GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of Senior Deputy Director/Medicaid Director **Transmittal #17-20**

To: All District of Columbia Medicaid Hospital Providers

From: Claudia Schlosberg, JD
Senior Deputy Director and State Medicaid Director

Date: August 11, 2017

Subject: Provider Billing Changes for Alliance Beneficiaries receiving Labor and Delivery Services

This transmittal provides notice of changes to the claims submission process for services related to labor and delivery provided to beneficiaries covered under the Alliance program. It is the policy of the Department Healthcare Finance (DHCF) and the Economic Security Administration (ESA) to provide Emergency Medicaid coverage to individuals who receive treatment for an emergency medical condition and who meet all eligibility requirements of the Medicaid program except for citizenship and immigration status.

Emergency Medicaid does not provide comprehensive health care coverage or continual Medicaid coverage. Emergency Medicaid only provides coverage and payment for the treatment of the emergency medical condition. If approved, Emergency Medicaid coverage is only for the duration of the emergency medical condition request or until the emergency medical condition is stabilized, as determined by a clinician.

Effective August 1, 2017, all claims related to labor and delivery for beneficiaries enrolled in the DC Healthcare Alliance program must be submitted to DHCF following the normal claims submission process. Providers may resubmit labor and delivery claims with a date of service beginning August 1, 2016 to the present for payment. The claims must be submitted within the 365 days timely filing period.

Under Transmittal #12-21, published on August 15, 2012, DHCF established a new payment policy for Medicaid-reimbursable emergency medical services for DC Healthcare Alliance beneficiaries. The transmittal clarified that Medicaid-reimbursable emergency medical services are not included in the Alliance benefit package and allowed hospitals providing Medicaid-reimbursable emergency medical services to submit claims directly to DHCF for reimbursement. Under this new transmittal, hospital claims submissible for reimbursement will now include professional and facility services related to labor and delivery.
This billing change should have no impact on Alliance beneficiaries' access to emergency medical

services. The Emergency Medicaid (780) request is no longer required for Alliance beneficiaries receiving labor and delivery services. It is the responsibility of the hospital to ensure that the beneficiary is active and enrolled in the Alliance program. The allowable labor and delivery services include the initial inpatient hospital stay, as well as, any physician services related to the stay. It also allows for any claims related to the transfer of the beneficiary to another institution due to complications. Hospitals must ensure that the diagnosis code related to labor and delivery is on the inpatient claim. Services provided to an Alliance beneficiary that do not qualify as a Medicaid-reimbursable emergency medical service should be billed to the beneficiary's health plan.

If an uninsured individual experiences an emergency and attests to not having U.S. citizenship or an eligible immigration status for Medicaid, the hospital should inform the individual about the Emergency Medicaid application process and assist with submitting the DC Health Link Application and the Emergency Medicaid Query Form, with all required documentation to ESA

Questions regarding Emergency Medicaid or any changes to the eligibility determination process should be directed to Kivon Allen at kivon.allen@dc.gov or Danielle Lewis at danielle.lewis@dc.gov.

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: Emergency Medicaid **Policy Number:** HCPRA-003-17

Policy Scope: Department-wide	**Number of Pages:** 9
Responsible Office or Division: Health Care Policy and Research Administration	**Number of Attachments:** N/A
Supersedes Policy Dated:	**Effective Date:** 8/11/2015
Cross References and Related Policies:	**Expiration Date, if Any:** N/A

I. PURPOSE

The purpose of this document is to establish policies and procedures for the Emergency Medicaid program in the District of Columbia.

II. APPLICABILITY

This policy applies to the departments involved in processing Emergency Medicaid requests: the Economic Security Administration (ESA) and the Department of Health Care Finance (DHCF) and Medicaid providers.

III. AUTHORITY

The authority and functions of the DHCF as set forth in the "DHCF Establishment Act of 2007" effective February 28, 2008 (D.C. Law 17-109).

Medicaid coverage for treatment of emergency medical conditions is authorized under 8 U.S.C. §1396b (v) and 42 C.F.R. §440.255(c).

