Arkansas Medicaid is the only insurance carrier in Arkansas that reimburses for three different emergency department (ED) service types that may be provided to an Arkansas Medicaid beneficiary. The three service types — assessment, non-emergent treatment and emergent treatment — and the Medicaid guidelines for each are outlined below.

**Assessment** is an evaluation of the beneficiary’s complaint or presenting condition. During an assessment, diagnostic testing may be performed to determine the beneficiary’s condition. Treatment that requires a skilled medical person to perform may not be given to the beneficiary. For example, ED personnel could apply a band aid or give over-the-counter (OTC) medicines. If a prescription is written for a drug (including an OTC drug), this would be considered treatment because licensed medical professional prescription-writing privileges are necessary.

An assessment does not require a referral from the beneficiary’s primary care provider (PCP). However, in order for the assessment to be covered, the beneficiary being assessed must be enrolled with a PCP, if their Medicaid aid category requires PCP assignment. Whether or not a PCP is required can be determined by checking their eligibility on the Arkansas Medicaid website, [www.medicaid.state.ar.us/Provider/Provider.aspx](http://www.medicaid.state.ar.us/Provider/Provider.aspx). If a PCP is required but not yet assigned, this information will also be on the eligibility pages.

**Non-emergent treatment** occurs after an assessment has been performed and the beneficiary is deemed non-emergent, but wants to receive treatment in the ED rather than seeing their PCP after being discharged from the ED.

A referral is required from the beneficiary’s PCP for non-emergent treatment in order for the ED/hospital to be reimbursed by Medicaid. It is at the PCP’s discretion to give or not give a referral for non-emergent treatment in the ED. This includes non-emergent treatment given in the ED after normal PCP office hours.

Referrals can be verbal or written. Both verbal and written referrals should be entered in the beneficiary’s medical record. If a verbal referral is received, the date of service, time of referral, name of the referring provider and the PCP office employee who gave the referral, should be entered in the beneficiary’s medical record, along with the referral instructions.

The only time Medicaid will reimburse for non-emergent treatment in the ED without a PCP referral is when non-emergent treatment is rendered on the same day the beneficiary was assigned to a PCP by the ED. If the PCP...
information on the eligibility pages states a PCP is required but not yet assigned, the ED may assist the beneficiary in selecting a PCP. PCP assignment can be made during the beneficiary’s ED visit by calling the Voice Response System (VRS) and following the automated PCP assignment steps.

The box (right) contains the section from Arkansas Medicaid’s Hospital Manual that details the steps to follow when making PCP assignment in the ED.

The PCP assignment service must be billed on the same claim form as the non-emergent treatment. The hospital will receive a $5 fee for assigning the PCP the beneficiary selected.

For adult beneficiaries (age 21 and over), non-emergent visits count toward the 12 outpatient hospital maximum per State Fiscal Year (SFY) July 1-June 30. Adults also have a benefit limit for outpatient lab and X-ray services in the amount of $500 per SFY. Magnetic resonance imaging (MRI) and cardiac catheterization procedures are excluded from the $500 benefit limit.

Beneficiaries under age 21 are not subject to the 12 outpatient hospital benefit limit. The non-emergent PCP referral rule applies to beneficiaries of all ages.

ARKids First-B can have a maximum copay of $30 for non-emergent treatment in the ED. For example, a beneficiary presents and assessment is performed with lab and X-ray. A $10 copay is required for all three service types performed. If the ARKids First-B beneficiary presents to their PCP for treatment, only a $10 copay is required.

Emergent treatment is the third type of ED visit. The emergent visit is based on the prudent layperson’s definition of “emergency medical condition:” A prudent layperson is someone with an average knowledge of health and medicine who would expect the lack of immediate treatment to cause significant deterioration of the beneficiary’s health.

Sudden or Recent Onset of Symptoms

Presenting Chief Complaint

(See the box above for this section from the Medicaid Manual.)

Neither a referral nor a prior authorization is required for emergent treatment in the ED.

In addition to giving PCP information, eligibility details such as the beneficiary’s aid category and plan description are also included on the eligibility pages. Not all beneficiary aid categories provide full coverage. For example: Pregnancy Medicaid Plan 61 only covers emergencies related to the pregnancy or unborn child. If a beneficiary presents to the ED with a broken leg, unless there is a threat to her unborn child, this would not be a Medicaid-covered benefit.

Lastly, inpatient hospital admissions resulting from treatment in the ED do not require a PCP referral. Direct inpatient hospital admits by the beneficiary’s PCP do require a PCP referral.

If you have questions, your AMS or AFMC policy and education outreach specialist can assist by emailing gboone@arkmed.org or calling 870-918-0944. ▲

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