


ISSUE DATE April 13, 2023	EFFECTIVE DATE April 13, 2023	NUMBER 99-23-02
SUBJECT Updates to the Emergency Medical Condition Information Eligibility Form (PA 1917)		BY  Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

PURPOSE:

The purpose of this bulletin is to inform providers of updates to the Emergency Medical Condition Information Eligibility Form (PA 1917).

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance Program.

BACKGROUND/DISCUSSION:

Under Federal law, an individual (non-citizen) who is not lawfully admitted to the United States, or who has been permanently residing in the United States for less than 5 years and does not meet an exception to the federal 5-year bar, is not eligible for Medicaid except for services that are necessary for the treatment of an emergency medical condition, unless they are under 21 or pregnant and lawfully in the United States. 42 U.S.C. § 1396b(v)(1) and (2). This is referred to as Emergency Medical Assistance (EMA).

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at:

<https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx>.

In order to determine if a non-citizen is eligible to receive EMA, a licensed physician, physician assistant, or certified registered nurse practitioner must complete a PA 1917 Form, which describes the emergency medical condition and the emergency medical treatment needed, including any hospitalization dates for treatment. The PA 1917 Form and any additional information is reviewed by the Department to determine if the non-citizen is eligible for the provision of emergency medical treatment for the specified period.

The Department has updated the PA 1917 Form to specify conditions that have frequently been determined eligible for EMA, which will streamline the eligibility determination process. If the non-citizen has one of these conditions, which are identified in the chart below, they will be considered eligible for EMA.

High Risk Pregnancy
Type I diabetes (insulin dependent) under the age of 21
Diabetic emergencies
Renal failure requiring ongoing dialysis
Fracture of a bone in the skull, arm, leg, neck, spine, or pelvis (within the past two months)
Hypertensive emergencies
Unstable seizure disorder
Cancer undergoing active treatment related to a current diagnosis
Ventilator dependency
Labor and delivery
Acute inpatient psychiatric hospitalization

Some of the conditions on the updated PA 1917 Form have additional diagnostic criteria that must be present for the condition to be considered an emergency medical condition.

EMA eligibility is not limited to individuals who present with the conditions identified on the updated PA 1917 Form. The Department's clinical evaluation team will review requests for EMA for individuals with conditions that are not specifically identified on the form.

Qualifying non-citizens who are lawfully present in the United States may also be eligible for GA-related Medical Assistance.

PROCEDURE:

Effective with the issuance of this bulletin, providers are to utilize the updated PA 1917 Form for non-citizens who seek to be approved for EMA. Physicians, physician assistants and certified registered nurse practitioners who complete the PA 1917 Form for a non-citizen who presents with one of the conditions listed in Section I of the PA 1917 Form should select the appropriate diagnosis box, describe the needed treatment plan, and sign and date the form.

Physicians, physician assistants and certified registered nurse practitioners who complete the PA 1917 Form for a non-citizen who presents with a condition not listed on the PA 1917 Form should select the box for "any condition not described above." The practitioner will need to include supporting documentation to verify why the condition is an emergency

medical condition. Supporting documentation includes documentation relating to a hospital admission history or emergency room visit, rehabilitation, clinic visits, pathology reports, results of biopsies and other diagnostic testing that supports the diagnosis and the presence of an emergency medical condition.

The completed form must be submitted to the County Assistance Office for eligibility determination.

ATTACHMENTS:

Emergency Medical Condition Information Eligibility Form (PA 1917)

CAO NAME AND ADDRESS

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE
WORKER				

Pennsylvania Department of Human Services

EMERGENCY MEDICAL CONDITION INFORMATION ELIGIBILITY FORM

Certain non-citizens may be eligible to receive Medical Assistance (MA) to cover medical expenses necessary to treat an emergency medical condition. For purposes of MA eligibility for certain non-citizens, an emergency medical condition is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ. 42 U.S.C. 1396b(v)(3)

Please note that care and services related to an organ transplant procedure is not considered to be an emergency medical condition.

HOW TO COMPLETE THE FORM:

Section I: Select any of the medical conditions which apply.

NOTE: There are many emergency medical conditions that are not listed in Section I. If the emergency medical condition is not listed, please select option L. "Any condition not described above" and list the condition. These applications will be reviewed by the department's clinical evaluation team.

Section II: State the beginning and expected end date of the treatment of the emergency medical condition.

Section III: State the treatment that is needed for each diagnosis listed.

Section IV: Certification and signature of medical provider.