Medicaid State Plan: Section 4 - General Program Administration - Attachment 4.19B, Part 1

In accordance with 42 C.F.R. §435.907(a), applications for Emergency Medicaid must be submitted by the applicant, an adult in the applicant's household as defined in 42 C.F.R. 435.603(f) or family as defined in 26 C.F.R. 1.36B-1(d).

Authorized representatives submitting applications for Emergency Medicaid on behalf of an individuals is authorized under 42 C.F.R. §435.923.

45-day processing period for Emergency Medicaid is authorized under DC CODE § 4-205.26.

Retroactive coverage for Emergency Medicaid is authorized under 42 C.F.R. §435.915

IV. DEFINITIONS

Alliance Beneficiary: An individual who is eligible for and enrolled in the D.C. Health Care Alliance Program.

Authorized Representative: An authorized representative is an individual or organization designated by an applicant or beneficiary to act responsibly on their behalf to assist with application submission, renewal of eligibility, and other ongoing communication with DHCF.

Combined Application for Benefits (Combined Application): The District of Columbia's Combined Application for Medical Assistance, Food Stamps, and Cash Assistance for disabled individuals and individuals with families.

Department of Health Care Finance (DHCF): District of Columbia's state Medicaid agency, which serves as the single state agency for the District responsible for the policy development and administration of the District of Columbia Medicaid program.

Economic Security Administration (ESA): The Department of Human Services (DHS), Economic Security Administration (ESA) determines eligibility for Medicaid and other public assistance programs available in the District of Columbia based upon the policies and procedures established by the Department of Health Care Finance (DHCF).

Emergency Medical Condition: The sudden onset of a medical condition requiring immediate medical attention, which includes labor and delivery, but does not include care and services related to organ transplant procedures, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

a. placing the patient's health in serious jeopardy,
b. serious impairment to bodily functions, or
c. serious dysfunction of a bodily organ or part.

The "sudden onset" qualifier means the first appearance of signs or symptoms of an illness in an acute condition. The condition may be life threatening in nature and requires medical intervention. In addition, care and services related to an organ transplant procedures are not a covered under Emergency Medicaid. With respect to labor and delivery services, all labor and delivery is considered an emergency medical condition.

Federal Poverty Level (FPL): The Federal standards for determining the maximum income level allowed to be eligible for medical assistance. The Federal Poverty Level is updated annually in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility

in accordance with 42 C.F.R. §435.603(h).

Modified Adjusted Gross Income (MAGI) - A simplified methodology used to calculate income eligibility for Medicaid, CHIP and financial assistance programs available through the health insurance Marketplace as defined in 26 U.S.C. §36B(d)(2)(B) and 42 C.F.R. § 435.603.

Medicaid-Reimbursable Emergency Medical Services: Services consistent with the requirements of 42 CFR § 440.255 that are necessary to treat the condition and are rendered after the sudden onset of an emergency medical condition as defined above.

Retroactive Medicaid coverage: The three (3) month period before the date of application during which the District may make Medicaid coverage available if an individual is determined eligible.

V. POLICY

Emergency Medicaid Policy and Alliance Submission Process Change

It is the policy of Department Healthcare Finance (DHCF) and Economic Security Administration (ESA) to provide Emergency Medicaid coverage to individuals who receive treatment for an emergency medical condition and who meet all eligibility requirements of the Medicaid program except for citizenship and immigration status.

Emergency Medicaid provides limited Medicaid coverage to individuals who meet financial, medical and non-financial eligibility factors except for U.S. citizenship/eligible immigration status for the District of Columbia Medicaid program. Emergency Medicaid does not provide comprehensive health care coverage or continual health coverage. Emergency Medicaid only provides coverage and payment for the treatment of the emergency medical condition. If approved, Emergency Medicaid coverage is only for the duration of the emergency medical condition request. Emergency Medicaid only covers medical services associated with direct treatment of the emergency medical condition.

