Washington Apple Health (Medicaid)

Alien Medical Program Billing Guide

April 1, 2021

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide[*]

This publication takes effect **April 1, 2021** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-507 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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.

Refer also to HCA's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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[*] This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Throughout guide	Added program numbers to each of the four treatments provided under the Alien Medical Program (AMP)	Clarification
Coverage	Reordered, clarified, and streamlined some programs listed under this section	Clarification. No policy changes have been made as part of these revisions.
Emergency medical conditions (Program 1)	For emergency room services, added other qualified health care professionals as those that may provide care	Revised to align with HCA's current practice
	A behavioral health administrative service organization approves the hospital psychiatric setting for a psychiatric admission. (This replaces approval by an administrative service organization or a behavioral health organization.)	Clarification
What supporting medical documents are required for AMP/Emergency Related Service Only (ERSO)?	Added section that identifies the supporting documents needed for the qualifying medical conditions	Clarification

Subject	Change	Reason for Change
What is not covered under the Alien Medical Program?	Included language stating that a condition not related to a qualifying medical condition is not covered	Clarification

Table of Contents

Resources Available

Topic	Resource
Finding out about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's ProviderOne Resources page
Electronic billing	See HCA's ProviderOne Resources page
Accessing HCA publications, including Medicaid Billing Guides, provider notices, and fee schedules	See HCA's ProviderOne Resources page
Private insurance or third-party liability	See HCA's ProviderOne Resources page
How do I obtain prior authorization?	You may submit requests for prior authorization (PA) online through direct entry into ProviderOne (see HCA's prior authorization webpage for details) You may also fax or mail your PA request to HCA. Requests 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/mail your request to: Authorization Services Office PO Box 45535 Olympia, WA 98504-5535 1-866-668-1214 For information about downloading forms, see Where can I download HCA forms?

About the Program

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 covered under pregnancy-related Washington Apple Health programs and are not covered under AMP emergency assistance. See the Maternity Support Services Billing Guide.

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.

> **Note**: When eligibility is established for AMP emergency assistance, clients will receive a ProviderOne number and have a code designating Emergency Related Services Only (ERSO) and Alien Emergency Medical (AEM).

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 (Program 1)

- A cancer diagnosis with an active treatment plan (Program 2)

- Dialysis treatment (Program 3)

- Anti-rejection medication for an organ transplant (Program 4)

- 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

For more information about qualifying and applying for AMP emergency assistance, visit HCA's Apple Health Alien Medical programs webpage.

> **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 state-only funded Apple Health for Kids. See WAC 182-503-0535, WAC 182-505-0210, and WAC 182-507-0110.

Coverage

What is covered under the Alien Medical Program (AMP)?

Emergency medical conditions (Program 1)

HCA covers emergency medical conditions under Alien Medical Program (AMP) emergency assistance. HCA 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 or other qualified health care professional

- Inpatient

- Outpatient surgery

For qualifying emergency involuntary and voluntary psychiatric admissions, the behavioral health administrative service organization (BH-ASO) must approve the treatment setting. (See HCA's Mental Health Services Billing Guide.)

HCA pays for all related medically necessary health care services and professional services provided for the emergency condition. 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

HCA 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.

- The admission is prior authorized according to LTAC and PM&R program rules.

HCA 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 HCA'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.

Cancer treatment and life-threatening benign tumors (Program 2)

Surgery, chemotherapy, and/or radiation therapy to treat cancer or life-threatening benign tumors is covered under AMP emergency assistance.

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. AMP emergency assistance does not pay for cancer screenings, surveillance of cancer, or diagnostics for a work-up to establish the presence of cancer or life-threatening benign tumors.

Dialysis (Program 3)

Dialysis to treat acute renal failure or end stage renal disease (ESRD) is covered under AMP emergency assistance.

Covered services for cancer treatment and dialysis

When related to treating the qualifying medical condition for cancer treatment (Program 2) or dialysis (Program 3), covered services include, but are not limited to:

- Inpatient and outpatient hospital care
- Dialysis
- Surgical procedures and care
- Office or clinic based care
- Pharmacy services
- 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 nondurable medical equipment

- Nonemergency transportation
- Interpreter services

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.

