Washington State Health Care Authority

Washington Apple Health (Medicaid)

Nursing Facilities Billing Guide

July 1, 2023

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2023** and supersedes earlier billing guides to this program.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, visit the HCA website.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Provider Resources	Added Nursing Facility Level of Care (NFLOC) related inquiries and associated email to contact.	Updated information
Who is eligible for Skilled Nursing Facility (SNF) services	Added note box to clarify prior authorization requirements for existing SNF clients who are away from the SNF facility for a short period for outpatient procedures or ER/observation. Clients may return to their current facility without the requirement of a new authorization. Inpatient admission will require a new prior authorization request.	Clarification of prior authorization requirements for existing SNF clients.
When are clients not eligible for long-term care under the fee-for-service program	Added new contact name and email for inquiries about state-funded non-citizen skilled nursing facility programs that require prior approval.	Updated contact information

Subject	Change	Reason for Change
When is an institutional award letter not issued	Added bullet "The client is already an NFLOC resident and receives outpatient services or ER/observation level of care services at the hospital."	Clarification that an award letter is not issued for an existing NFLOC resident receiving outpatient care at the hospital.
Patient class code – 62 EBS Plus (Behavioral Support Plus)	Changed language from "NF Rate flat rate of $425" to "NH patient class code 20 daily rate plus $175."	To align with industry standards of an add-on rate rather than a flat rate for contracted facilities.
Patient class code – 63 ECS Respite (Behavioral support respite)	Changed language from "NF Rate flat rate respite bed of $425" to "NH patient class code 20 daily rate plus $175."	To align with industry standards of an add-on rate rather than a flat rate for contracted facilities.
Patient class code – 66 Ventilator	Changed language from "designated calculated rate" to "$192."	To reflect a standard increase to a higher rate across contract facilities.
Patient class code – 67 Tracheotomy	Changed language from "designated calculated rate" to "$123."	To reflect a standard increase to a higher rate across contract facilities.

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Self-Service Provider Resources

Department of Social and Health Services (DSHS)

I have a question about:	Contact:
Becoming a provider or submitting a change of address or ownership	Aging and Long-Term Support Administration Business Analysis and Applications Unit (BAAU) 360-725-2573 or baau@dshs.wa.gov
Questions about what is included in the nursing facility per diem, or general rate	Aging and Long-Term Support Administration (ALTSA) Office of Rates Management 360-725-2448 or nfrates@dshs.wa.gov
Prospective ALTSA payment rates	See ALTSA's Nursing Facility Rates and Reports page and WAC 388-96-704
Department of Social and Health Services (DSHS) nursing facilities form	• Electronic DSHS Forms • Nursing Facility Notice of Action (DSHS 15-031) form • Intake and Referral (DSHS 10-570) form
Find a local HCS office, questions about client responsibility amounts, and LTC award letter	See the ALTSA Contact Information page See the Find Local Services, Information and Resources for the HCS office in each county See the DSHS Regional Map – Contact Information Nursing Facility Case Management.
Community Services Office	Department of Social and Health Services Community Services Office Customer Connection 1-877-501-2233
State-funded non-citizen long-term care (LTC)	See HCA's State-funded non-citizen long-term care webpage for more information or contact Emily Watts at Emily.Watts1@dshs.wa.gov.
Contracted skilled nursing facility/requesting a contract	Contact the HCS Systems Change Specialist at Julie.cope@dshs.wa.gov

Health Care Authority (HCA)

I have a question about:	Contact:
Coordination of benefits for clients with private insurance and Medicaid as secondary insurance; questions about payments on remittance advice, hospice claims, and bariatric beds	Medical Assistance Customer Service Center (MACSC) 1-800-562-3022 Contact Web Form
Questions about payments, denials, claims processing, claim appeal requests, service complaints, or vent trach claims	Nursing Home Claims of Health Care Authority 1-800-562-3022 ext. 16820 HCANursingHomeClaims@hca.wa.gov
Finding HCA documents such as billing guides and fee schedules	See HCA's Billers, providers, and partners webpage. See the Webinar's webpage for additional training.

Managed Care Organization (MCO)

I have a questions about:	Contact:
Contacting the managed care organizations (MCO), MCO prior authorization, MCO approval/denial letters, MCO payments	• Amerigroup Washington, Inc. (AMG) Provider line: 1-800-454-3730 • Community Health Plan of Washington (CHPW) Provider line: 1-800-440-1561 • Coordinated Care of Washington (CCW) Provider line: 1-877-644-4613 • Molina Healthcare of Washington, Inc. (MHC) Provider line: 1-800-869-7175 • United Healthcare Community Plan (UHC) Provider line: 1-877-542-9231

Provider Resources

I have a question about:	Contact:
Reported record of ProviderOne issues	ProviderOne Discovery Log