To be considered eligible for Emergency Medicaid, the applicant must meet the following non-financial and financial eligibility factors:

a. Must meet the District's residency requirement for D.C. Medicaid;
b. Must meet an emergency medical condition;
c. Must not be a U.S. Citizen or have eligible immigration status for on-going Medicaid;
d. Must meet the income standards for the specific eligibility category for which the individual qualifies for Emergency Medicaid;
    i. For Aged, Blind, Disabled (ABD) category only, resources cannot exceed $4,000 for an individual and $6,000 for couple. The Aged, Blind, and Disabled category is the only eligibility category in which a resource test applies.

The income threshold for Emergency Medicaid shall be determined based on the particular eligibility category. Depending on the particular eligibility category, the prospective applicant will be determined using MAGI or non-MAGI rules. The MAGI methodology shall apply to the following eligibility groups:

- Childless Adults (21-64)
- Children (0-20)
- Parents/Caretaker Relatives
- Pregnant Women

Non-MAGI methodology shall apply to the Aged, Blind, or Disabled group.

Applications for Emergency Medicaid may be submitted by the applicant, an adult in the applicant's household, an authorized representative, or, if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. Pursuant to 42 C.F.R. §435.923, a provider cannot submit an application unless the applicant has designated the provider to be the authorized representative.

ESA has up to 45 days to process the application and determine eligibility for Emergency Medicaid. If an individual is approved for Emergency Medicaid, any services related to the emergency medical condition that was treated within the three months before the date of application may be covered. If approved for retroactive Medicaid but the claim associated with the treatment of the emergency medical condition is prior to the maximum three months retroactive Medicaid eligibility effective date, the requested Emergency Medicaid service will not be covered.

Application Submission

Effective immediately, individuals applying for Emergency Medicaid are required to submit the DC Health Link application along with the Supplemental Form and Emergency Medicaid Query Form. If Emergency Medicaid coverage is being requested retroactively (for services that were provided within the three months period prior to the application submission date) for a MAGI beneficiary, a DC Health Link Retroactive Medicaid application must also be completed and submitted with the application package.

The applicant must meet financial, medical, and other non-financial eligibility factors to qualify for Emergency Medicaid. To the greatest extent possible, electronic data sources shall be leveraged to verify eligibility factors with the exception of medical documentation. DHCF clinical review team must review and verify medical documentation to determine if an emergency medical condition exists.

The Medicaid service delivery type for Emergency Medicaid is fee-for-service and program code assignment is 780D for MAGI groups and 780N for Non-MAGI groups. Alliance beneficiaries seeking coverage for emergency services do not need to have any updates made to their program code or eligibility spans.

VI. PROCEDURE

Uninsured individuals who receive emergency services

i. An uninsured individual, who receives emergency services including labor and delivery, may apply for Emergency Medicaid coverage using the Combined Application for Medical Assistance, Emergency Medicaid Query form, and if MAGI, the supplemental

question form.

To be eligible for Emergency Medicaid, an applicant must have an emergency medical condition and must meet financial and non-financial eligibility factors.

ii. Applications for Emergency Medicaid will be reviewed and processed by the Medicaid Branch at ESA.

iii. If eligibility factors could not be verified through the use of electronic data hubs, the applicant may be required to provide additional documentation to verify any outstanding eligibility factors. The applicant must provide clinical documentation from a medical professional of the existence of an emergency medical condition.
   a. Acceptable clinical documentation for labor and delivery includes:
      i. Birth Certificate (if available)
      ii. Certificate of Birth
      iii. Hospital Discharge Summary
   b. Acceptable clinical documentation for an emergency medical condition includes:
      i. Medical examination report
      ii. Hospital Discharge Summary
      iii. Medical Records

iv. Emergency medical conditions, excluding labor and delivery, must be verified by a DHCF licensed health care professional.

NOTE: The submission documents must include the date(s) of services for labor and delivery or the emergency hospital stay.

v. If the request for Emergency Medicaid is related to labor and delivery, ESA will verify all financial and non-financial eligibility factors and review the submission documents to either approve or deny Emergency Medicaid.

vi. If the request for Emergency Medicaid is not related to labor and delivery, ESA will determine if all financial and non-financial eligibility factors are met. The Emergency Medicaid medical documentation will be forwarded to DHCF's clinical review team to complete the clinical review.

vii. ESA will send the medical documentation to DHCF to initiate the clinical review process even if all other verification documents have not been received. Review of non-medical eligibility factors can occur prior to or while the clinical review is being conducted. If after review of the eligibility factors ESA determines that the individual does not meet any of the non-financial or financial eligibility factors, then ESA must inform DHCF that further review is not needed due to ineligibility for Emergency Medicaid.

<u>DHCF Receipt of Emergency Medicaid Request</u>

i. DHCF shall review the Emergency Medicaid request to ensure that the information is complete and contains appropriate clinical documentation to make a decision.

ii. The Health Care Operation Administration at DHCF has the responsibility of conducting the initial clinical review of all Emergency Medicaid clinical requests.
iii. If the request is incomplete, DHCF shall forward the request back to ESA to indicate that a clinical decision cannot be made and additional documentation is needed.
iv. ESA will send out a notice informing the client that additional clinical information is needed.
    a. If additional clinical information is not received within 45 days of the application date, the application will be denied and the applicant will be sent a legally sufficient and timely denial notice.
v. If the clinical information is complete, the DHCF Clinical Reviewer shall determine whether the medical documentation meets the definition of an emergency medical condition.
vi. If the criteria for an emergency medical condition are met, the DHCF Clinical Reviewer will notify ESA of the emergency medical condition approval. If the applicant meets all other eligibility factors for Emergency Medicaid, then an approval notice will be sent to the applicant.
vii. If the request does not meet the criteria for Emergency Medicaid, the DHCF Clinical Reviewer shall deny the Emergency Medicaid request and forward the request to the DHCF Medical Director who is the second-level clinical reviewer of all denied requests. The first-level Clinical Reviewer's denial decision shall be documented in the request package.
viii. The Medical Director shall confirm or disagree with the first reviewer's denial by reviewing documentation on whether the circumstances met the definition of an emergency medical condition.
ix. If the Medical Director agrees with the denial of the request, he or she shall confirm the decision. The request will be sent back to ESA indicating that DHCF has completed the clinical review. ESA will deny the Emergency Medicaid application.
x. If the Medical Director disagrees with the denial, he or she shall document the evidence in support of an Emergency Medical Condition. The request will be sent back to ESA indicating that DHCF has completed the clinical review and approved the emergency medical condition.
xi. If the applicant wishes to dispute this decision, he or she may submit a formal request for an administration hearing with the Office of Administration Hearings (OAH).

Economic Security Administration's receipt of Request for Emergency Medicaid determination:

i. If the clinical review has been completed with an approval status and all financial and non-financial eligibility factors have been verified, the Medicaid Unit at ESA will approve eligibility for Emergency Medicaid.

ii. If the clinical review has been completed with a denied status or financial and other non-financial eligibility factors have not been verified within the 45 days application processing period, the Medical Unit at ESA shall deny the request for Emergency Medicaid application.

Alliance Beneficiaries and Medicaid-Reimbursable Emergency Services

Medicaid reimbursable emergency services, including services related to labor and delivery, are not included in the Alliance benefit package and will not be paid to network hospitals by managed care organizations participating in the Alliance program. These claims must be submitted directly to DHCF for payment. Providers must check for active Alliance eligibility prior to service delivery. Current Alliance beneficiaries will remain in program code 470.

Hospitals providing Medicaid reimbursable emergency medical services to Alliance beneficiaries should submit claims for these services directly to DHCF when the following conditions are met:

i. Services were provided to an eligible and enrolled Alliance beneficiary;
ii. Services were provided to treat an emergency medical condition;
iii. Services are not related to an organ transplant procedure or dialysis; and
iv. The principal diagnosis code is an emergent diagnosis with a positive emergency room indicator value and any of the following qualifying values are present:
    a. Hospital outpatient claim with revenue codes of 0450-0459;
    b. Hospital inpatient claim with an emergency room admission based on the presence of revenue codes of 0450-0459.

Effective August 1, 2017, claims for services related to labor and delivery must also be submitted to DHCF directly. This benefit change should have no impact on Alliance beneficiaries' access to emergency medical services. The Emergency Medicaid (780) request should only be submitted for individuals who are uninsured. Claims related to labor and delivery for Alliance beneficiaries will be paid as Fee for Service claims. The claims submitted for reimbursement shall include the initial inpatient hospital stay, as well as, any claim related to complications that may occur during the stay or physician charges. This new policy also allows for the reimbursement of any claims related to the transfer of the beneficiary to another institution due to health complications. Hospitals must ensure that the diagnosis codes related to labor and delivery are on the initial inpatient claim. Please reference Transmittal No. 12-27 and Transmittal No. 17-20 for more information.

Alliance Beneficiaries and Dialysis Services

The DC Healthcare Alliance program covers Dialysis services as a part of the managed care plans covered benefits. If an Alliance beneficiary needs to access dialysis services, an Emergency Medicaid application is not required. Providers should no longer submit an application for Emergency Medicaid; instead providers may bill the managed care organizations directly for dialysis services. For more information, refer to Transmittal No. 13-15: Dialysis Coverage for DC Health Care Alliance issued on September 23, 2013.

Options for Alliance Coverage for Individuals who Received or Were Ineligible for Emergency Medicaid

If a beneficiary wishes to continue health coverage beyond the Emergency Medicaid eligibility period or if Emergency Medicaid coverage has been denied and the individuals wishes to be determined eligible for the Alliance program, the individual must contact ESA to conduct a face-to-face interview to determine eligibility. ESA will review the combined application. If needed,

ESA will send a notification to the applicant requesting additional documentation. The beneficiary is not required to submit a separate application to be determined eligible for Alliance if the face-to-face interview is conducted within 45 days of the initial date of application. The process should be seamless for the applicant and reduce redundancies in processing multiple applications for the same individual.

For beneficiaries who request the face-to-face interview and supply ESA with all verification documents, eligibility for the Alliance will be determined. The eligibility start date will be the first day of the month of application. The eligibility for Alliance will override the eligibility span for Emergency Medicaid.

If an individual would like to purchase a plan through the DC Health Link marketplace, the applicant can visit www.dchealthlink.com to submit an application for medical coverage and to see how much cost sharing reductions (CSRs) or advanced premium tax credits (APTCs) they will be approved for. To be eligible for a qualified health plan, the beneficiary must have an eligible immigration status. For information regarding application submission and citizenship requirements, the beneficiary must contact the DC Health Link Customer Service number at (855) 532-5465.

Retroactive Coverage Option for Alliance beneficiaries

Individuals applying for the Alliance program but who need coverage for an emergency service that occurred within the three months prior to the application submission date, can apply for Emergency Medicaid to have that claim paid. The applicant must complete the Emergency Medicaid Query Form.

Emergency Medicaid Beneficiaries Receiving Dialysis Treatment

For Emergency Medicaid beneficiaries assigned the 780 program code due to dialysis treatment:

a. Effective October 1, 2013, prior to the end date of the Emergency Medicaid eligibility period, individuals receiving Emergency Medicaid for dialysis services must apply for the DC Healthcare Alliance Program by submitting a combined application. The individual has to be determined eligible for Alliance coverage to continue to receive dialysis. On a temporary basis, ESA may waive the face-to-face requirement.
b. Individuals who had active Alliance coverage prior to transitioning to Emergency Medicaid program code 780 can automatically be converted back to program code 470. No new application is required.

Examples:

a. Miriam is a 27 year old uninsured individual who does not meet the citizenship/eligible immigration status for continued Medicaid coverage. She receives services for an emergency medical condition at Howard University Hospital. She submits an application for Emergency Medicaid to cover her emergency treatment. Miriam provides verification of income, DC residency, non-U.S. citizenship, immigration status and medical documentations. ESA will review the case to see if Miriam meets financial and non-financial eligibility requirements and then forward the case to DHCF for the clinical review to commence. A DHCF Clinical Reviewer will evaluate the submission documents to

determine whether an emergency medical condition was met. DHCF Clinical Reviewer approved the requested service and Miriam met the financial and non-financial eligibility requirements. The system will assign program code 780D (Emergency Medicaid) to cover the dates of service for the emergency hospital stay. She should also be provided the opportunity to apply for Alliance coverage through the combined application if she wants ongoing healthcare coverage.

b. John is a U.S. citizen and eligible for Medicaid, although he is not enrolled. He receives treatment for an emergency medical condition. He applies for Emergency Medicaid coverage. Although he has an emergency medical condition, John is not eligible for Emergency Medicaid coverage because he is a U.S. Citizen. Emergency Medicaid is only available to individuals who do not meet the immigration and citizenship eligibility requirement.

