Emergency Medicaid Only (EMO) Billing Instructions

Overview

Emergency Medicaid Only (EMO) provides medical coverage to uninsured individuals who do not qualify for Medicaid due to citizenship/immigration status. This program may pay health care costs for individuals who have experienced a medical emergency.

As defined by 42 Code of Federal Regulations (CFR) 440.255, Federal Emergency Services (FES) Program, also known as EMO, allows undocumented/non-citizens, who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States, to receive emergency services that are due to a sudden onset emergency medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) or outpatient End Stage Renal Disease (ESRD), such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment of bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Who is Eligible?

- A Nevada resident;
- Meet income and resource requirements;
- Not eligible for ongoing Medicaid due to citizenship/immigration status; and
- Only covers emergency medical services as outlined in 42 CFR 440.255.

Policy

Refer to Medicaid Services Manual (MSM) Chapter 200 - Hospital Services, Attachment A, Policy #02-02, for additional policy and guidelines specific to EMO.

Nevada Medicaid's service policies can be found on the Division of Health Care Financing and Policy (DHCFP) website, under Medicaid Services Manual.

Covered Services

Nevada Medicaid reimburses for emergency medical services which meet the definition referred to in 42 CFR 440.255. Coverage is limited to an acute emergency medical condition, labor and delivery, and outpatient dialysis services, otherwise known as End Stage Renal Disease (ESRD).

To view a list of approved diagnosis codes for which emergency medical services are covered by Nevada Medicaid for non-U.S. citizens with an emergency medical condition, visit ICD-10-CM Emergency Diagnosis Codes for Non-Citizens with Emergency Medical Only Coverage. This list of ICD-10 diagnosis codes may not be all inclusive. Additional codes may support EMO coverage as allowable. When submitting claims in which the diagnosis codes are not listed in the ICD-10-CM Emergency Diagnosis Codes for Non-Citizens with Emergency Medical Only Coverage, providers should attach the appropriate clinical documentation supporting the EMO criteria as met.

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All EMO services are evaluated based on medical necessity and must meet the definition of 42 CFR 440.255. **Limited** services may be provided if the condition meets the definition of EMO criteria for most provider types. Please see the table below for examples of limitations on services that may be covered. Once a recipient is stabilized, coverage will cease.

SERVICE	COVERAGE & LIMITATIONS
Hospitals - Inpatient, Outpatient, Emergency Department (ED)	Facility services provided may be covered if the condition meets the definition of EMO and medical necessity. • Emergency-related services are **limited.** • Follow-up care to emergency treatment and chronic care (e.g., organ transplants, chemotherapy, etc.) are **not** covered. • Organ transplants are **not** covered. • Elective and/or non-emergent surgeries are **not** covered. • Outpatient services are **limited** to the treatment of emergency conditions. • **Note:** Once an EMO recipient is stable, additional days/services are **not** covered. • **Additional note:** Date of discharge is **not** covered unless discharge/death occurs on the day of admission.
Laboratory Services	**Limited** to services related to labor and delivery or necessary to diagnose/treat an emergency condition. Follow-up services to emergency treatment is **not** covered.
Mental Health and Alcohol and Substance Abuse Services	**Limited** to emergency stabilization of a psychiatric episode within the emergency department of a medical hospital. Substance Use Disorder (SUD) treatment is **limited** to medically necessary inpatient detoxification services in a life-threatening situation. Inpatient detoxification of a recipient who is simply incapacitated is **not** covered.
Physician Services - Maternity Care, Labor and Delivery, Family Planning	**Limited** services related to labor and delivery only. Prenatal and post-partum care is **not** included. Family planning is **not** covered. For example, sterilizations performed in conjunction with delivery are **not** covered.
Physician Services - Physicians, M.D., Osteopath, D.O.	Professional services provided may be covered if the condition meets the definition of EMO and medical necessity. **Note:** Once an EMO recipient is stable, professional services are **not** covered.
Prescribed Drugs/Pharmacy	**Limited** to those drugs/pharmaceuticals related to the emergency condition. Refills are **not** covered. Refer to MSM Chapter 1200 - Prescribed Drugs for additional information.
Transportation Services	**Limited** to emergency transport (ground or air) to a hospital emergency department (ED) and non-emergency medical transportation to and from dialysis.

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Non-covered Services

Please see the table below for examples of non-covered services. All services are not covered unless they meet the definition of 42 CFR 440.255. Once a recipient is stabilized, coverage will cease.

SERVICE	COVERAGE & LIMITATIONS
Case Management	**Not** covered
Dental	**Not** covered
Durable Medical Equipment (DME) Disposable Supplies and Supplements	**Not** covered
Hearing Aid Dispenser & Related Supplies	**Not** covered
Home Health, Personal Care Services, and Private Duty Nursing Services	**Not** covered
Hospice	**Not** covered
Nursing Facility	**Not** covered.
Ocular Services - Optometry (i.e., Eyeglasses, contacts, etc.)	**Not** covered
Physician Services - Chiropractor	**Not** covered
Physician Services - Podiatry	**Not** covered
Preventative Services	**Not** covered
Non-Emergency Medical Transportation (NEMT)	**Not** covered. **Limited** to non-emergency medical transportation to and from dialysis.
Therapy	**Not** covered. Rehabilitation services such as speech, occupational, or physical therapy are **not** covered.

Additional services not covered by Nevada Medicaid include, but are not limited to, the following:

- Any service not currently approved under Nevada Medicaid's State Plan.
- Any service that does not meet the EMO criteria as defined by 42 CFR 440.255.
- Follow-up care related to the emergency condition.
- Emergency medical conditions do not include conditions that are debilitating or that require rehabilitation.
- Medical screening examination and ancillary service(s) when it is determined an emergency medical condition does not exist.
- Chronic conditions with the exception of outpatient ESRD.
- Organ transplants.
- Antepartum and postpartum maternity care visits.
- Date of discharge is not covered unless discharge/death occurs on the day of admission.
- Once an EMO recipient is stable, additional days/services are not covered.

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Prior Authorization (PA)

For hospital **inpatient or outpatient and professional** prior authorization requirements, please refer to Authorization Criteria for details. Prior authorizations must also be in alignment with applicable policies outlined in the Medicaid Services Manual.

If a prior authorization is required, the request will be evaluated based upon the clinical information submitted with the request to ensure that the emergency medical criteria as defined in 42 CFR 440.255 is met.

Outpatient ESRD services do not require a PA; however, documentation must exist, and the proper forms must be placed in the recipient's medical record. Visit the Prior Authorization Forms webpage for the required forms.

- FA 100 – Initial Emergency Dialysis Care Certification form must be completed at the time end stage renal disease is diagnosed and placed in the recipient's medical record.
- FA 101 – Monthly Emergency Dialysis Case Certification form must be completed monthly and placed in the recipient's medical record.

Concurrent reviews must be requested within five business days of the last day of the current PA period.

Date of Decision During Inpatient Stay

If a patient is not eligible for EMO coverage upon admission, but is later determined eligible during their inpatient stay, the provider must request authorization within ten business days of the date of eligibility decision (DOD).

For newborns, this is ten business days from the birth date. If the recipient's DOD includes the admission date, an approved request can cover the entire stay, including day of admission. If the provider fails to request authorization within the ten-day window, and the recipient is determined eligible while in the facility, authorized days can begin the day that Nevada Medicaid receives the authorization request including all required clinical documentation.

When a recipient is determined eligible for EMO coverage after the service is rendered, the provider has up to 90 calendar days from the eligibility decision date to submit a PA (a.k.a. retro-eligibility).

Billing Requirements or Instructions

Services rendered to recipients with EMO coverage are considered to have fee-for-service (FFS) coverage. EMO is not a covered benefit under the Managed Care Organizations (MCOs).

Refer to MSM Chapter 100 - Medicaid Program for provider requirements, reimbursements, billing recipients, and billing time frames (stale dates).

In order for claims to be considered timely, claims must be received within 180 days for services provided in-state. Out-of-State providers' timely filing period is up to 365 days. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames. Professional billings for services rendered by anyone other than the provider under whose name and provider number the claim is submitted will neither be accepted nor reimbursed.

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Billing a Recipient with EMO

Recipients with EMO coverage may be billed for non-emergent services or once the emergency medical condition is stabilized and the recipient no longer meets the definition of 42 CFR 440.255. On days where services and/or procedures rendered are not deemed emergent, providers may bill the recipient for those non-covered days/procedures. For further details on billing recipients, refer to the "Billing Medicaid Recipients" section in MSM Chapter 100 - Medicaid Program.

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How to Apply for EMO Coverage

Eligibility for EMO coverage is determined by the Nevada Division of Welfare and Supportive Services (DWSS). For questions about EMO application, please call the DWSS at (800) 992-0900.