I have a question about:	Contact:
ProviderOne access, password issues, new users, and administrator replacement	ProviderOne Security
Questions on electronic/paper claim billing or ProviderOne submission issues	• Billers and Providers webpage • ProviderOne Billing and Resource Guide • ProviderOne Webinars • Direct Data Entry of an Institutional Claim webinar • Submit Nursing Home Institutional Claims Using Templates webinar
Attaching backup to claims, cover sheet for backup guide/ECB	• ProviderOne Billing and Resource Guide • Document submission cover sheets
Checking claim status using the IVR (Interactive Voice Response)	See the ProviderOne Billing and Resource Guide
Eligibility Checks in ProviderOne system	See the ProviderOne Billing and Resource Guide
Medicare crossover claim payment methodology	See the ProviderOne Billing and Resource Guide
ProviderOne Fact Sheets	ProviderOne Fact Sheets
National Health Care Provider Taxonomy, Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC)	Washington Publishing Company webpage
ALTSA provider update alerts	See the ALTSA listserv page
Nursing facility rates for ALTSA payments	See WAC 388-96-704
Electronic billing	See HCA's Billers, Providers, and Partners webpage. See the Webinars webpage for additional training.
Nursing Facility Level of Care (NFLOC) related inquiries	NFLOCResolution@dshs.wa.gov

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a list of definitions for Washington Apple Health and WAC 182-513-1100 for definitions for long-term services and supports (LTSS).

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, with limitations.

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

Record – Dated reports supporting claims submitted to HCA 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.

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

Skilled Care* – Skilled care in a nursing facility is care provided by trained individuals (registered nurses, physical therapists, occupational therapists, speech therapists, or respiratory therapists) and typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (rehabilitation, for example) or due to chronic or acute medical conditions or disabilities. **

Skilled care is:

- Rehabilitative: Care provided for or after an acute illness or injury with the intent of restoring or improving lost or impaired skills or functions.
- Skilled medical: Care provided daily and includes, but not limited to, intravenous therapy, intramuscular injections, indwelling and suprapubic catheters, tube feeding, total parenteral nutrition, respiratory therapy, or wound care.

*Any services or equipment reimbursed as skilled care is unallowable on the Medicaid cost report.

** Once improvement is no longer evident, it is no longer covered under the rehabilitative/skilled care benefit.

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About the Program

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 Apple Health clients. The NF billing process for clients was developed by the Aging and Long-Term Support Administration (ALTSA) and HCA. See **chapter 74.46 RCW** (Nursing Facility Medicaid Payment System) and **Title 71A RCW** (Developmental Disabilities) for further information.

When does HCA pay for services?

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

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Client Eligibility

Most Apple Health clients are enrolled in HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older, or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Backdated eligibility

Financial institutional eligibility may be backdated up to three months before the date of application as long as the client is otherwise eligible. As soon as it is determined that a current resident will likely need custodial care funded by the state and the resident begins the application for Apple Health, the SNF must request a NFLOC assessment to verify functional eligibility by faxing a completed Intake and Referral (**DSHS 10-570**) form to DSHS/Home and Community Services (HCS). The fax number is located on the form by region.

Note: Program eligibility for hospice **cannot** be backdated to more than five business days before HCA's receipt of the *HCA/Medicaid Hospice Notification* (**HCA 13-746**) form.

Who is eligible for Skilled Nursing Facility (SNF) Services?

The implementation of the Affordable Care Act and the expansion of Washington Apple Health means eligibility for skilled nursing facility (SNF) care has changed. Clients in certain ACES (Automated Client Eligibility System) coverage groups are eligible for SNF care, and the SNF can bill for that care when all other billing criteria are met.

Nursing facilities must always verify that a patient has Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. The coverage groups eligible for SNF care are identified in the **ProviderOne Billing and Resource Guide, Section 3 and Appendix E.**

If the payer is an HCA-contracted MCO (see Managed Care), the SNF must obtain prior authorization from the MCO before admission.

Clients enrolled in state-funded medical care service programs (A01, A05, and A24) are not enrolled in an HCA-contracted MCO; this is a state-funded Medical Care Services (MCS) program. A pre-approval by Home and Community Services (HCS) before admission is not required as long as the client meets nursing facility level of care (NFLOC). An award letter is not required when billing for A01, A05, and A24. Submit an *Intake Request* (**DSHS 10-570**) form to HCS for a determination of NFLOC. The fax number is located on the form.

> **Note:** State-funded long-term care coverage for non-citizens program. Coverage groups L04 and K03 require a pre-approval by ALTSA.

An award letter is issued to all clients who are eligible to receive institutional Aged, have a Blindness, or a Disability (non-MAGI) Apple Health and meet nursing facility level of care (NFLOC). An institutional benefits award letter does not guarantee payment for clients. Apple Health is the payer of last resort if there is another payer available.

> **Note:** Clients who need to be briefly treated for an outpatient procedure (e.g., endoscopy) or receive ER/observation level of care (e.g., rule out chest pain) and are already accepted and receiving SNF level of care services may return to their current facility without the requirement of a new authorization. Days should be adjusted accordingly for billing purposes if the client is away more than 24 hours in an ER/observation level of care. Inpatient admission will require a new prior authorization request.

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

(WAC 182-507-0125)

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

Some 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) (non-citizen) program. ALTSA has a limited state-funded non-citizen SNF program that requires prior approval. Contact Emily Watts at Emily.Watts1@dshs.wa.gov for more information.

Award letter

When is an institutional benefits award letter issued?

An institutional benefits award letter is issued by DSHS to clients who have been verified eligible and approved for long-term care services.

The institutional benefits award letters (approval letters) are required for non-MAGI (SSI-related) Medicaid clients only. They are not required for MAGI-based clients or QMB only cases. See the **ProviderOne Billing and Resource Guide** for a list of the ACES program codes.

Award letters are sent to the provider mailing address listed in ProviderOne. (See **Resource table DSHS LTC award letter**).

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 primary health insurance.

Medically fragile children who are Washington residents and placed in the Providence Child Center in Portland, Oregon, do not require a NFLOC assessment by DSHS staff for payment. Children placed in this facility meet NFLOC. All other billing conditions apply.

> **Note:** The skilled nursing facility (SNF) must bill under QMB-only with no award letter. An award letter may exist for the client's Medicaid coverage but is not necessary for Medicare days in the SNF. (Patient Class Codes 24, 29, 56)

When is an institutional award letter not issued?

If the client is eligible to receive health care coverage in a Medical Care Services (MCS) or 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 be paid, the skilled nursing facility (SNF) must request a NFLOC assessment for MCS or MAGI client when:

- It is determined the client will likely no longer meet rehabilitation or skilled nursing criteria;
- The client is not enrolled in managed care; or
- The client is already an NFLOC resident and receives outpatient services or ER/observation level of care services at the hospital.

Both MCS and MAGI-based clients are identified in the ProviderOne client benefit inquiry screen with the appropriate ACES program code.

Medically fragile children who are Washington residents and placed in the Providence Child Center in Portland, Oregon do not require a NFLOC assessment by DSHS staff for payment. Children placed in this facility meet NFLOC. All other billing conditions apply.

Provider Responsibilities

Are providers responsible to verify a client's coverage?

Yes. Providers must verify the client's eligibility in ProviderOne before providing services.

If ProviderOne indicates the client is enrolled in an HCA-contracted managed care organization (MCO), contact the client's MCO for all coverage conditions and limits on services. (See Managed Care).

Who do I contact if I have questions related to patient responsibility?

Providers should reach out to their regional contact with questions related to patient responsibility. When sending a request, include the following information:

- Client's Full Name
- DSHS/ACES Client ID
- Summary of the issue, including month and year

Region	County	Contact
Region 1	Eastern Washington	gary.olson@dshs.wa.gov
Region 2	King, Snohomish, Whatcom, Skagit, Island, San Juan	jerald.ulrich@dshs.wa.gov
Region 3	Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania, Wahkiakum	altsar3hcsfinshpchelpdesk@dshs.wa.gov

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

(42 CFR 483.100 – 483.138, WAC 388-97-1910 and 388-97-1915)

Yes. Under state and federal law, all people referred for care in a Medicaid licensed nursing facility (NF), regardless of payment source, are required to have a Level One Preadmission Screening and Resident Review (DSHS 14-300) performed by the professional making the referral (usually a doctor, registered nurse practitioner, or hospital social worker). The Level I screening looks for indicators that a person may have an intellectual disability or related condition, or a serious mental illness. A Level II screening is required prior to admission when indicated by the Level I screen. The NF is responsible for ensuring that the entire PASRR process is complete and accurate prior to admission to their facility (the Level I for every person and the Level II if indicated).

More information regarding the PASRR process can be found on the DSHS website. For clients whose Level I screen indicated intellectual disabilities or related conditions with a referral to a DDA PASRR Coordinator, information can be found on DSHS's PASRR Program webpage. For clients whose Level I screen indicated serious mental illness and a referral to a BHA PASRR contractor information can be found on DSHS's PASRR Program webpage.

The PASRR is subject to post-payment review and audit by HCA or its designee. HCA may deny payment to the skilled nursing facility (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 must the skilled nursing facility (SNF) notify the state of an admission or status change?

See the *Nursing Facility – Notice of Action* (DSHS 15-031) form 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.

After an Aged, Blind or Disabled Medicaid client has been admitted to the skilled nursing facility (SNF), the SNF must complete the *Nursing Facility – Notice of Action* (DSHS 15-031) form, by following the instructions on the back of the form.

Nursing facility (NF) limitations on billing:

- For recipients with Apple Health coverage, the NF cannot bill a person who applies for or receives institutional services for the days between admission and the date the facility first notified DSHS of the admission. See RCW 74.42.056.
- For applicants, HCA will backdate NF payment authorization for up to three months as long as the person is otherwise eligible for institutional services.

What steps are necessary at admission, conversion, or application of an Apple Health Medicaid client (non-MAGI and MAGI-based) to ensure timely payment?

After an Apple Health client (non-MAGI and MAGI-based) has been admitted to the skilled nursing facility (SNF) and converted from a medical benefit or submitted a Medicaid application, the SNF must:

- Submit a *Nursing Facility – Notice of Action* (DSHS 15-031) form. The form must include the date of admit and the date the client's status changed (if applicable).
- For a client who will likely receive long-term care services in the facility, fax a *Home and Community Services (HCS) Intake and Referral* (DSHS 10-570) form to the HCS office in your region to request a nursing facility level of care (NFLOC) assessment through the HCS social service intake process. The fax numbers and region information are located on the form. A NFLOC assessment must be completed by HCS and in place to receive payment through fee-for-service. Medicaid payment begins either on the date of the request for a NFLOC assessment or the date of admission to the SNF, whichever is later.

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

> **Note**: Clients who are eligible for MCS or MAGI-based ACES coverage groups do not contribute towards the cost of care. SNFs cannot collect participation for these clients. An award letter is not needed to submit a claim.

What are the requirements at the time of discharge?

The provider must bill the discharge date by submitting the discharge hour on the nursing home claim. The provider must meet all federal and state discharge/transfer requirements (see 42 CFR 483.15; RCW 74.42.450; WACs 388-97-0120, 388-97-0140 and 388-97-0160).

Note: Billing for the date of discharge ensures that other providers can bill as necessary.

Example: Client discharges on July 2nd from the skilled nursing facility and the facility has not billed for the discharge date. On July 15th, the client tries to fill a prescription at a pharmacy, but the pharmacy claim is denied. The client will not be able to fill the prescriptions until the nursing facility has billed for the discharge date, which updates the client profile in ProviderOne. This affects the client and does not allow other providers to successfully bill their claims.

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Managed Care

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible for skilled nursing facility (SNF) coverage?

Yes. Most Medicaid-eligible clients are enrolled in one of the HCA-contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. MCOs pay for medically necessary skilled nursing facility (SNF) stays for rehabilitation or skilled medical care when the MCO determines that nursing facility care is more appropriate than acute hospital care. These services require prior authorization (PA) by the MCO or a Single Case Agreement (SCA) 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 beyond what is outlined in the PA or SCA. Clients remain enrolled in managed care even when the MCO is not responsible for payment of the client's nursing facility stay.

> **Note:** If the client is enrolled in managed care, contact the MCO prior to admittance to determine the duration and scope of services. See the Resources table for MCO contact information.

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 coverage
- Clients in the Medically Needy program

Managed care enrollment

Apple Health (Medicaid) enrolls clients into an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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.

Checking eligibility

- 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 policies. See **Resources** table for specific MCO information.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**: Go to the **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website.**
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at **ProviderOne Contact Us** and select client (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's **Apple Health Managed Care** web page.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that

may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health managed care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as: **"Coordinated Care Health Options Foster Care."**

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What should the SNF do before admitting an MCO-enrolled client?

Prior to any admission, the SNF must request authorization from the client's HCA-contracted managed care organization (MCO). The payer that is financially responsible for the client at the time of admission is responsible for rehabilitation or the skilled nursing facility stay. 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-enrolled client from a transferring SNF?

Prior to any admission, the receiving SNF must request authorization from the MCO. If the authorization is approved, the SNF must bill the MCO. If the authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met.

What are the SNF's options if the authorization is denied by the MCO for skilled or rehabilitative care?

If the MCO denies the authorization for skilled or rehabilitative care and the skilled nursing facility (SNF) disagrees with this determination, the SNF may file an appeal through the MCO and provide additional documentation supporting the need for skilled or rehabilitative care.

What should the SNF do when an MCO client's hospice election ends?

Prior to any admission of a hospice client (or for clients who have ended their hospice election), the receiving SNF must ask the discharge planner at the hospice agency which HCA-contracted managed care organization (MCO) authorized the stay. Prior to any admission to the SNF (or transfer from hospice), the SNF must request authorization from the MCO. If the authorization is

approved, the SNF must bill the MCO. If the authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met.

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

Prior to any admission, it is essential that the SNF coordinate with the HCA-contracted managed care organization (MCO) authorizing the rehabilitation or skilled nursing services. It is the nursing facility'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. The SNF must have an agreement with the MCO to receive payment. All billing for rehabilitation or skilled nursing services must be submitted to the MCO following the terms of their agreement including appropriate MCO covered days.

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 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. See Provider Responsibilities for HCS contact information.

> **Note**: A client's managed care plan may change. However, the MCO responsible at the time of admission remains responsible for the client's care, covered under the Apple Health contract, even if the client changes to another MCO after admission. See the **Resources** table for MCO contact information.

The SNF must request written confirmation from the MCO that services are approved or denied:

- 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 written confirmation when:

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

Written confirmation from an MCO or its subcontractor must include:

- Member name

- Date of birth
- Member ID
- ProviderOne ID
- Service description (ex. Skilled Nursing Facility Care)
- Name of admitting facility
- Facility admit date
- Dates approved (ex. MM-DD-YYYY through MM-DD-YYYY)
- Date denied
- Specific reason for denial

What happens if an MCO client's skilled nursing or rehabilitation status is denied or changes to long-term care?

When a managed care organization (MCO) client's skilled nursing or rehabilitation status is denied or changes to long-term care (sometimes called custodial care), the skilled nursing facility (SNF) must do the following for non-MAGI and MAGI Apple Health clients:

- Submit a *Notice of Action – Adult Residential Services* (DSHS 15-031) form. The form must include the date the client's status changed, with the date of hospice election or revocation, if applicable.

- Fax the Home and Community Services (HCS) *Intake and Referral* (DSHS 10-570) form to the HCS office in your region to request a nursing facility level of care (NFLOC) assessment through the HCS social service intake process for a client who will receive long-term care services. The fax numbers and region information are on the form. A NFLOC assessment must be completed to receive payment through fee-for-service.

    - For non-MAGI Apple Health clients, the date of request for NFLOC is recorded on the *Financial/Social Services Communication* (DSHS 14-443) form which is completed by the nursing facility case manager.

    - For MAGI Apple Health clients, the date of request for NFLOC is recorded on a *NFLOC Determination Modified Gross Income (MAGI) Clients* (DSHS 15-442) form or directly entered into ProviderOne. This is completed by the Home and Community Services-assigned nursing facility case manager.

Note: When a client elects hospice, nursing facilities must submit the *Nursing Facility – Notice of Action* (DSHS 15-031) form to DSHS, and the hospice provider must submit the Hospice Notification (HCA 13-746) form to HCA. HCA must receive the HCA 13-746 form within five business days of the hospice election date.

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* (DSHS 10-570) form, to request an assessment. The telephone and FAX numbers for HCS social service intake are located on the form.

The SNF is responsible to report changes when the client's status changes to long-term care (custodial care).

How does the SNF bill if the client has other primary health insurance and is enrolled in an MCO?

Medicaid is the payer of last resort. Providers must follow these steps for billing:

1. Follow the primary health insurance policies (including requesting authorization) for coverage of the nursing facility stay.

2. You may request authorization concurrently with the MCO for a medical necessity determination.

3. If the primary health insurance denies the service, you must request authorization from the HCA-contracted managed care organization (MCO) immediately.

4. If the MCO authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met. When billing fee-for-service, the primary health insurance denial and MCO authorization denial letter must be included.

Note: When the stay is covered by the primary health insurance, bill the same patient class code that would be used when submitting as fee-for-service; bill patient class code 55 when the stay is covered by the MCO.

Washington State Health Care Authority

Specialized Nursing Facility Programs

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

Expanded Behavior Supports

Program overview

Expanded Behavior Supports (EBS) is designed to provide enhanced behavior support services to clients who have either moved into the community after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs. This is also offered on a targeted basis for residents discharging from Western State Hospital (EBS Plus) and for respite behavioral care from a community setting providing intensive behavior support services called Expanded Community Services (ECS Respite).

Contracted SNF providers

The SNF is required to hold a contract for this scope of work to either provide or subcontract for the enhanced Behavior Support Services offered to the authorized Medicaid resident.

To request a contract, the SNF must contact their local Home and Community Services (HCS) Case Manager or contact the HCS Systems Change Specialist. See the Resource table for DSHS contact of the HCS Systems Change Specialist.

Authorization

Once contracted, a SNF is eligible to serve clients identified by HCS as EBS eligible. To authorize services, the HCS Behavior Support 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
- EBS service start date

If approved, the SNF receives an EBS approval letter. The EBS approval letter is the SNF's authorization for payment of this service but does not guarantee payment.

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

- Name of the contracted SNF caring for the qualified client
- Name of qualified client
- Date of birth of qualified client

- Date of EBS Service Level Change or End Date

Payment

For EBS, the SNF must use patient class code 50 with value code 24 in the *Value Information* section of an electronic institutional claim to receive a specialized payment for an EBS resident.

For EBS Plus, the SNF must use patient class code 62 with value code 24 in the *Value Information* section of an electronic institutional claim to receive a specialized payment for an EBS client.

For ECS Respite, the SNF must use patient class code 63 with value code 24 in the *Value Information* section of an electronic institutional claim to receive a specialized payment for an ECS client.

Ventilator/Tracheotomy program

Program overview

The Ventilator/Tracheotomy (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.

Wrap Around Services for Vent/Trach Clients

SNFs that are currently enrolled in the Vent/Trach program receive a wrap-around payment for the services required by clients in these units. The payer responsible for room and board costs makes this payment.

Payment

Facilities must use class codes 66, 67, 68 or 69 when billing for the specialized payment for a client.

Nursing facilities designated to provide ventilator and tracheotomy services must bill for consistent dates of service to be paid for their calculated wrap around rate. The facilities will bill for both the combined daily rate and wrap around rate using the designated patient class code as outlined in the **Patient Class Code table**. If a paid nursing facility claim is not on file for the client for the noted dates of service, the vendor claim will be denied. The vendor will be required to rebill for these services after the nursing facility claim for the dates of service is paid. In addition to this policy, the nursing facility will not be paid for these services for the client discharge date; this policy is congruent with the nursing facility claim policy for FFS.

Respiratory Services

The Department of Social and Health Services (DSHS) requires contracted Vent/Trach program facilities to contract with a respiratory provider or provide respiratory therapy services, supplies and equipment.

The payer responsible for room and board costs is also responsible to pay for respiratory services covered under the Vent/Trach program contract (procedure code E1399 with appropriate modifiers).

If respiratory services are provided by the Vent/Trach program facility, the facility is not eligible for payment of procedure code E1399.

Respiratory services covered under the Vent/Trach contract are allowable only for days when a client is eligible for SNF care and is inpatient in a contracted Vent/Trach program facility.

After the nursing facility has billed consistent dates of service to be paid for the respiratory services, the respiratory vendor can bill for the wrap around rate as a vendor claim. These claims must include either the claim modifier for ventilator services or tracheotomy services provided. The vendor cannot bill for a client receiving both services.

If the medical equipment and supplies vendor is paid for the services provided for the client under their vendor claim, but the nursing facility FFS claim is recouped, then the medical equipment and supplies vendor's claim will also be recouped at the same time. The medical equipment and supplies vendor must rebill for the vendor claim after the nursing facility has rebilled the claim and claim has been adjudicated as "paid."

For services and supplies provided other than those under procedure code E1399 covered in the Vent/Trach contract, refer to HCA's **Respiratory Care Billing Guide** for the appropriate billing process.

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), and (f), including all of the following:

- Be ineligible for federally funded or matched programs
- Be at least 19 years of age
- Meet NFLOC requirements (**WAC 388-106-0355**)
- 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 Emily Watts at Emily.Watts1@dshs.wa.gov 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 patient class code 45 with value code 24 in the *Value Information* section of the electronic institutional claim to receive a specialized payment under this program.

Exceptional Care Needs Program

Program Overview

The Exceptional Care Needs Program is a limited duration authorization for those clients with exceptional care needs who are leaving hospitals and in need of skilled nursing or extensive skilled therapy in a SNF with the goal of returning to a community setting.

Medically complex clients whose needs exceed a typical skilled nursing stay include individuals with longer term daily skilled nursing care needs such as wound care, bariatric, IV therapy, and nutritional interventions such as PEG tube/TPN.

Services provided under this program are authorized for a limited duration, typically 60 to 90 days, and are negotiated by the payer on a case-by-case basis.

Who qualifies?

The client must be Medicaid-eligible and assessed to meet NFLOC.

A client eligible for this service must meet the following criteria:

- Have a history of frequent or lengthy hospitalization where recovery and return to living in a community setting has been compromised by the client's exceptional care needs
- Is willing to actively participate in goal-oriented skilled nursing and intensive therapies with the goal of returning to a community setting

Examples of exceptional care needs include:

- Medical equipment and supplies necessary to meet treatment or care needs
- Skilled therapy or nursing service needs not covered in the Medicaid daily rate
- Medical supplies or medically necessary medications which exceeds formulary

Authorization

For dual-eligible admissions for FFS clients, HCS and the SNF coordinate to submit a completed authorization request listing services and cost calculations which is then reviewed by HCS and HCA. An approval letter is provided to the nursing facility outlining billing/claiming instructions to receive an approved exceptional care needs rate. The approval letter is the SNF's authorization for payment of these services.

Note: For admission of an agency-contracted managed care organization (MCO) enrolled client, the client's SNF coordinates with the MCO to create a single case agreement (SCA).

Community Home Project

Program overview

The Community Home Project (CHP) is a limited duration authorization to assist clients in an inpatient hospital setting whose SNF services are not included in the daily rate and plan to return to a community setting.

Authorization

The limited duration authorization for CHP is based on an HCS assessment and lack of other available funding to support the service required.

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

Payment

The SNF must use patient class code 60 with value code 24 in the *Value Information* section of an electronic institutional claim to receive a specialized payment for a CHP client.

Medicare

How is Apple Health (Medicaid) different from Medicare?

Apple Health (Medicaid) and Medicare are very different programs. Medicare is an entitlement program funded entirely at the federal level. It is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease. For more information on Medicare, see the Centers for Medicare and Medicaid Services (CMS) website.

The Medicare program provides:

- Medicare Part A, which covers inpatient hospital services
- Medicare Part B, which covers professional, and vendor services
- Medicare Part C, which is a managed care version of Medicare, also called a Medicare Advantage Plan, and offered through private insurance companies
- Medicare Part D, which covers prescription drugs

Apple Health is a needs-based program with eligibility determined by income and covers a wider range of health care services than Medicare (e.g., dental). Some people are eligible for both Medicaid and Medicare. These clients are referred to as "dual-eligible" clients.

> **Note:** When Medicare is the primary payer and denies a service not included in the NH per diem but covered by HCA with a prior authorization requirement, HCA waives the "prior" requirement in this circumstance. Refer to the appropriate billing guide for the service and submit a request for authorization. Attach the Explanation of Benefits (EOB) to the request for services denied by Medicare.

Does HCA pay for Medicare Advantage Plans (Part C) cost-sharing expenses?

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

The skilled nursing facility (SNF) must first bill the client's Managed Medicare – Medicare Advantage (Part C) Plan. If money is owed after the Managed Medicare – Medicare Advantage (Part C) plan has been billed and payment received, the

SNF must submit a claim to HCA for additional payment with patient class code 24, following the instructions in one of the webinars listed in the Resources table.

HCA must receive claims for additional payment within six months of the Managed Medicare - Medicare Advantage (Part C) plan payment date.

Does HCA pay Medicare cost-sharing expenses for Qualified Medical Beneficiary (QMB) clients?

Yes. HCA reimburses nursing facilities for Medicare cost-sharing expenses under Medicare Part A, Part B, and Part C (except for Part C premiums). For QMB clients, HCA reimburses up to the maximum reimbursement limits established in WAC 182-502-0110 and WAC 182-517-0300.

HCA issues a QMB program approval letter to the client. Clients who are covered by QMB-only do not receive an institutional award letter. QMB-only clients do not pay towards the cost of care for Medicare-only days, and nursing facilities must not collect participation from these clients for Medicare-only days. For more information, see the Client Eligibility section for more information on eligibility and coverage groups.

For clients who are also eligible for long-term care, Home and Community Services issues an institutional award letter.

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

Bill Medicare first, then bill Medicaid.

- Patient class codes 29 and 56 are not entitled to secondary Medicaid payment. Claims submitted with patient class codes 29 and 56 will receive a $0.00 reimbursement from Medicaid.
- If money is owed to the skilled nursing facility (SNF) after Medicare makes a payment, the SNF can submit a claim to HCA for additional payment with patient class code 24 and follow the instructions in one of the webinars listed in the Resources table.
- If Medicare pays the claim, the SNF must bill HCA within 6 months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, the SNF must meet HCA's 365-day requirement for an initial claim.

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

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see **Paperless Billing at HCA.**

For providers approved to bill paper claims, see **HCA's Paper Claim Billing Resource.**

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under **Webinars**.

For information about billing electronically through a clearinghouse, see HCA's **Reporting Medicare/Managed Medicare and commercial payer data on an 837 transaction**.

See HCA's ProviderOne Resources **Fact Sheets** page for quick reference guides for various ProviderOne processes and policy issues.

What is the admission date?

The admission date is the date the person physically admitted or readmitted to the SNF.

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

Bill the other primary health insurance before billing Medicaid; Medicaid is the payer of last resort. After other primary health insurance is billed, refer to one of the webinars listed in the **Resources** table.

For affected billing changes, see **How does the SNF bill if the client has other primary health insurance and is enrolled in an MCO**?

How does the SNF bill for a discharged client?

The SNF must bill for the date of discharge using the discharge hour, the appropriate patient status code and enter the total number of units, not including the discharge day. HCA does not pay the skilled nursing facility (SNF) for the date of discharge unless the client is admitted and dies on the same day. When a client is discharged from the SNF in the same month as they are admitted, use the appropriate patient status code and enter the total number of units, not including the discharge day.

How does the SNF bill for date of death?

The SNF must bill for the date of discharge using the discharge hour and the appropriate patient status code. When a client dies, use patient status code 20

and enter the total number of units, not including the death/discharge day. HCA does not pay the nursing facilities for the date of discharge unless the client is admitted and dies on the same day. Use patient status 20 and enter the total number of units including the death/discharge day.

How do SNF providers enrolled in Medicaid bill for dual-eligible clients?

SNFs enrolled in the state's Medicaid program must submit claims with patient class code 24 for dual-eligible Medicare/Medicaid clients during Medicare days.

How do SNF providers not enrolled in Medicaid bill for QMB cost-sharing expenses?

SNFs not enrolled in the state's Medicaid program must submit claims with patient class code 56 for Qualified Medicare Beneficiaries (QMB) cost-sharing expenses. The SNF must notify DSHS/ALTSA contracts and complete appropriate documentation to submit these claims.

How does the SNF bill for social leave?

HCA pays for the first 18 days of social leave in a calendar 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 15-031) form.

Does the SNF bill HCA for clients in hospice status?

No. If the client in an SNF is on hospice status, it is the hospice provider's responsibility to bill HCA using HCA's Hospice Services Billing Guide. The SNF should work with the hospice provider for appropriate billing.

> **Note**: For non-MAGI Medicaid clients who elect or revoke hospice, the nursing facility must notify DSHS/ALTSA using *Notice of Action* DSHS 15-031 form. The hospice provider must notify HCA using HCA *Medicaid Hospice Notification* (HCA 13-746) form; this form is required from the hospice provider to authorize Medicaid payment.

How does the SNF change a previously paid claim?

If the SNF needs to make changes to claims for dates of service for which HCA has already paid, refer to the ProviderOne Billing and Resource Guide section on adjusting claims.

Where on the institutional claim 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. These funds must be contributed toward the patient's cost of care.

The patient participation amount must be submitted on each claim using the *Value Information* section, value code 31, even if the participation amount is zero.

The SNF cannot collect participation from an HCA client when billing for patient class codes 24, 29, 55, 56 or MAGI-based clients.

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

HCA 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 institutional claim 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 HCA. See WAC 182-519-0110.

Enter the client spenddown amount into the Value Information section using value code 66.

How do I submit claims?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Webinars. You may also view the Submit Nursing Home Institutional Claims Using Templates Webinar.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

The following instructions are specific to nursing facilities.

- **Type of Facility**: enter 2-Skilled Nursing.
- **Statement Dates**: enter the beginning and ending dates of service for the period covered by the bill. Bill only dates of service for which the client is eligible.
- **Medicare Crossover Claims**: refer to the instructions in one of the webinars listed in the Resources table.