Anti-rejection medications (Program 4)

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

What is not covered under the Alien Medical Program?

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

- Any services provided during a hospital admission or visit unrelated to the treatment of the qualifying emergency medical condition
- Emergency room visits, surgery, or hospital admissions
- Hospital clinic services
- Laboratory x-ray, or other diagnostic procedures
- Organ transplants, including pre-evaluations and post-operative care
- Physical, occupational, speech therapy, or audiology services
- Services provided outside of a hospital setting, including but not limited to:
  - Dental services
  - Durable and nondurable medical supplies
  - Hearing services
  - Home health services
  - Hospice services
  - Interpreter services
  - Laboratory, radiology, and any other diagnostic testing
  - Nonemergency medical transportation
  - Nursing facility services
  - Office or clinic-based services provided by a physician, an ARNP, or any other licensed practitioner
  - Personal care services

- o Pharmacy services, except when prescribed on the same day and associated with the qualifying visit or service. In this case, HCA will pay for a one-time fill and pay according to HCA's **Prescription Drug Program Billing Guide**.
- o Physical, respiratory, occupational, and speech therapy services
- o Prenatal care, except labor and delivery
- o School-based services
- o Vision services
- o Waiver services

> **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, HCA's exception to rule process in **WAC 182-501-0160** is not available.

Required Supporting Medical Documents for AMP/Emergency Related Services Only (ERSO)

Eligibility determinations for both modified adjusted gross income (MAGI) clients and classic Medicaid alien emergency medical (AEM) clients require an **AEM cover sheet** that includes the fax number of the requesting facility or provider when submitting the supporting documents described below based on an emergent condition.

Emergency medical conditions (Program 1)

- **Emergency room treatment page(s)**
    - Include all documentation to include provider evaluation and management, treatment provided, client response, and disposition to determine emergency condition
    - Copy of the completed hospital claim form (UB04)

- **Outpatient surgery care**
    - Operative notes (description of procedure performed)
    - Copy of the completed hospital claim form (UB04) that includes:
        - Documentation of associated emergency visit for initial evaluation (provider evaluation and management, treatment provided, patient response and disposition)
        - Documentation from surgical consult/referral source to determine emergency condition.

- **Inpatient admission**
    - History and physical (admission note)
    - Hospital discharge summary
    - Copy of the completed hospital claim form (UB04)
    - Documentation of associated emergency visit for initial evaluation (provider evaluation and management, treatment provided, patient response, and disposition)

- **Extended inpatient admission**
    - Clinical documentation from the first and last date of requested dates (i.e.: if a three-month span is requested, include the provider progress note from the first and last date requested)
    - Documentation of transfer note if the client is transferred to a different department, or facility

- If the client is discharged during the requested extension dates, include:
  - The hospital discharge summary.
  - A copy of the completed hospital claim form (UB04).

Cancer treatment plan (Program 2)

- Pathology report that determined cancer diagnosis
- Current oncology consult/progress note that includes providers current/active treatment plan for client. (Do not include infusion center documentation.)
- If cancer diagnosis was established during inpatient admission, include hospital discharge summary.

Dialysis treatment (Program 3)

- Current dialysis flow charts from dialysis center
- Treatment plan from the attending physician

Anti-rejection treatment for a post organ transplant (Program 4)

- Treatment plan from the attending physician or provider

State-funded long-term-care services

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

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

Authorization

What is prior authorization?

Prior authorization (PA) is the process HCA 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 prior authorization

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

- Dialysis for acute renal disease services

- Durable and nondurable medical equipment

- Home health

- Hospice

- IV therapy

- Oxygen and respiratory

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

How do I request prior authorization?

See **Resources Available**

Billing

All claims must be submitted electronically to HCA, except under limited circumstances.

For more information about this policy change, see **Paperless Billing at HCA**.

For providers approved to bill paper claims, see HCA's **Paper Claim Billing Resource**.

What are the general billing requirements?

Providers must follow HCA's **ProviderOne Billing and Resource Guide**. These billing requirements include, but are not limited to, the following:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA 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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners** webpage, under **Webinars**.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI)** webpage.