individuals who do not meet citizenship or immigration status requirements.

Pregnancy-related hospitalizations are not covered under AMP emergency assistance, but are covered under pregnancy-related Washington Apple Health programs.

Client Eligibility

Who is eligible for alien medical program emergency assistance?

There is no precertification or prior authorization for eligibility under this program. Eligibility for the Alien Medical Program (AMP) emergency assistance does not have to be established before an individual begins receiving emergency treatment. However, eligibility is not guaranteed.

To qualify for AMP emergency assistance, noncitizens must have or need at least one of the following:

- A qualifying emergent medical condition that places the person's health in serious jeopardy
- A cancer treatment plan
- Dialysis treatment
- Anti-rejection medication for an organ transplant
- Long-term care services

The person also must:

- Be age 19 or older
- Not be pregnant
- Meet the eligibility criteria under WAC 182-507-0110

Note: Clients age 18 and younger who do not qualify for Washington Apple Health because of their immigration status are covered for health care under the Children's Health Insurance Program (CHIP). See WAC 182-505-0225 (7).

Coverage

What is covered under the Alien Medical Program?

Emergency Medical Conditions

The Medicaid agency covers emergency medical conditions under Alien Medical Program (AMP) emergency assistance. The agency determines if the primary condition requiring treatment meets the definition of an emergency medical condition in WAC 182-500-0030, and the condition is confirmed through review of clinical records.

A qualifying emergency medical condition must be treated in one of the following hospital settings only:

- Emergency room services, which must include an evaluation and management visit by a physician
- Inpatient
- Outpatient surgery
- Psychiatric setting authorized by the agency's inpatient mental health designee

The agency pays for all related medically necessary health care services and professional services provided. These services include, but are not limited to:

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

The agency pays for admissions to an LTAC facility or an inpatient PM&R unit when:

- The person is transferred directly to this facility from the hospital and
- The admission is prior authorized according to LTAC and PM&R program rules

The agency does not pay for any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition. However, pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service are covered for a one-time fill and paid according to the agency's Prescription Drug Program Billing Guide.

The certification is only for the date of service for an inpatient stay, emergency room service, or outpatient surgery related to an emergency room visit. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

Dialysis

(WAC 182-507-0120)

Dialysis to treat acute renal failure or end stage renal disease is considered an emergency and is covered under Alien Medical Program (AMP) emergency assistance.

When related to treating the qualifying medical condition, the agency pays for the following services:

- Anesthesia services
- Dialysis
- Durable and nondurable medical equipment
- Home health services, limited to two visits
- Hospice services
- Inpatient and outpatient hospital care
- Interpreter services
- Laboratory, x-ray, or other diagnostic studies
- Nonemergency transportation
- Office or clinic based care
- Oxygen services
- Pharmacy services
- Physician and ARNP services
- Respiratory and intravenous (IV) therapy
- Surgical procedures and care

All hospice, home health, durable and nondurable medical equipment and supplies, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization.

Any prior authorization requirements that apply to the other services must also be met according to specific program rules.

Coverage for dialysis begins on the date the person begins dialysis treatment, which includes fistula placement and other required access.

The agency does not pay for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis under AMP emergency assistance.

Cancer treatment and life-threatening benign tumors

(WAC 182-507-0120)

Treatment for cancer and life-threatening benign tumors is considered an emergency and is covered under Alien Medical Program (AMP) emergency assistance.

When related to treating the qualifying medical condition, the agency pays for the following services include but are not limited to:

- Anesthesia services
- Chemotherapy
- Durable and nondurable medical equipment
- Home health services, limited to two visits
- Hospice services
- Inpatient and outpatient hospital care
- Interpreter services
- Laboratory, x-ray, or other diagnostic studies
- Nonemergency transportation
- Office or clinic based care
- Oxygen services
- Pharmacy services
- Physician and ARNP services
- Radiation therapy to treat cancer or life-threatening benign tumors;
- Surgery
- Surgical procedures and care and intravenous (IV) therapy
- Respiratory

All hospice, home health, durable and nondurable medical equipment and supplies, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services must also be met according to specific program rules.

To be eligible for coverage for cancer treatment or treatment of life-threatening benign tumors under this program, the diagnosis must be already established or confirmed. The agency does not pay for cancer screenings or diagnostics for a work-up to establish the presence of cancer or life-threatening benign tumors.

Anti-rejection medications

If the person has had an organ transplant, the agency will pay only for anti-rejection medications under this program.

State-funded long-term-care services

The agency covers long-term care services provided in one of the following settings:

- In a person's own home
- Nursing facility
- Adult family home
- Assisted living facility
- Enhanced adult residential care facility
- Adult residential care facility

Note: The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Long-term care services cannot be authorized for eligible people prior to a determination by the Aging and Long-Term Support Administration (ALTSA) that caseload limits will not be exceeded as a result of the authorization.

What is not covered under the Alien Medical Program?

When the agency determines that a condition is not a medical emergency, the agency does not cover related hospital services, care, surgeries, or inpatient admissions including but not limited to:

- Laboratory x-ray, or other diagnostic procedures
- Physical, occupational, speech therapy, or audiology services
- Hospital clinic services
- Emergency room visits, surgery, or hospital admissions
- Any services provided during a hospital admission or visit unrelated to the treatment of the qualifying emergency medical condition
- Organ transplants, including pre-evaluations and post-operative care
- Services provided outside of a hospital setting, including but not limited to:

  - ✓ Office or clinic-based services provided by a physician, an ARNP, or any other licensed practitioner
  - ✓ Prenatal care, except labor and delivery
  - ✓ Laboratory, radiology, and any other diagnostic testing
  - ✓ School-based services
  - ✓ Personal care services
  - ✓ Physical, respiratory, occupational, and speech therapy services
  - ✓ Waiver services
  - ✓ Nursing facility services
  - ✓ Home health services
  - ✓ Hospice services
  - ✓ Vision services
  - ✓ Hearing services
  - ✓ Dental services
  - ✓ Durable and nondurable medical supplies
  - ✓ Nonemergency medical transportation
  - ✓ Interpreter services
  - ✓ Pharmacy services, except when prescribed on the same day and associated with the qualifying visit or service. In this case, the agency will pay for a one-time fill and pay according to the agency's Prescription Drug Program Billing Guide.

Note: The services listed in this "What is not covered" section are not within the scope of service categories for the Alien Medical Program. Therefore, the agency's exception to rule process in WAC 182-501-0160 is not available.

Authorization

What is prior authorization?

Prior authorization (PA) is the process the agency uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations.

Services requiring PA

The agency requires PA for all Alien Medical Program emergency assistance, including:

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

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

How do I request PA?

Prior authorization requests must be faxed or mailed to the agency and must include the following documentation is required:

- A completed, TYPED *General Information for Authorization* form, 13-835, which MUST be the initial page when you submit your request.

- A completed *Fax/Written Request Basic Information* form, 13-756, if there is not a form specific to the service being requested, and all the documentation is listed on this form with any other medical justification.

This documentation must be submitted either:

- **By Fax**
  Fax prior authorization requests to:
  866-668-1214

-OR-

- **By Mail**
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency ProviderOne Billing and Resource Guide.
These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the agency for eligible clients.
- When providers may bill a client.
- Third-party liability.
- Record keeping requirements.

Billing for multiple services

If multiples of the same procedures are performed on the same day, providers must bill with the appropriate modifier (if applicable) and must bill all the services on the same claim form.

How do I complete the CMS-1500 claim form?

Instructions on how to bill institutional claims or crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form (version 2/12).

How do I complete the UB-04 claim form?

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee.