

WAC 182-507-0115 Alien emergency medical program (AEM). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) or (c) of this subsection:

(a) The medicaid agency determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 182-500-0030, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(i) Inpatient;

(ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section).

(2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:

(a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

(b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(i) Medications;

(ii) Laboratory, X-ray, and other diagnostics and the professional interpretations;

(iii) Medical equipment and supplies;

(iv) Anesthesia, surgical, and recovery services;

(v) Physician consultation, treatment, surgery, or evaluation services;

(vi) Therapy services;

(vii) Emergency medical transportation; and

(viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the agency or its designee as described in subsection (3) of this section.

(3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the agency or its designee under this program. Exception: 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 (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

(a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - The admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. 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.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 182-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the agency to be a qualifying emergency medical condition, including but not limited to:

(i) Laboratory X-ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(d) Services provided outside the hospital settings described in subsection (1) of this section including, but not limited to:

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;
(xi) Vision services;
(xii) Hearing services;
(xiii) Dental services;
(xiv) Durable and nondurable medical supplies;
(xv) Nonemergency medical transportation;
(xvi) Interpreter services; and
(xvii) Pharmacy services, except as described in subsection (4) of this section.

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

[Statutory Authority: RCW 41.05.021. WSR 12-24-038, § 182-507-0115, filed 11/29/12, effective 12/30/12. WSR 12-13-056, recodified as § 182-507-0115, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. WSR 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]