

	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	2050	Effective Date:	December 2019
	Policy Title:	Emergency Medical Assistance		
Policy Number:	2054	Previous Policy Update:	MT 51	

REQUIREMENTS

Emergency Medical Assistance (EMA) provides medical coverage to individuals who meet all requirements for a Medicaid Class of Assistance (COA) except for citizenship/immigration status and enumeration requirements and have received an emergency medical service.

NOTE: EMA does **not** provide coverage for Planning for Health Babies® or PeachCare for Kids® Medical Assistance COAs.

BASIC CONSIDERATIONS

A non-immigrant applicant is potentially eligible for EMA under any Medicaid COA (except for P4HB or PCK).

The applicant must meet all eligibility criteria for the COA with the following exceptions:

- citizenship/immigration status and identity
- enumeration

Approval for EMA will be for a service that was provided prior to the date of application. Emergency Medical Assistance applications are not to be approved prior to an emergency, including labor and delivery. **No future eligibility dates are to be used.**

NOTE: Chafee Independence Program Medicaid was authorized as of July 1, 2008. No EMA is available under this COA prior to this date.

Emergency Medical Assistance provides payment for the treatment of emergency services as defined in federal law in 1903 (v) of the Social Security Act and 42 CFR 440.255 when such care and services are necessary for the treatment of an emergency medical condition, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

BASIC CONSIDERATIONS (cont.)

- placing the patient's health in serious jeopardy
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part

Services can include labor and delivery, from active labor until delivery is complete and mother and baby are stabilized.

A physician must determine the need for an emergency medical service and verify that the service has been rendered. The physician verifies emergency medical services by completing DMA Form 526, "Physician's Statement for Emergency Medical Assistance", or another written statement.

A written statement must include all information on the DMA Form 526, specifying the date(s) an emergency medical service has been rendered. No future eligibility dates are to be used. The form must contain an original signature.

The EW will accept DMA Form 526 and proceed with the eligibility determination, regardless of level or type of medical service rendered. DMA will determine if claims submitted by providers meet the definition of an emergency medical service. Only emergency medical services should be reimbursed.

Georgia residency is required and is established by the A/R's verbal or written statement that s/he lives or has intent to live in the state and is physically present in Georgia.

An application for EMA is processed within 45/60 days. If an individual applies for an emergency medical service to be received at a future date, the application is denied and the applicant may reapply after emergency services are provided.

A woman who is approved for Pregnant Women Medicaid EMA may also be eligible for EMA during the 60-day pregnancy transition if she receives emergency medical treatment during this period.

EMA is approved only for the date(s) specified on the DMA Form 526 or a physician's written statement. In order for a Form 526 to be valid, it must have both a begin and an end date for services provided and the dates of service must be prior to the date the form is signed by the physician. No future eligibility dates should appear on the DMA Form 526.

A child born to a woman approved for EMA for the delivery is eligible for Newborn Medicaid. Refer to Section [2174](#), Newborn Medicaid.

An EMA applicant/member has the right to request a Fair Hearing. Refer to [Appendix B](#), Fair Hearings, for additional information.

A Continuing Medicaid Determination (CMD) is not required upon termination of EMA.

BASIC CONSIDERATIONS (cont.)

NOTE: Other family members who meet citizenship/immigration status and enumeration requirements can request Medicaid coverage. Follow application procedures appropriate for any other COA for those family members.

Determine eligibility and provide notification of case disposition within the following Standards of Promptness (SOP):

- within 45 days for pregnant women
- within 45 day for Family Medicaid COAs and ABD COAs for aged, blind applicants
- within 60 days for ABD COAs for disabled applicants

PROCEDURES

Follow the steps below to approve EMA:

- Step 1** Obtain a signed application from the applicant and determine the appropriate COA under which EMA will be processed.
- Step 2** Review and obtain a signed Notification of Eligibility – Emergency Medical Assistance Program form from each individual making application for EMA. A copy of the signed notice should be placed in the case record. If the applicant is not present for a face-to-face interview the EMA Notification form must be mailed to the applicant. It is preferable that the notice be signed and returned but it is not required.
- Step 3** Determine the AU and BG and complete the budgeting process for the appropriate COA.
- Step 4** Establish basic eligibility for the AU with the exception of citizenship/immigration status, identity, and enumeration.
- Step 5** Obtain DMA Form 526 or a written, signed statement from the physician verifying the need for emergency medical services. The signature should be the original signature of the physician or a medically trained employee of the physician designated to act on his/her behalf. Forms using the physician's stamped signature are not acceptable. Faxes are acceptable if the form is faxed from the physician's office and the signature on the faxed form was original. When questionable, contact the physician's office to verify.

NOTE: The following providers are authorized to sign Form 526: Any qualified licensed professional (i.e. RN, MD, advanced practice RNs, midwife, PA, etc.) DMA Form 526 or physician's statement should not indicate a period of emergency service exceeding 30 days

PROCEDURES (cont.)

from condition onset date. No future dates are to appear on DMA Form 526. In order for a Form 526 to be valid, it must have both a begin and an end date for services provided and the dates of service must be prior to the date the form is signed by the physician or qualified licensed professional.

Step 6 Approve the case using the appropriate COA if the applicant meets all eligibility criteria. Notify the AU of the eligibility determination. The notice should include the following:

- approval/disposition date
- Gateway Client ID number
- date(s) of eligibility

Step 7 A CMD is not required. Applicants will need to complete a new application for subsequent emergency services received.

SPECIAL CONSIDERATIONS**Hearings**

Refer to [Appendix B](#), Hearings

Claim Submission And Prior Approval

Providers should submit claims for services rendered to EMA applicants, on the web portal at www.mmis.georgia.gov with supporting documentation. Supporting clinical documentation should include form 520 (Provider Inquiry Form), history and physical, any emergency room records, physician's progress notes, physician order sheets, discharge summary, consultation record, nurse's notes, and death summary if applicable. Claims without supporting documentation will be denied as incomplete. Providers can follow the procedures for prior approval for clearance as to whether a medical charge or prescription will be covered. However, prior approval does not guarantee payment. Providers who do not routinely submit EMA claims for review and possible payment by the Department should attempt to provide some notice of such policy to the potential EMA member. The Department strongly encourages providers to negotiate payment plans that assist these members with payment of these services. If the Department determines that the EMA claim contains both emergent and non-emergent services, payment will only be rendered for emergency services. Providers will be informed by the fiscal agent of the need to submit additional documentation to facilitate the rendering of such payment.

Failure to submit the required documentation within 30 days of the date of the split decision notice will result in the denial of the entire claim. If the Department determines that services rendered were non-emergent, providers may bill EMA members for those services. The Department strongly encourages providers to negotiate payment plans that assist these members with payment of these services. Denial of EMA claims are subject to the administrative appeal process as outlined in Part I, Chapter 500. EMA claim denials

SPECIAL CONSIDERATIONS (cont.)

that result from a provider's failure to submit these claims according to this subsection are subject to the provisions of Part I, § 106(Q).

For instructions on prior approval providers can refer to Part I Policy and Procedure in the DXC Billing Manual