

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201973 DECEMBER 19, 2019

IHCP clarifies Package E – Emergency Services Only coverage and billing

The Indiana Health Coverage Programs (IHCP) provides the *Package E – Emergency Services Only* (Package E) benefit for certain non-U.S. citizens. Some noncitizens are eligible for full coverage if they meet certain immigration criteria.

Noncitizens eligible only for emergency services will receive a Hoosier Health Card. When providers use the Eligibility Verification System options to verify eligibility, the enrollee's limited coverage will be reported. Providers are alerted to this coverage limitation, and they have information on the definition of an emergency and claims payment restrictions.



Package E coverage

Emergency services are defined as services required for a medical condition manifesting itself by acute symptoms (including severe pain) serious enough that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Some example medical conditions include:

- Labor and delivery, including a C-section
- A suspected heart attack or stroke
- An eye injury that could cause loss of vision
- An injury that would lead a reasonable person to use the emergency department (ED), such as a broken arm or leg, a head injury, significant blood loss, or difficulty breathing

Package E will cover **all** the following aspects of emergency care:

- Hospital inpatient costs
- Inpatient and outpatient physician costs
- Pharmacy/prescription drug costs
- Labs
- Imaging test (for example, X-ray or ultrasound)
- Anesthesia

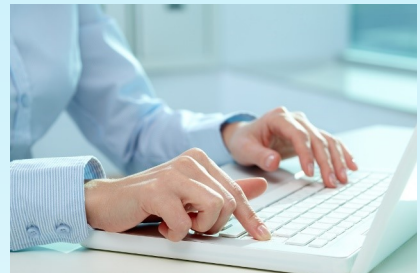
If the Package E member seeks *nonemergency* care, he or she can be billed by the provider. This includes using the ED for primary care, such as for an earache or common cold. For information regarding charging members for noncovered services, see the *Charging Members for Noncovered Services* section in the [Provider Enrollment](#) provider reference module.

If the Package E member has an emergency (or birth) and seeks services, he or she should not be billed for any part of that care. IHCP providers are not allowed to bill members for covered services and are responsible for billing correctly.

Coverage for Package E members is limited to *only* emergency services. For these members, services must meet the emergency criteria noted in this bulletin to be eligible for IHCP reimbursement. In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions. For more information about Package E eligibility and benefit criteria, see the [Member Eligibility and Benefit Coverage](#) provider reference module.

Package E billing and reimbursement

Covered services for Package E members are reimbursed under the fee-for-service (FFS) delivery system. When billing for Package E members, providers must indicate in the appropriate field on the claim that the service rendered meets the definition of an emergency service. Providers are responsible for maintaining documentation to support the claim and the appropriateness of the service.



For coverage of emergency services rendered to Package E members, claims must indicate that the service is an emergency, as follows:

- **Professional** claims (*CMS-1500* claim form or electronic equivalent) must have the emergency indicator (EMG) field marked for each service detail.
- Institutional **outpatient** claims (*UB-04* claim form or electronic equivalent) must include an emergency diagnosis code in the principal (primary) position.
- Institutional **inpatient** claims (*UB-04* claim form or electronic equivalent) must include an admission type code of 1, indicating an emergency admission.
- **Dental** claims must have the word *Emergency* in the Predetermination/Preauthorization Number field for paper claims (*ADA 2012* claim form) or the emergency indicator field marked for electronic claims (Provider Healthcare Portal dental claim or 837D electronic transaction), and the procedure must be for an IHCP-designated emergency dental service (see the *Dental Procedure Codes Allowed for Package E Members* table in *Dental Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers).
- **Pharmacy** claims must have the emergency indicator field marked, must be for a limited-supply prescription (4 days or less) associated with a covered emergency medical service, and must be submitted on a paper pharmacy claim.

For more detailed Package E billing instructions, see the *Emergency Services Only (Package E) Billing* section of the [Claim Submission and Processing](#) provider reference module.

Qualifications

Individuals who are not U.S. citizens may qualify for full coverage Medicaid assistance based on their status granted by the U.S. Citizenship and Immigration Service (USCIS). The following are “qualified” immigrants as defined in federal law:

- Lawful Permanent Resident under the Immigration and Naturalization Act (INA) (*see below for more details*)
- Asylees under Section 208 of the INA
- Refugees under Section 207 of the INA

- Parolees under Section 212(d)(2) of the INA if paroled for at least 1 year
- Persons whose deportation is withheld under Section 243(h) of the INA
- Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980
- Cuban and Haitian entrants
- Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461

Lawful Permanent Residents (LPRs) who were residing in the United States before August 22, 1996, can be eligible for full Medicaid coverage as long as they have maintained continuous residency during that time.

LPRs who enter the United States on and after August 22, 1996, are restricted to Package E coverage only for 5 years, in most cases. At the end of the 5-year period, these LPRs can be eligible for full coverage. Women who are LPRs and become pregnant can also receive prenatal and postpartum services until 60 days after the pregnancy ends. Package E women who are not LPRs are not eligible for routine prenatal and postpartum services.



Immigrants without immigration documentation or whose immigration status cannot be verified, as well as certain visitors and nonimmigrants who are not specified previously can be eligible for Package E Medicaid coverage only if they meet all other requirements of the category in which they qualify – including state residency.

However, any of the following statuses that do not meet state residency requirements are not eligible for Package E coverage: visitors, tourists, foreign students, temporary workers, crewmen on shore leave, diplomats, members of foreign information media, exchange visitors, and so forth, who are lawfully admitted for specific periods of time and with no intention of establishing a permanent residence in the United States.

A child born in Indiana to a mother who was eligible for Package E coverage will be eligible for full Medicaid coverage without any further documentation required, other than reporting the birth to the Division of Family Resources (DFR).

If an immigrant alleges to have a qualified immigrant status as defined above, but is unable to present documentation, the DFR must advise them in writing of their obligation to contact the U.S. Citizenship and Immigration Services (USCIS) to obtain the documentation. The DFR will also attempt to verify the applicant's immigration status through electronic verification sources.

If such an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling their immigration verification requirement, the applicant should be determined eligible without undue delay. If they do not verify immigration status within the 90-day period given by the DFR, and DFR is unable to verify using electronic sources, the individual's Medicaid account will be closed.

Members who do not attest to having a qualified immigration status can be determined eligible for Package E coverage without verifying their status (based on client attestation), as long as all other eligibility requirements are met. These members should not be given full coverage for the 90-day period, but should be opened into Package E coverage without any waiting period.

QUESTIONS?

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