Notice: **We launched a new web site. As a result, past versions of the billing guide, such as this one, have broken hyperlinks. Please review the current guide for the correct hyperlinks.**

NURSING FACILITIES
Provider Guide

April 1, 2016

About this guide*

This publication takes effect April 1, 2016, and supersedes earlier guides to this program.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016**, important changes are taking place that **all providers** need to know. Information has been added regarding new policy for early enrollment into managed care, implementation of fully integrated managed care in SW WA Region, Apple Health Core Connections for Foster Children, Behavioral Health Organizations (formerly RSNs), and contact information for southwest Washington.	Program changes
Contact Information	Updated contact information for the ALTSA Residential Services Program Manager throughout	Housekeeping
Vent-Trach Program	Added clarification to Respiratory services under the Vent-Trach Program: The state requires contracted vent-trach facilities to contract with Advanced Lifeline Services (ALS) to provide respiratory therapy services, supplies and equipment. The payer responsible for room and board costs makes this payment.	Clarification
Specialized SNF Programs	Added section on specialized nursing facility program called Non-citizen's Long-Term Care Program	Clarification
Patient Class Code	Updated name for Patient Class Codes: 45: Non-Citizen's Long-Term Care (NCLTC) Program	Program name clarification

*This publication is a billing instruction.

Subject	Change	Reason for Change
	56: QMB Cost Sharing (Non-Medicaid Contracted)	
SNF Admission	Added clarifications to How does the SNF admit a patient who is authorized for rehabilitation or skilled nursing services by an MCO?:	
	Added clarification to: It is the hospital discharge planner's or nursing facility intake staff's responsibility to contact the MCO for prior authorization (PA) for a client being admitted or any time the client leaves the facility for more than twenty-four hours and is readmitted.	Clarification
	Revised blue note box: A client's managed care plan may change at any time. However, the MCO that approved the initial hospitalization or placement remains responsible for the client's care, covered by the Apple Health contract, even if the client changes to another managed care plan after admission.	To clarify that the MCO is responsible for rehab and skilled NF care in the contract, but not long-term stays at a NF.
Billing	Updated How does the SNF complete the CMS-1500 claim form?	Webinars no longer available
Billing	Added new section SNF providers enrolled to bill through Medicaid and updated SNF providers not enrolled to bill through Medicaid	Clarification
Forms	Added new form requirement under What happens if the client's status changes from rehabilitation to long-term-care services? DSHS 15-031, *Intake and Referral* form, is now used to send information to Social Services Intake regarding a person requesting a functional assessment for long-term services and supports (LTSS). This form replaces all regional forms that are in use currently around the state.	New requirement
Behavioral Health Organization	Removed all references to regional support networks (RSN) and changed them to behavioral health organizations (BHO). This change aligns with new rules under Chapters 182-538A, 182-538B, 182-538C WAC effective April 1, 2016.	New terminology
Patient Status	Updated codes 01 and 04; Added codes 06, 07,	To align with national

Subject	Change	Reason for Change
Codes	and 09	patient status code changes

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available online**.**

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	Aging and Long-Term Support Administration 1-800-422-3263
What is included in the nursing facility per diem or general rate questions	
Questions about payments, denials, claims processing, or agency managed care organizations	Claims Processing Nursing Facilities Unit 1-800-562-3022 ext. 16820 Fax: 1-866-668-1214
Coordination of benefits for clients with private insurance and Medicaid as secondary insurance	Coordination of Benefits 1-800-562-3022 Fax: 360-586-3005
Electronic or paper billing	See the agency Resources Available web page.
Finding agency documents such as provider guides and fee schedules	

Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the agency's Washington Apple Health Glossary for a more complete list of definitions.

Aging and Long-Term Support Administration (ALTSA) - As a component of the Washington State Department of Social and Health Services, ALTSA provides a broad range of social and health services to adult and older people living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system which enables people served to achieve the maximum degree of independence and dignity of which they are capable.

Behavioral health organization (BHO) – means a single- or multiple-county authority of other entity operating as a prepaid health plan with which the Medicaid agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area. (WAC 182-500-0015)

Intermediate/Intellectual Disabilities (ICF/ID) - An ICF/ID facility for DDA is defined as a Title XIX-certified intermediate care facility for people with intellectual disabilities. These facilities:

- Provide IMR services to eligible clients with intellectual disabilities or related conditions who require intensive habilitation training.
- Provide support services which may best be provided in a 24-hour residential care facility.
- Meet the standards and guidelines of the federal nursing facility ICF regulations 42.483 subpart.

Nursing Facility Rates For ALTSA Payment - Prospective payment rates as outlined in WAC 388-96-704.

Per Diem Costs - (Per patient day or per resident day) Total allowable costs for a fiscal period divided by total patient or resident days for the same period. (WAC 388-96-010)

Qualified Medicare Beneficiary (QMB) Program – This program pays for Medicare Part A and Part B premiums, and deductibles, coinsurance and copayments, under Part A, Part B, and Part C.

QMB Only – A person who is eligible for the QMB program but is not eligible for a Categorically Needy (CN) or Medically Needy (MN) Medicaid program.

Record – Dated reports supporting claims submitted to the agency for medical services provided in a client's home, a physician's office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Rehabilitation Services - The planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

Resident – A person residing in a nursing facility. The term resident excludes outpatients and people receiving adult day or night care, or respite care.

Program Overview

What is the purpose of the Nursing Facilities program?

The purpose of the Nursing Facilities program is to pay for medically necessary nursing facility (NF) services provided to eligible Medicaid clients. The NF billing process for the Health Care Authority (agency) clients was developed by the Aging and Long-Term Support Administration (ALTSA) and the agency. See Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and Title 71A RCW (Developmental Disabilities) for further information.

When does the agency pay for services?

The agency pays nursing facilities for costs only when the client is not covered by Medicare, a managed care organization, or third party insurance. Washington Apple Health covers only those services that are ordinary, necessary, related to the care of Washington Apple Health clients, and not expressly unallowable. See RCW 74.46 and WAC 388-96-585 for examples of unallowable costs.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who wish to apply for Washington Apple Health can do so in the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. MCOs are responsible for payment of medically necessary skilled nursing facility (SNF) stays for rehabilitation or skilled nursing services when the MCO determines that nursing facility care is more appropriate than acute hospital care. These services require prior authorization (PA) by the MCO. SNFs must check Apple Health client eligibility and work with hospital staff and MCO staff to ensure authorization is obtained for skilled rehabilitation or nursing services for clients transferring from a hospital. Once admitted to a SNF, it is the responsibility of the SNF to obtain additional authorization from an MCO for ongoing skilled rehabilitation or nursing services.

Note: If the client is enrolled in managed care, contact the MCO prior to admittance to determine what services have been authorized and for how long.

Who is not enrolled in managed care?

Most people receiving long-term care are Medicare-eligible and are not enrolled in managed care. Clients who meet the following criteria are not enrolled in managed care:

- Clients with Medicare
- Clients with comparable primary insurance coverage
- Clients in the Medically Needy program

Who is eligible for SNF services?

The implementation of the Affordable Care Act and the expansion of Washington Apple Health means eligibility for SNF care has changed. Clients who receive coverage in the following ACES (Automated Client Eligibility System) coverage groups are eligible for payment for SNF care assuming all other billing criteria are met. Nursing facilities must always verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. If the payer is an MCO, the SNF must obtain prior authorization from the MCO before admission.

Classic Apple Health programs 30 days or longer:

- Long-Term care coverage: K01, K95, L01, L02, L95
- State-funded long-term care coverage for non-citizens. Program requires a pre-approval by ALTSA: L04.

Classic Apple Health programs 29 days or less:

- Apple Health non-institutional coverage: A01, A05, D01, D02, D26, G01, G02, G03, G95, R03, S01, S02, S08, S95

- Apple Health spenddown cases – (eligible if spenddown is met) : F99, K99, G99, L99, P99, S99

- Apple Health long-term care (in home /residential) coverage: L21, L22, L31, L32, L41, L42, L51, L52.

- State-funded long-term care (in home/residential) coverage for non-citizens. Program requires a pre-approval by ALTSA: L24

- Programs transitioning to MAGI-based coverage: P02, P04.

New MAGI-based programs, regardless of length of stay:

- Apple Health MAGI-based coverage: N01, N02, N03, N05, N10, N11, N13, N23, N31, N33

State-funded SNF Program (ALTSA):

- Only with prior authorization from ALTSA program manager: L04, K03

See Appendix A for the Medical Coverage Group Desk Tool.

The SNF must verify which MCO the client is enrolled in. In addition, the SNF must recognize that the MCO in which the client is currently enrolled is not necessarily the payer. Identifying the payer before admitting the client helps prevent delivering a service for which the SNF will not be paid.

Is a completed Preadmission Screening and Resident Review (PASRR) required?

42 CFR 483.100 – 483.138 and WAC 388-97-1920 and 388-97-1940

Yes. Under state and federal law, all people must be screened using the Preadmission Screening and Resident Review (PASRR) screening tool before admission. The screening process has two levels, PASRR Level I and PASRR Level II. The entire PASRR process must be completed before admission.

The agency may deny payment to the SNF if the SNF is unable to prove that the required PASRR process was timely completed.

Note: There are some exceptions to the PASRR requirement. These exceptions are listed on the PASRR Level I form.

When are clients not eligible for long-term care under the fee-for-service program?

Clients covered under an agency-contracted MCO or Medicare are not eligible to receive payment under the long-term care fee-for-service program until rehabilitation or skilled nursing services authorized by the MCO or Medicare has ended.

Some Washington Apple Health clients are eligible for stays of 29 days or fewer, but are not eligible for periods longer than that because they do not meet the eligibility criteria for long-term care programs.

SNF services are not covered under the Alien Emergency Medical (AEM) program. ALTSA has a limited state-funded SNF program that requires a prior approval. Contact Sandy Spiegelberg at (360) 725- 2576 for more information.

Note: An award letter is issued to all clients who are eligible to receive institutional (Classic Apple Health) Medicaid and meet nursing facility level of care (NFLOC). An institutional benefits award letter does not guarantee payment for clients. Washington Apple Health is the payer of last resort. If there is another payer available, Apple Health will not pay.

Qualified-medical-beneficiary-only (QMB) clients

QMB-only clients are eligible for Medicare cost-sharing expenses under Medicare Part A, Part B, and Part C (except for Part C premiums and Part D costs). Maximum reimbursement under this program is subject to the limits established in WAC 182-502-0110 and WAC 182-517-0320.

Clients who are eligible under this program do not receive an institutional award letter. Eligibility for a QMB-only client can be verified by reviewing the following information:

- Agency QMB program approval letter
- ProviderOne for the QMB program (ACES coverage group S03)

QMB-only clients do not pay towards the cost of care, so nursing facilities must not collect participation for these clients.

Managed Care

What should the SNF do before admitting an MCO client from a hospital?

Before admitting a client from a hospital, the SNF must ask the hospital discharge planner which MCO (if any) authorized the hospitalization. The SNF must request authorization from an MCO for any admittance. The payer that was financially responsible for the client when the client was originally admitted to the hospital remains responsible for rehabilitation or skilled nursing services. This applies to any transfer of care from an MCO to another MCO, and to transfers from an MCO to fee-for-service.

What should the SNF do before admitting an MCO client from another SNF?

Before admitting a client from another SNF, the receiving SNF must ask the discharge planner at the other SNF which MCO authorized the stay in that SNF. The receiving SNF must bill the payer who authorized the first SNF stay.

Additionally, the SNF must contact the MCO for prior authorization (PA) before admitting the client.

How does the SNF admit a patient who is authorized for rehabilitation or skilled nursing services by an MCO?

It is essential that the SNF coordinate with both the hospital discharge planner and the MCO authorizing the rehabilitation or skilled nursing services. It is the hospital discharge planner or nursing facility intake staff's responsibility to contact the MCO for (PA) for a client being admitted or any time the client leaves the facility for more than twenty-four hours and is readmitted. The SNF must have an agreement with the MCO in order to receive payment. All billing for rehabilitation or skilled nursing services must be submitted to the MCO following the terms of their agreement.

The SNF must confirm PA with the MCO before admitting the client for rehabilitation or skilled nursing services. The MCO must indicate on the PA the number of rehabilitation or skilled nursing days that are approved. If additional days are needed, the SNF must coordinate this with the MCO. If additional days are not authorized, and the SNF believes that the client continues to meet criteria, the SNF may assist the client in filing an appeal with the MCO. At the time the request for additional days is denied, the SNF must determine if discharge to the community is appropriate. If ongoing services are needed, either in the SNF or in the community, the SNF must contact Home and Community Services (HCS) for an assessment.

> **Note:** A client's managed care plan may change at any time. However, the MCO that approved the initial hospitalization or placement remains responsible for the client's care, covered under the Apple Health contract, even if the client changes to another managed care plan after admission.

The SNF must request written confirmation from the MCO that services are authorized:

- Before the client is admitted to the SNF.
- If the facility is requesting additional rehabilitation or skilled-nursing services.

The MCO must provide the SNF with confirmation of a change in coverage when:

- The length of a previously authorized stay is being reduced.
- The client does not meet the MCO's rehabilitation or skilled-nursing criteria.

What happens if the client's status changes from rehabilitation to long-term-care services?

When an MCO client's status changes from rehabilitation to long-term-care services (sometimes called custodial care), the SNF must:

- For classic Medicaid clients: FAX a *Notice of Action – Adult Residential Services* form, DSHS 15-031, to DSHS at 855-635-8305. The form must include the date the client's status changed.

- For MAGI-based Medicaid clients:

  1. FAX a *Notice of Action – Adult Residential Services* form, DSHS 15-031, to the agency at 1-866-841-2267. The form must include the date the client's status changed.

  2. Following local protocols, request a nursing facility level of care (NFLOC) assessment through the Home and Community Services (HCS) social service intake process for a client who will be receiving long-term-care services. A NFLOC assessment must be in place to receive payment through fee-for-service. The payment start date for clients who meet NFLOC will be based on the date of the request for NFLOC.

  3. Submit to the agency a claim with the appropriate Medicaid patient class code and include the MCO's denial of authorization for rehabilitation or skilled-nursing services.

If the client needs services in the community, the SNF must request a social service assessment intake from HCS and coordinate with the MCO when discharge planning begins. The SNF must use the *Intake and Referral* form, DSHS 10-570, to request an assessment. The phone and FAX numbers for HCS social service intake are on the form.

The payer responsible for a continuous health event changes when the client is discharged to a home or homelike setting, or the client's status changes to long-term care (custodial care).

Example

> If MCO #1 is the payer at time of admittance, and the client changes to MCO #2 during a rehabilitation or skilled-nursing stay, MCO #1 remains responsible until rehabilitative skilled days end, at which time MCO #2 assumes financial responsibility for the client's covered benefits.

Even when room and board for long-term care is a fee-for-service carve out, the MCO remains financially responsible for all the client's other covered benefits.

When must the SNF notify the state of an admission or status change?

See the *Notice of Action – Adult Residential Services* form, DSHS 15-031 for instructions on how and when to notify the state of an admission, discharge, or status change. Instructions are printed on the back of the form.

For classic Medicaid clients

After a classic Medicaid client has been admitted to the SNF, the SNF must complete the *Notice of Action – Adult Residential Services* form, DSHS 15-031, by following the instructions on the back of the form, and fax the form to DSHS at 1-855-635-8305.

A01, A05, D01, D02, D26, G01, G02, G03, G95, G99, K01, K95, L01, L02, L21, L22, L95, L99, L04, L24, L31, L32, L41, L42, R03, S01, S02, S95, S99, S08

For MAGI-based Medicaid clients

After a MAGI-based Medicaid client has been admitted to the SNF, the SNF must complete a *Notice of Action – Adult Residential Services* form, DSHS 15-031, by following the instructions on the back of the form, and fax the form to the Health Care Authority Claims Processing—SNF Unit at 1-866-841-2267.

MAGI-based ACES coverage groups are: N01, N02, N03, N05, N10, N11, N13, N23, N31, and N33

Clients must continue to meet nursing facility level of care (NFLOC) in order to receive payment.

Note: Clients who are eligible for MAGI-based ACES coverage groups do not contribute towards the cost of care—SNFs do not need to collect participation for these clients.

When will DSHS/ALTSA issue an institutional benefits award letter?

For classic Medicaid clients not enrolled in managed care, DSHS/ALTSA issues an institutional benefits award letter to clients who have been approved for long-term care services if:

- ALTSA has approved payment for a short stay (fewer than 30 days in the facility).
- ALTSA has approved an institutional program.

Note: These approval letters are required for classic Medicaid clients only —they are not required for MAGI-based clients or QMB only cases.

For a classic Medicaid client who is not enrolled in managed care, there is no change in how to bill for a short stay or long-term care services coverage. Continue to follow existing processes for Medicare crossover claims or Medicaid fee-for-service claims for these clients.

When will DSHS not issue an institutional benefits award letter?

If the client is eligible to receive health care coverage in a MAGI program, regardless of setting, the client will **not** contribute to the cost of care and **no** institutional benefits award letter will be sent. However, for claims to pay, the SNF must request a NFLOC assessment for a MAGI client when:

- It is determined the client will likely no longer meet rehabilitation or skilled nursing criteria, or
- The client is not enrolled in managed care.

MAGI-based clients are identified in the ProviderOne client benefit inquiry screen with the following codes: N01, N02, N03, N04, N05, N10, N11, N13, and N23.

Note: Receipt of an award letter **does not guarantee payment** of the service if the client is enrolled in managed care, or has primary coverage under Medicare or other insurance.

Billing

How does the SNF complete the CMS-1500 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

How does the SNF bill if the client has other insurance?

Bill the other insurance before billing Medicaid—Medicaid is the payer of last resort. When billing Medicaid, state on the claim form that the SNF has already billed the other insurance.

Third-party liability is discussed on the agency's Coordination of Benefits Information for Medicaid Contracted Providers web page. Navigate to that page and select "Download a file on Cost Avoidance" for more information.

How does the SNF bill when a client is admitted and dies on the same day?

If a client is admitted and dies on the same day, use *Patient Status* 20 when billing this claim. This does not include when a client is admitted and discharged on the same day.

How does the SNF bill for a client who is discharged in a current month?

When discharging a client from the SNF, use the appropriate patient status code and enter the total number of units not including the discharge day.

Will the SNF be paid for the date of discharge?

No. The agency does not pay nursing facilities for the date of discharge (keep this in mind when entering total number of units).

How does the SNF bill for MAGI-based clients if no institutional benefits award letter is issued?

For MAGI-based clients enrolled in managed care, the SNF must bill the MCO. When the client does not meet rehabilitation or skilled nursing criteria with the MCO, the SNF must request a nursing facility level of care (NFLOC) assessment through the HCS intake process and bill HCA for the stay. NFLOC for MAGI clients must be verified prior to payment from the Health Care Authority (HCA). The SNF must bill ProviderOne with the appropriate patient class code and attach a copy of the MCO's letter stating that skilled nursing and rehabilitation have ended.

Bill fee-for-service for all other clients through ProviderOne with the appropriate patient class code.

How does the SNF bill for clients who are eligible for Medicare and Medicaid or who are QMB-only?

Bill Medicare first. If the SNF bills Medicaid for a class 24, 29 or 56 before the Medicare payment, the SNF will automatically receive a $0.00 reimbursement from Medicaid. If money is owed to the SNF on a class 24 claim after Medicare makes payment, the SNF must submit an adjustment form with the appropriate Medicare backup.

- If Medicare pays the claim, the SNF must bill the agency within 6 months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, the SNF must meet the agency's 365-day requirement for an initial claim.

Note: Patient class codes 29 and 56 are not entitled to secondary Medicaid payment.

Example:

The SNF bills the agency for Class Code 24 days and Medicare pays $150 per day. If the Medicaid rate is $165 per day, the SNF may submit a claim adjustment for $15 per day unless another insurer is liable for the difference. The SNF may not collect additional fee-for-service or Part C coinsurance costs from the client.

Note: Clients who are eligible under QMB only do not receive an institutional award letter.

For more details concerning Medicare crossover claims, see the agency's ProviderOne Billing and Resource Guide.

SNF providers enrolled to bill through Medicaid

All SNFs enrolled in the state's Medicaid program are required to bill Medicaid with class code 24 for Dual Medicare/Medicaid.

SNF providers not enrolled to bill through Medicaid

All SNFs not enrolled in the state's Medicaid program may submit claims with class code 56 for Qualified Medicare Beneficiaries (QMB) cost-sharing. The SNF must sign a limited purpose contract in order to submit these claims.

Medicare Advantage Plans (Part C)

The agency reimburses nursing facilities for Medicare Part C cost sharing expenses up to the maximum reimbursement limits established under WAC 182-502-0110 and WAC 182-517-0320.

In order to receive payment from the agency, the SNF must follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the agency. If the SNF bills Medicaid for a class 29 or 24 prior to Managed Medicare payment, Medicaid automatically pays a $0.00 reimbursement to the SNF.

> **Note:** Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C). The Managed Medicare – Medicare Advantage Plan is the primary payer and must be billed first.

After the Medicare Advantage plan processes the claim, if money is owed, the SNF must submit an adjustment form with the appropriate Managed Medicare – Medicare Advantage (Part C) EOB to DSHS. Bill the agency on the same claim form used to bill the Medicare Advantage plan. Make sure the services and billed amounts match what the SNF billed to the Medicare Advantage plan. Attach the Medicare Advantage EOB.

The agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

If Medicare denies a service that requires prior authorization (PA), the agency waives the PA requirement, but still requires some form of agency authorization based on medical necessity.

Billing for Managed Medicare – Medicare Advantage (Part C) Plans

In order to receive payment from the agency, follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the agency.

If there is a capitated copayment due on a claim:

Capitated copayments do not require the biller to submit an explanation of benefits (EOB); with the claim. Indicate "Managed Medicare capitated copayment" on billing forms as follows:

- UB-04 in box 80
- Direct data entry (DDE) submission

If there is coinsurance, a deductible, or a noncapitated copayment due on a claim:

If no balance is due for services provided, the agency pays the claim at zero.

If a balance is due for services provided:

- Bill all services, paid or denied, to the agency on one claim form, and attach an EOB.
- Indicate "Managed Medicare" on billing forms as follows:
  - ✓ UB-04 in box 80
  - ✓ Direct data entry (DDE) submission
- The agency will compare the allowed amount for DSHS and Managed Medicare – Medicare Advantage and select the lesser of the two. Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage

Billing for social leave

The agency pays for the first 18 days of social leave in a year. Report the client as still a client for these days. Do not discharge and readmit the client. After 18 days of social leave have been used, report discharge and readmission only if the client left the facility for at least a full 24-hour period. SNFs are required to notify DSHS of social or therapeutic leave in excess of 18 days per year through a *Notice of Action* (DSHS form 15-031).

Billing for hospice clients

If the client in a SNF is on hospice status, bill the hospice agency according to the instructions on the agency's Hospice Services Medicaid Provider Guide.

Changing a previously paid claim

If the SNF needs to make changes to claims for dates of service for which the agency has already paid, refer to the ProviderOne Billing and Resource Guide, Key Step 6 in the "Submit Fee-for-Service Claims to Medical Assistance" section.

Specialized nursing facility programs

Note: Authorization for a specialized SNF program does not replace all other requirements for admission or payment.

Expanded Community Services

Program overview

Expanded Community Services (ECS) is designed to provide enhanced behavior support services to clients who have either moved into a community setting after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs.

Contracted SNF providers

The ECS contract requires the SNF to either provide or contract for the Behavior Support Services offered by an ECS team that can meet the scope of the SNF ECS contract.

To request a contract, the SNF should contact the local Home and Community Services (HCS) Resource Support & Development Program Manager.

Authorization

Once contracted, a SNF is eligible to serve individuals identified by HCS as ECS eligible. In order to authorize services, the ECS coordinator needs the following information:

- Name of the contracted SNF that will be accepting the qualified client
- Name of qualified client
- Date of birth of qualified client

If approved, the SNF receives an ECS approval letter. The ECS approval letter is the SNF's authorization for payment of this service.

The SNF must contact the ECS coordinator when there has been a change in an ECS client's condition that could impact ECS eligibility or behavioral support needs. The notice must include the following information:

- Name of the contracted SNF that will be discharging the qualified client
- Name of qualified client
- Date of birth of qualified client

Payment

The SNF must use class code 50 in the value code column in the UB-04 claim form in order to receive a specialized payment for an ECS client.

Community Home Project

Program overview

The Community Home Project (CHP) is a specialized authorization to assist clients who reside in an inpatient hospital setting who are transitioning home. CHP provides services in a SNF that are not included in a daily rate and not payable through other means.

Services provided under this program are authorized for a limited duration of up to 90 days.

Authorization

Qualification is based on an HCS assessment and lack of other available funding or setting to support the service required.

The SNF must coordinate with HCS to request authorization. If approved, the SNF receives a CHP approval letter. The CHP approval letter is the SNF's authorization for payment of this service.

Payment

The SNF must use class code 60 in the value code column in the UB-04 claim form in order to receive a specialized payment for a CHP client.

Bariatric Nursing Home Pilot Program

WAC 182-531-1600

Program overview

The Bariatric Nursing Home Pilot Program is a short-term placement option for individuals with bariatric issues who are leaving hospitals and need of extensive therapy in a SNF.

Services provided under this program are authorized for a limited duration of up to 90 days.

Who qualifies?

The client must be Medicaid eligible, have a current assessment from HCS, and meet NFLOC. A client eligible for this service must meet the following criteria. The client:

- Has a history of hospitalizations related to bariatric issues.
- Is willing to actively participate in the intensive therapies and expectations of the Bariatric Nursing Home Pilot Program.
- Has a physician order stating that the client needs specialized bariatric Physical Therapy and Occupational Therapy in a SNF, and can tolerate the therapies.
- Has documentation that there is no other placement option at this time for the client.

Authorization

HCS and the SNF coordinate to submit a completed authorization request using form HCA 13-785. The request must list services and cost calculations, and must include a treatment plan for the client.

If approved, HCS will send the SNF an approval letter. The approval letter is the SNF's authorization for payment of this service.

Payment

The SNF must use revenue code 169 in the revenue code column in the UB-04 claim form in order to receive a specialized payment for a client.

Vent-trach program

Program overview

The Vent-Trach program is designed to maintain quality of life for ventilator-dependent clients who reside in a facility with a specialized Vent-Trach unit. The facility must have a contract with ALTSA to provide these specialized services.

Wrap Around Services for Vent-Trach Clients

SNFs that have a contracted vent-trach unit, receive a wrap-around payment for the services required by clients in these units. The payer responsible for r room and board costs makes this payment.

Respiratory services

The state requires contracted vent-trach facilities to contract with Advanced Lifeline Services (ALS) to provide respiratory therapy services, supplies and equipment. The payer responsible for room and board costs makes this payment.

Payment

Facilities must use procedure code 94799 in box 24D of the CMS-1500 claim form to receive a specialized payment for a client.

Non-citizen's long-term care program

Program overview

The Non-Citizen's Long-Term Care (NCLTC) Program is a state-funded program that provides the categorically needy scope of medical coverage for qualified aliens who are not eligible for any other service due to their citizenship or alien status.

Who qualifies?

The client must be an undocumented alien, which means they are not legally present in the United States and will never be eligible for state medical care services or federal Medicaid unless there is documentation that their Immigration and Naturalization Service (INS) status has changed to "legally admitted." Clients must meet the additional eligibility criteria in WAC 182-503-0505(2) and (3)(a,b,e,f), including:

- Be ineligible for federally-funded or matched programs;
- Be at least 19 years of age;
- Meet NFLOC requirements (WAC 388-106-0355); and
- Be considered a resident of Washington State.

Authorization

Clients may not be enrolled in this program without authorization from DSHS' Aging and Long-term Services Administration (ALTSA) Residential Services Program Manager. Authorization is required prior to the client's admission. Contact Sandy Spiegelberg at (360) 725- 2576 for more information. A SNF authorization in the NCLTC Program is coded as L04.

Note: Providers must have authorization before admitting a client to the NCLTC program. There are limited spaces available in this program.

Payment

Facilities must use class code 45 in the value code column in the UB-04 claim form in order to receive a specialized payment under this program.

Where on the UB-04 claim form do I enter patient participation?

"Patient participation" refers to the amount a client is responsible to pay each month toward the total cost of long term care services they receive. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

Enter the client patient participation amount into boxes 39-41 using value code 31; do not enter it into box 57. These funds must be contributed toward the patient's cost of care.

The SNF cannot collect participation from an agency client when billing for patient class codes 24, 29, 55, or MAGI-based clients.

The agency cannot reduce a Medicaid client's participation liability using unpaid Part C copayment or coinsurance charges if the Medicare payment exceeds the maximum reimbursement that is allowed under Medicaid.

The agency does not calculate participation for QMB-only clients. These clients are not required to contribute toward the cost of care while in the SNF.

Where on the UB-04 claim form do I enter the spenddown amount?

"Spenddown" means the process by which a person uses incurred medical expenses to offset income, resources, or both to meet the financial standards established by the agency. See WAC 182-519-0110.

Enter the client spenddown amount into boxes 39-41 using value code 66; do not enter it into box 57.

Completing the UB-04 claim form

Providers may access online webinars demonstrating how to submit institutional fee-for-service claims using direct data entry and how to upload a HIPAA batch file.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee.

The following instructions are specific to nursing facilities. Bill only dates of service for which the client is eligible.

Box	Name	Entry
1	Provider Name, Address & Telephone Number	Enter the provider name, address, and telephone number as filed with the agency.
4	Type of Bill	Enter: a. 0211 for claims; b. 0217 for adjustments, resubmit denied claim; and c. 0218 for voids.
6	Statement Covers Period	Enter the beginning and ending dates of service for the period covered by this bill.
8.a	Patient ID Number	Enter the client's ProviderOne *Client ID* if different from the subscriber/insured's ID.
8.b	Patient Name	Enter the client's last name, first name, and middle initial as shown on the client's Services Card.
9	Patient Address	Enter the client's address.
10	Patient Birthdate	Enter the client's birthdate (MMDDYYYY).
11	Patient Sex	Enter the client's sex (M or F).
12	Admission Date	Enter the client's admission date (MMDDYYYY).
14	Priority (Type) of Visit	The priority (type) of admission. Enter: a. 1 for Emergency b. 2 for Urgent c. 3 for Elective d. 5 for Trauma
15	Admission Source	The source of admission. Enter: a. 1 for Physician Referral b. 2 for Clinic Referral c. 3 for HMO Referral d. 4 for Transfer from a Hospital

Box	Name	Entry
		e. 5 for Transfer from a Skilled nursing facility f. 7 for Emergency Room g. A for Transfer from a Critical Access Hospital
17	Discharge Status/Patient Status	Enter a valid *Patient Status* code to represent the disposition of the patient's status.
39-41	Value Codes and Amounts	The following Value Codes are required to process nursing facility claims: Value Code 24 – Enter this code in the *code* field with the Patient Class immediately following in the *amount* field. See Patient Class codes. (e.g., 20.00= patient class code 20) Value Code 31 – Enter this code in the *code* field with the Patient Participation amount for the entire month immediately following in the *amount* field. Value Code 66 – Enter this code in the code field with the entire Patient Spenddown Amount immediately following in the *amount* field.
42	Revenue Code	Enter revenue code 0190.
43	Revenue Descriptions (Procedure Descriptions)	(Required for Paper Only) The description of the related revenue code. Abbreviations may be used.
44	HCPCS/Rates	Enter NF daily rate.
45	Service Date	Same as box 6.
46	Units of Service	Enter the number of days. Do not include the date of discharge.
47	Total Charges	Equals the amount in box 44 multiplied by the amount in box 46.
48	Non-Covered Charges	Any charges not covered by the agency.
50	Payer Identification: A/B/C	All health insurance benefits available. 50A: Enter Primary Payer. 50B: Enter the name of the Secondary Payer (e.g., Medicaid, Medicare, Aetna, etc.), if applicable. 50C: Enter the name of the Tertiary Payer, if applicable.
54	Prior Payments: A/B/C	The amount due or received from all insurances. Do not

Box	Name	Entry
		include participation amount here. 54A: Any prior payments from payer listed in box 50A. 54B: Any prior payments from payer listed in box 50B. 54C: Any prior payments from payer listed in box 50C.
55	Estimated Amount Due	Expected Medicaid payment
58	Insured's Name: A/B/C	The insured's name if other insurance benefits are available and coverage is under another name.
60	Insured's Unique ID: A/B/C	Enter the unique number assigned by the health plan to the insured (following A/B/C for boxes 50-55). For the line represented by Medicaid, enter the ProviderOne Client ID exactly as displayed in ProviderOne.
69	Admitting Diagnosis Code	The ICD diagnosis code provided at the time of admission as stated by the physician.
76*	Attending Provider	The attending provider's national provider identifier (NPI)

∗ The attending provider's NPI must be known in ProviderOne.

Patient class code

Enter Value Code 24 with the appropriate patient class code (see table below) in box 39-41 on the UB-04 claim form.

Patient Class Code
20: NF
23: IMR-Title XIX Eligible
24: Dual Medicare/Medicaid
26: Swing Bed
27: IMR-non eligible for Title XIX
29: Full Medicare
40: Exceptional Therapy Care
45: Non-Citizen's Long-Term Care (NCLTC) Program
50: Behavioral support
54: Specialized Behavior Support – Level 1
55: Rehabilitation with Managed Medicaid (Managed Care MCO)
56: QMB Cost Sharing (Non-Medicaid contracted)
60: Community Home Project
62: Department Of Corrections
63: Traumatic Brain Injury

Patient status codes

Enter the appropriate patient status code from the table below in box 22 on the UB-04 claim form.

CMS Patient Status Code	Description
01	Home or Self Care
02	To hospital
03	To skilled nursing facility
04	To ICF (Intermediate Care Facility) / Custodial or Supportive Care
05	Discharged/Transferred to a designated cancer center or children's hospital
06	To Home for Home Care Services
07	Left Against Medical Advice
09	Admitted as an Inpatient to this hospital
20	Expired (also use when a patient is admitted and dies on the same day)
30	Still a patient
50	Hospice/Home
51	Hospice/Medical facility
70	To another type of institution

Admission date

If the client is being admitted to a SNF from an inpatient setting, the SNF must use the date of admission to the hospital as the admission date for its SNF claim.

If the client is being admitted to a SNF from a home or community setting, the SNF must use the date of admission to the SNF as the admission date for its SNF claim.

Revenue code

Bill SNF claims using revenue code **0190** (Subacute Care General Classification) in box 42 on the UB-04 claim form.

Medical Coverage Group Desk Tool

Program Category	ACES	Description	Scope	HCB Waiver	CFC	MPC	SNF short stay [b] (if not managed care)	Institutional [b] 30 days or more
SSI and SSI-related (non-institutional) ABD category Disability is determined by SSA, or by NGMA referral to DDDS	**S01**	SSI Recipients Categorically Needy (CN)	CN		a	x	x	
	S02	SSI-related	CN		a	x	x	
	S03	QMB Medicare Savings Program (MSP). Medicare premiums, copayments, coinsurance, deductibles.	MSP				Pays Medicare co-insurance days as a claim if QMB only. No application required for SNF if co-insurance days only & no other service is needed. Instructions in SNF billing guide.	
	S04	Qualified disabled working individual (QDWI). Medicare Part A premiums.	MSP					
	S05	Specific low-income Medicare beneficiary (SLMB). Medicare Part B premiums.	MSP					
	S06	Qualified individual (QI-1). Medicare Part B premiums.	MSP					
	S07	SSI-related Alien Emergency Medical (AEM). Emergency Related Service Only (ERSO).	ERSO					Hospital, cancer, or end stage renal
	S95	SSI-related Medically Needy (MN) no spenddown	MN				x	
	S99	SSI-related with spenddown	MN				If SD met	
SSI-related (non-institutional) Living in an alternate living facility (ALF) - AFH,	**G03**	Income under the SIL & under state rate x 31 days + $38.84. Used for MPC and BHO placements.	CN		a	x		
	G95	ALF private pay no spenddown. Income under the SIL, and under the private rate	MN				x	

Program Category	ACES	Description	Scope	HCB Waiver	CFC	MPC	SNF short stay [b] (if not managed care)	Institutional [b] 30 days or more
AL or DDA group home.	**G99**	ALF private pay with spenddown. Income under the SIL, but over the private rate.	MN				If SD met	
SSI-related (non-institutional) Healthcare for Workers with Disabilities (HWD)	**S08**	Premium based program. Substantial Gainful Activity (SGA) not a factor in disability determination.	CN	x	x	x	x	
HCB Waiver (institutional) SSI or SSI-related 1915(c) waivers authorized by HCS or DDA	**L21**	SSI recipients	CN	x	x		x	
	L22	SSI-related. DDA – income at or below special income level (SIL). HCS – income ≤ effective MNIL after deducting state SNF rate.	CN	x	x		x	
	L24	Undocumented Alien / Non-Citizen LTC. Must be preapproved by HCS (Sandy Spiegelberg). State-funded CN (SFCN) scope. Community component of 45-slot program.	SFCN	State-funded personal care based on MPC criteria. Financial Eligibility based on HCB Waiver rules. If in SNF 30 days or more, changed to L04 program. In home or state funded services in an AFH or ARC				
SSI and SSI-related (non-institutional) PACE or Hospice	**L31**	Effective 10/01/2015. SSI recipient on PACE; or SSI recipient in institution on hospice	CN				SNF services included in PACE. Hospice services provided in institutions.	
	L32	Effective 10/01/2015. SSI-related PACE or hospice as a program. PACE is managed care (no CFC or HCB waiver with PACE). CFC or HCB waiver with hospice only. Hospice + HCB waiver will trickle to L22 as priority program.	CN	x	x		SNF services included in PACE Hospice services provided in institutions.	
SSI and SSI-related Roads to Community Living	**L41**	Effective 10/01/2015. SSI recipient on RCL.	CN				x	

Program Category	ACES	Description	Scope	HCB Waiver	CFC	MPC	SNF short stay [b] (if not managed care)	Institutional [b] 30 days or more
(RCL)	**L42**	Effective 10/01/2015. SSI-related RCL. 365 day medical upon approval by social services. Must be receiving Medicaid on day of institutional discharge.	CN				x	
SSI and SSI-related Community First Choice (CFC)	**L51**	Effective 10/01/2015. SSI recipient on CFC.	CN		x		x	
	L52	Effective 10/01/2015. SSI-related CFC. L52 includes S02 and G03 eligibility rules with spousal impoverishment considerations.	CN		x		x	
SSI and SSI-related (institutional) In a medical institution for 30 days or more	**L01**	SSI recipient	CN					x
	L02	SSI-related. Income under the SIL.	CN					x
	L04	Undocumented Alien / Non-Citizen LTC. Must be preapproved by HCS (Sandy Spiegelberg). (institutional component of 45-slot program)	SFCN					x
	L95	SSI-related no spenddown Income over the SIL, but less than the state rate.	MN					x
	L99	SSI-related with spenddown Income over the SIL and the state rate, but under the private rate. Client participation locked to state rate.	MN					Eligible for services, but client pays all cost of care
MAGI (institutional) Only used for individuals not eligible under non-institutional MAGI	**K01**	Categorically Needy Family in Medical Institution	CN					x
	K03	AEM Family in Medical Institution.	ERSO					Hospital, cancer or end stage renal.
	K95	Family LTC Medically Needy no Spenddown in Medical Institution	MN					x

Program Category	ACES	Description	Scope	HCB Waiver	CFC	MPC	SNF short stay [b] (if not managed care)	Institutional [b] 30 days or more
	K99	Family LTC Medically Needy with Spenddown in Medical Institution	MN					If SD met
Pregnancy/Family Planning	**P02**	Pregnant 185 FPL & Postpartum Extension	CN					
	P04	Undocumented Alien Pregnant Woman	CN					
	P05	Family Planning (FP) Service	FP					
	P06	Take Charge	FP					
	P99	Pregnant Women & Postpartum Extension	MN				If SD met	
Refugee	**R03**	Refugee Categorically Needy	CN					
Foster Care/JRA	**D01**	SSI Recipient FC/AS/JRA Categorically Needy	CN	x	x	x	x	
	D02	FC/AS/JRA Categorically Needy	CN	x*	x	x	x	
	D26	Title IV-E federal foster care – under 26	CN	x*	x	x	x	
MAGI	**N01**	Parent / caretaker	CN		x	x	Pays as a claim (no award letter)	
	N02	12 month transitional parent / caretaker	CN		x	x		
	N03	Pregnancy	CN		x	x		
	N05	Adult alternative benefit plan (ABP) (age 19-64)	ABP		x	x		
	N10	Newborn medical birth to one year	CN		x	x		
	N11	Children's (age under 19)	CN		x	x		
	N13	Children's Health Insurance Program (CHIP) (age under 19)	CN		c	x		
	N21	AEM parent / caretaker	ERSO					Hospital, cancer

Program Category	ACES	Description	Scope	HCB Waiver	CFC	MPC	SNF short stay [b] (if not managed care)	Institutional [b] 30 days or more
								or end stage renal
	N23	Pregnancy; not lawfully present	CN			x	Pays as a claim (no award letter)	
	N25	AEM (age 19-64)	ERSO					Hospital, cancer or end stage renal
	N31	Non-citizen children's (age under 19)	SFCN			x**	Pays as a claim (no award letter)	
	N33	Non-citizen CHIP (age under 19)	SFCN		x**	x**		
Medical Care Services (MCS) Medical eligibility through eligibility for HEN or ABD Cash	**A01**	ABD legally admitted persons in their 5-year bar or otherwise ineligible due to their immigration status. LTSS include state-funded residential and SNF.	MCS			x**	x	x
	A05	Incapacitated legally admitted persons in their 5-year bar or otherwise ineligible due to their immigration status. LTSS include state-funded residential and SNF.	MCS			x**	x	x
Breast and Cervical Cancer program	**S30**	Breast and Cervical Cancer (Health Department approval)	CN		x	x		

This is a desk tool used by Aging and Long Term Supports Administration (ALTSA) field staff that has all the medical coverage groups/programs in Washington and what Home and Community Service can be authorized under that medical program if functionally eligible.

x – Service is covered under the medical coverage group

a – Effective 10/01/2015, this is provided under L52

b – All SNF admissions for skilled or rehabilitation are the responsibility of the managed care entity if enrolled and must be pre-approved by the managed care plan

c – CHIP is Title XXI, and not eligible for Title XIX CFC. There will be a "CFC look-alike" service for Title XXI eligible individuals

***** Must have disability, resource, and income determination for HCB Waiver services. (HCB Waiver services can be used for individuals on cash assistance or foster care as long as a disability determination has been established and the financial worker must keep the assistance unit (AU) as a foster care AU. Until cash assistance is de-linked from the medical assistance, the cash AU must be used in ACES.

** State funded

Acronym	Definition
ABP	Alternative Benefit Plan
Classic	Medicaid programs that are not determined by the Health Benefit Exchange. These programs did not change with the Affordable Care Act (ACA). Classic programs are those who are age 65 or older and those under age 65 who are disabled or blind and not on Medicare. It also includes foster care medical, institutional, Home and Community Based (HCB) Waivers.
CN	Categorically Needy
ERSO	Emergency Related Services Only for Alien Emergency Medical (AEM)
FP	Family planning service
MAGI	Modified Adjusted Gross Income
MCS	Medical Care Services (state-funded medical assistance)
MN	Medically Needy
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
SNF	Nursing Facility
SD	Spenddown
SF	State-funded
SFCN	State-funded with state funded CN scope of care
WAH	Washington Apple Health. This general term is used for all medical coverage including MAGI, Classic Medicaid, MCS, Institutional and HCB Waiver medical.

MAGI-based medical programs are under the N track. N track with the exception of N21 and N25 cover SNF. All N track programs are done by the Health Benefit Exchange. These medical programs are NOT maintained by DSHS. Most MAGI-based clients are enrolled into an AH MCO plan the first of the month following the Medicaid opening. The AH MCO is responsible for pre-approved SNF rehabilitation and skilled nursing services. SNF fee- for- service is billed when WA MCO skilled nursing or rehabilitation days have ended.

- Classic Medicaid programs are for the Aged, Blind and Disabled. Institutional Medicaid programs are considered a Classic Medicaid program. Foster care medical is also considered Classic Medicaid

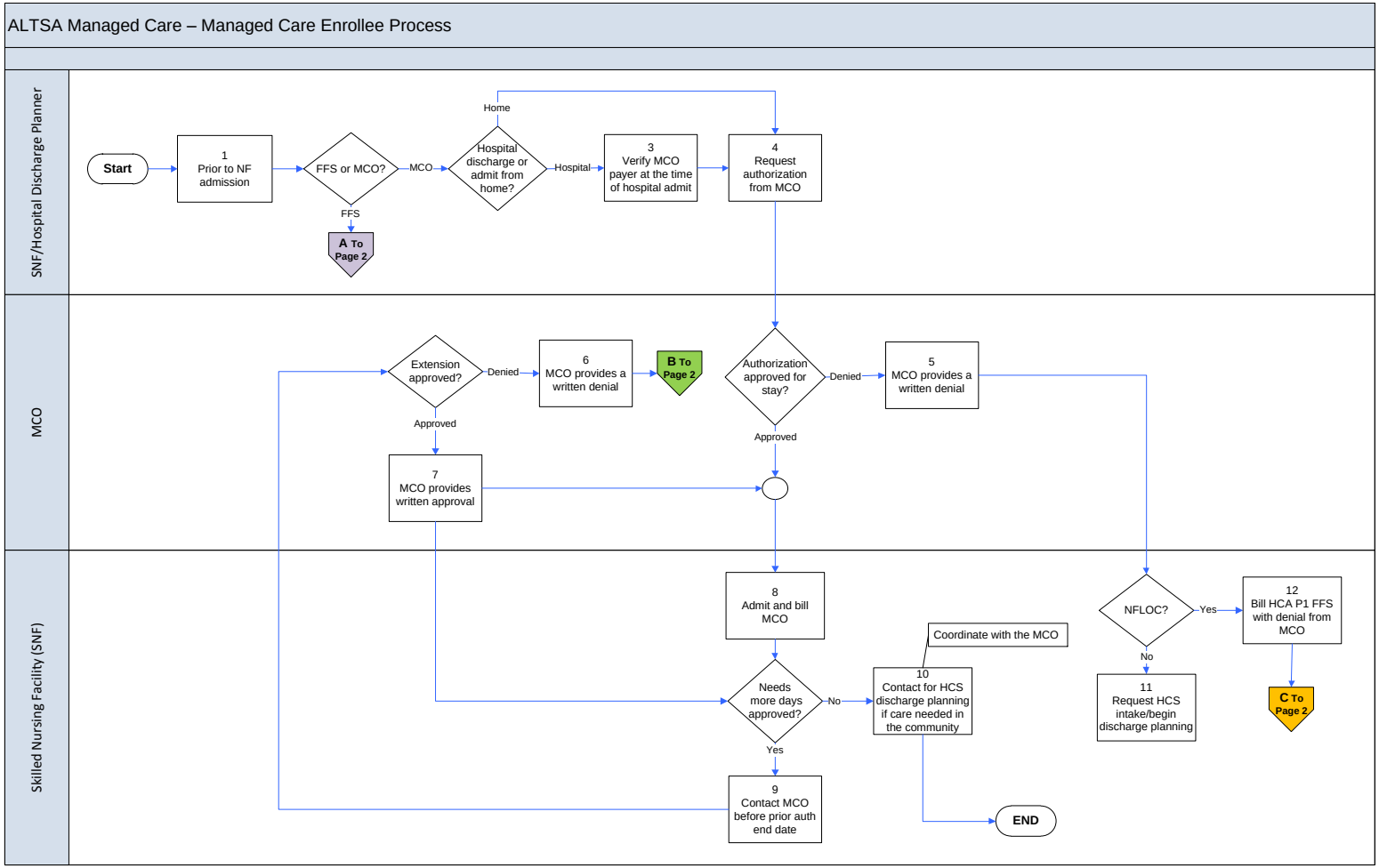
- Institutional Medicaid programs are under the L track and K track. The L track programs include those that are residing in a medical institution 30 days or more, Home and Community Based Waiver programs and Hospice. (Definition of institutional 182-513-1320). All institutional Medicaid programs have 2 parts to eligibility, initial and post eligibility treatment of income (PETI). The PETI calculation determines how much clients may need to pay toward their cost of care. All clients on an institutional program are subject to participation depending on their income and deductions.

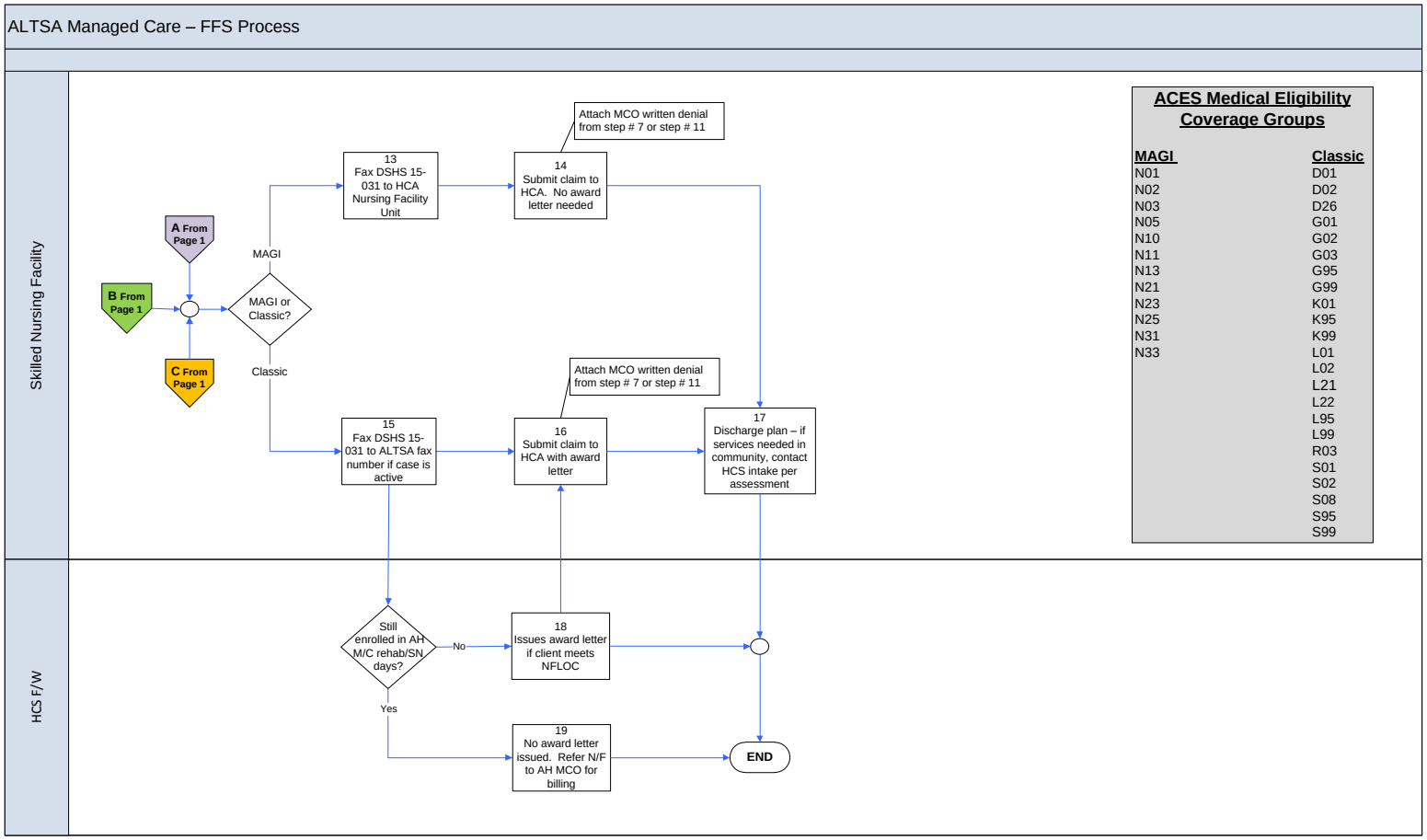
- For NON- MAGI-based clients that are on a non-institutional Classic Medicaid program, there is a requirement to do a redetermination under institutional Medicaid rules once a client is considered "institutionalized" or residing in an institution 30 days or more. When this redetermination is completed, the system will issue a new award letter showing the maximum participation a client must pay. This award letter DOES NOT MEAN a client enrolled under Washington Apple Health Managed Care is under FFS SNF. It means the client has been determined eligible for an institutional Medicaid program. For ALL Medicaid programs, if there is a primary coverage such as Medicare, insurance, LTC insurance or WA MCO coverage that is responsible for payment first because the client is in rehabilitation status, that entity is responsible for payment, not FFS-SNF. Medicaid FFS is the payer of last resort.

Description of MAGI groups paid as a SNF fee for service claim after WA MCO Rehabilitation days has ended	**Scope**	**RAC**	**ACES**
MAGI parent/caretaker Medicaid; adult	CN	1197	N01
12 month transitional MAGI parent/caretaker adult	CN	1198	N02
MAGI Pregnancy	CN	1199 and 1200	N03
MAGI adult Medicaid; income =<133% (Medicaid Expansion)	ABP	1201	N05
MAGI Newborn Medical birth to one year	CN	1202	N10

MAGI Children's Medicaid/age under 19,	CN	1203, 1204 and 1205	N11
MAGI Children's Health Insurance Program (CHIP) Children under 19; premium payment program	CN	1206 and 1207	N13
Non-citizen pregnant Covered under CHIPRA	CN	1209	N23

Managed care billing flow chart




ALTSA Managed Care – FFS Process
Skilled Nursing Facility
HCS F/W
A From Page 1
B From Page 1
C From Page 1
MAGI or Classic?
MAGI
Classic
13 Fax DSHS 15-031 to HCA Nursing Facility Unit
14 Submit claim to HCA. No award letter needed
Attach MCO written denial from step # 7 or step # 11
15 Fax DSHS 15-031 to ALTSA fax number if case is active
16 Submit claim to HCA with award letter
Attach MCO written denial from step # 7 or step # 11
17 Discharge plan – if services needed in community, contact HCS intake per assessment
Still enrolled in AH M/C rehab/SN days?
No
Yes
18 Issues award letter if client meets NFLOC
19 No award letter issued. Refer N/F to AH MCO for billing
END
ACES Medical Eligibility Coverage Groups
MAGI
N01
N02
N03
N05
N10
N11
N13
N21
N23
N25
N31
N33
Classic
D01
D02
D26
G01
G02
G03
G95
G99
K01
K95
K99
L01
L02
L21
L22
L95
L99
R03
S01
S02
S08
S95
S99