APPLICANT'S INFORMATION		
NAME	BIRTHDATE	RECIPIENT I.D. NUMBER
ADDRESS (Include street, city, state & ZIP code)		TELEPHONE NUMBER

TO BE COMPLETED BY MEDICAL PROVIDER (Must be a licensed physician, physician's assistant or certified nurse practitioner)

NOTE TO PROVIDER: Certain non-citizens may be eligible to receive Medical Assistance (MA) to cover medical expenses necessary to treat an emergency medical condition. For purposes of MA eligibility for certain non-citizens, an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of **immediate** medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ. Please note that care and services related to an organ transplant procedure are not considered to be an emergency medical condition 42 U.S.C. 1396b(v)(2)(c) & (v)(3).

I. MEDICAL CONDITION: Please select any of the medical conditions that apply. **If conditions A through K are not applicable, select condition "L. Any condition not described above."** These applications will be reviewed by the department's clinical evaluation team.

- A. High risk pregnancy (if any of the following conditions are present) – Expected Due Date:** _____
- Abruption (with current pregnancy; not on a prior pregnancy)
 - A past pregnancy with pre-term labor, premature delivery (before 37 weeks gestation), premature rupture of membranes (PROM)
 - Preeclampsia (confirmed diagnosis with current pregnancy)
 - Current active medical conditions - diabetes, gestational diabetes, hypertension (high blood pressure), uncontrolled asthma, uncontrolled hyperthyroidism, hepatitis, HIV infection
 - Serious mental illness (uncontrolled) - (any of the following)
 - Psychosis
 - Bipolar
 - Schizophrenia
 - Depression
 - Drug and alcohol abuse (current)
 - Multiple gestations (twins, triplets, etc.)
 - Incompetent cervix (current)
 - Women over the age of 40

- B. Type I diabetes (insulin dependent) under the age of 21**

C. Diabetic emergencies:

- Diabetic ketoacidosis - (which includes all of the following conditions)
 - Plasma glucose > 250 mg/dl
 - Arterial pH < 7.30
 - Serum bicarbonate level < 15 mEq/l
 - Moderate ketonuria and/or ketonemia
- Hyperglycemic hypersmolar state - (which includes all of the following conditions)
 - Impaired mental status
 - Plasma glucose >600mg/dl
 - Elevated serum osmolality > 320 mOsm/kg

D. Renal failure requiring ongoing dialysis

E. Fracture of a bone in the skull, arm, leg, neck, spine, or pelvis that occurred within the past two months

F. Hypertensive emergencies: (if any of the following conditions are present)

- Person presents with signs or symptoms of end organ damage, AND systolic blood pressure \geq 180 mmHg
- Diastolic blood pressure \geq 120 mmHg

G. Unstable seizure disorder: (if any of the following conditions are present)

- Person has \geq 5 minutes of continuous seizures
- Person has \geq 2 discrete seizures between which there is incomplete recovery of consciousness

H. Cancer undergoing active treatment related to a current diagnosis

I. Ventilator dependency

J. Labor and delivery – Delivery Date: _____

K. Acute inpatient psychiatric hospitalization

L. Any condition not described above: _____

Attach medical documentation to verify the condition is/was an emergency medical condition, such as:

- Hospital admission history and physical and discharge summaries, including rehab hospitals, clinic, or ER notes
- Results of pathology reports or biopsies, especially when for a diagnosis of cancer
- Results of other diagnostic testing that supports the diagnosis and presence of an emergency medical condition (e.g. CT, labs, ultrasound)

II. TREATMENT DATES:

Date(s) of Emergency Medical Treatment

BEGIN DATE

EXPECTED END DATE

III. EMERGENCY MEDICAL TREATMENT: Please list the medical treatment needed for each diagnosis, including any hospitalization dates for treatment.

IV. CERTIFICATION: As a medical provider, I certify that all of the information provided on this form is true and correct to the best of my professional knowledge. I further certify that the care rendered is for an emergency medical condition and that the absence of immediate medical treatment could reasonably be expected to result in placing the patient's health in serious jeopardy, OR serious impairment to a bodily function, OR serious dysfunction of a bodily organ or part. I certify that the emergency is not an organ transplant or related to an organ transplant procedure.

I understand and agree that the diagnosis and supporting documentation may be subjected to review by the Department of Human Services. I certify that submission of this form complies with all applicable privacy and security laws.

MEDICAL PROVIDER SIGNATURE

MEDICAL PROVIDER (Please print)	DATE	MA PROVIDER ID	NPI	TELEPHONE NUMBER
ADDRESS (Include street, city, state & ZIP code)				