VII. RESPONSIBILITY

The Economic Security Administration (ESA) and Department of Health Care Finance (DHCF) are responsible for the implementation of this policy and procedures.

For more information regarding this policy, please contact Kivon Allen, Management Analyst in the Division of Eligibility Policy at kivon.allen@dc.gov.

Claudia Schlosberg, JD
State Medicaid Director

8/11/17
Date

EMERGENCY MEDICAID QUERY FORM
WORKSHEET FOR ELIGIBILITY OF NON-QUALIFIED ALIENS FOR EMERGENCY SERVICES (780)

Emergency Medicaid (EM) is a health coverage program designed to provide Medicaid coverage to individuals who receive treatment for an emergency medical condition, including labor and delivery, and who meet all eligibility requirements of the Medicaid program except for citizenship and immigration status. Th EM Query Form form must be submitted when applying for EM. Your provider must enter the date of the labor and delivery or the duration of the emergency medicatl condition in the Part II section of the form and provide supporting documentation of the emergency condition along with with the form.

Submit completed form to the following address:
Department of Human Services
Attn: Medicaid Unit
645 H Street, NE
Washington, DC 20002
Phone: (202) 698-4220
Fax: (202) 724-8963

IMPORTANT: This form must be completed in conjunction with the Combined Application and the necessary medical documentation.

PART I (To be completed by applicant)			
Name			Date of Birth
Telephone number ( )	Email address		
Current address			
City	State	Zip Code	
Alliance ID No. (if applicable)	Alien ID: A ☐ Click here if Not Available		SSN: (if available)
AUTHORIZED REPRESENTATIVE			
Do you want someone else to act or represent you? ☐ Yes ☐ No			
Name of Authorized Representative:	Address of Rep:		Telephone:
SIGNATURE			
By signing below, I give permission to DHS to get information about me and process eligibility for Emergency Medicaid. I believe that all of my information on this Provider Query Form is accurate. I know that if I give any false information, I may be breaking the law. I know that State and federal officials will check this information. **Authorized Representatives**: If the applicant cannot sign this form, you may sign it for them. By signing, you certify that this person wants to apply for benefits and agrees to the conditions above. _____ _____ Signature Date			
PART II (To be completed by treating physician or Hospital Staff)			
Emergency Medicaid Eligibility Period Requested From: To:	Name of Hospital *(place where emergency incident was treated)*		
Is services related to labor and delivery: ☐Yes ☐ No			
Hospital Representative Name and Title:	Phone Number:	Date:	

PART III ***(To be completed by the Economic Security Administration)***			
Date EM Request Received	Case Number	Caseworker Assigned to	Date Sent to DHCF
For services not related to labor and delivery: □ **Hospital Discharge Summary** □ **Medical records** □ **Medical Examination Report**			
If additional information is requested by the clinical team, please complete the section below			
Notice Sent: □ **Yes** □ **No**	**Date Sent:**	**Additional Information Received:** □ **Yes** □ **No**	**Date Received:**
Date Information sent back to DHCF Clinical Team:			
Signature of ESA Caseworker:			
PART IV ***(To be completed by DHCF Clinical Reviewer)***			
Clinical Reviewer		Clinical Review Date	
Eligibility Period Approval Dates From: To:			
□ DHCF Approved □ DHCF Denial (not an emergency medical condition – forwarded to 2nd Level Reviewer) □ More Information/Medical Documentation Required			
Date Approved		Signature of Clinical Reviewer	
DHCF Emergency Determination – 2nd Level Clinical Review			
MD Review Date		Status: □ Approved (Denial Reversal) □ Denial Upheld	
Eligibility Period Approval Date From: To:			
Approval Reason:			
Denial Reason:			
Signature of MD Reviewer			