- **Discharge Hour**: required when submitting a patient status code other than status code 30 - Still Patient.
- Patient Status Codes: enter the appropriate patient status code; the following are some frequently used patient status codes:

  01 Discharged to home or self-care
  02 Discharged/transferred to a Short Term General Hospital for Inpatient Care
  03 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
  04 Discharged/transferred to an Intermediate Care Facility (ICF)
  05 Discharged/transferred to a Designated Cancer Center or Children's Hospital
  06 Discharged/transferred to home
  07 Left against medical advice or Discontinued Care
  20 Expired
  30 Still patient
  50 Hospice – home
  51 Hospice - medical facility
  61 Discharged/transferred to Hospital-based Medicare Approved Swing Bed
  70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

- **Value Information (Value Code/Value Amount):**
  - **Value code 24:** SNF claims must be submitted with value code 24. Enter this code in the *Value Code* field with the Patient Class immediately following in the *Value Amount* field. See Patient class codes. (e.g., 20.00= patient class code 20).
  - **Value code 31**: SNF claims must be submitted with value code 31. Enter this code in the *Value Code* field with the Patient Participation amount for the entire month immediately following in the *Value Amount* field.
  - **Value code 66**: Enter this code in the *Value Code* field with the entire Patient Spenddown Amount immediately following in the *Value Amount* field.

Note: When using value code 24 or 31, enter the code only once in the value code field. Duplicate value codes will be denied.

- **Attending/Servicing Provider**: Enter attending provider's national provider identifier (NPI) and taxonomy.
- **Other Insurance Information**: Enter primary health insurance other than Apple Health. Refer to one of the webinars listed in the Resources table.
- **Revenue Code**: Enter revenue code 0190.
- **Service Units**: Enter the number of days. Do not include the date of discharge unless a client is admitted and dies on the same day.
- **Total Line Charges**: Enter the SNF usual and customary daily rate.

Patient class code

Enter value code 24 with the appropriate patient class code below and submit as shown in How do I bill claims electronically? Claims submitted with an incorrect Class Code will be denied.

Patient Class Code ProviderOne (P1) Payment	Description A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories to bill for an identified service authorized and provided.	Billing Requirements
20: SNF	Daily Medicaid NH Rate. Set every semiannual period but can be more frequent.	Apple Health clients; default class when no other class is appropriate
23: IMR Title XIX Eligible	Intermediate/Intellectual Disability Services – Note Medicaid Title XIX Eligible (1997). This patient class is restricted and only used by a very few homes; Rocky Bay and facilities and Providence Health & Services-Oregon. While there are others that have used the rate in the past, these are the only ones currently billing.	Any Intermediate Care Facility - Intellectually Disabled (ICF-ID) will bill this patient class code for all Medicaid residents.
24: Dual Medicare/Medicaid	All SNFs enrolled in the state's Medicaid program are required to bill Medicaid with patient class code 24 for dual-eligible Medicare/Medicaid clients. Up to the first 100 days, patient class code pays difference if Medicaid rate is greater than Medicare rate.	Submit claim if money is owed to the SNF after Medicare makes a payment.
26: Swing Bed	Medicaid Hospital Swing Bed Rate. Set every July 1 using prior year July 1 patient class code 20 rate weighted by prior July 1 billed days (minus SNA component). Hospital facilities that have swing beds to service Medicaid nursing facility clients.	Hospitals that are approved through the Department of Health and have submitted a Core Provider Agreement through the Health Care Authority can bill this patient class code for Medicaid nursing facility clients occupying their swing beds.
29: Full Medicare	Patient class code 29 is not entitled to secondary Medicaid payment. Zero P1 remittance advice (the payment will always pay at zero) is produced to	SNFs can bill for this patient class code to receive claim verification and

Patient Class Code ProviderOne (P1) Payment	Description A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories to bill for an identified service authorized and provided.	Billing Requirements
	document claim used for Medicare bad debt cost reporting.	Remittance Advice generation for Medicare claims.
45: Non-Citizen's Long-Term Care (NCLTC) Program	Medicaid NH patient class code 20 daily rate for NH approved to serve non-citizen clients. The Non-Citizen's Long-Term Care (NCLTC) Program is a state-only 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 noncitizen status.	SNFs that admit a preapproved non-citizen client will bill for this patient class code for state covered services for undocumented residents. Preapproval from DSHS' Aging and Long-term Services Administration (ALTSA) is required.
50: EBS (Behavioral Support)	Medicaid NH patient class code 20 daily rate plus $80. Expanded Behavior Support (EBS) is designed to provide enhanced behavior support services to clients who have either moved into the NH after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs. Medicaid NF needs to get contract approval.	SNFs that have been awarded a contract allowing EBS services can bill for this patient class code. Residents must be preapproved for this program through the HCS Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.
54: COVID+ Units	Flat daily rate of $450. COVID positive units are designated to provide services to clients with a COVID positive diagnosis.	SNF has been awarded a contract amendment outlining the COVID unit capacity. Only COVID+ units can bill for this class code.
55: Rehabilitation with Managed Medicaid (Managed Care MCO)	SNF will bill patient class code 55 when the Medicaid stay is covered by the managed care organization (MCO).	SNFs will bill for this class code when the MCO covers the cost of the care for the client.

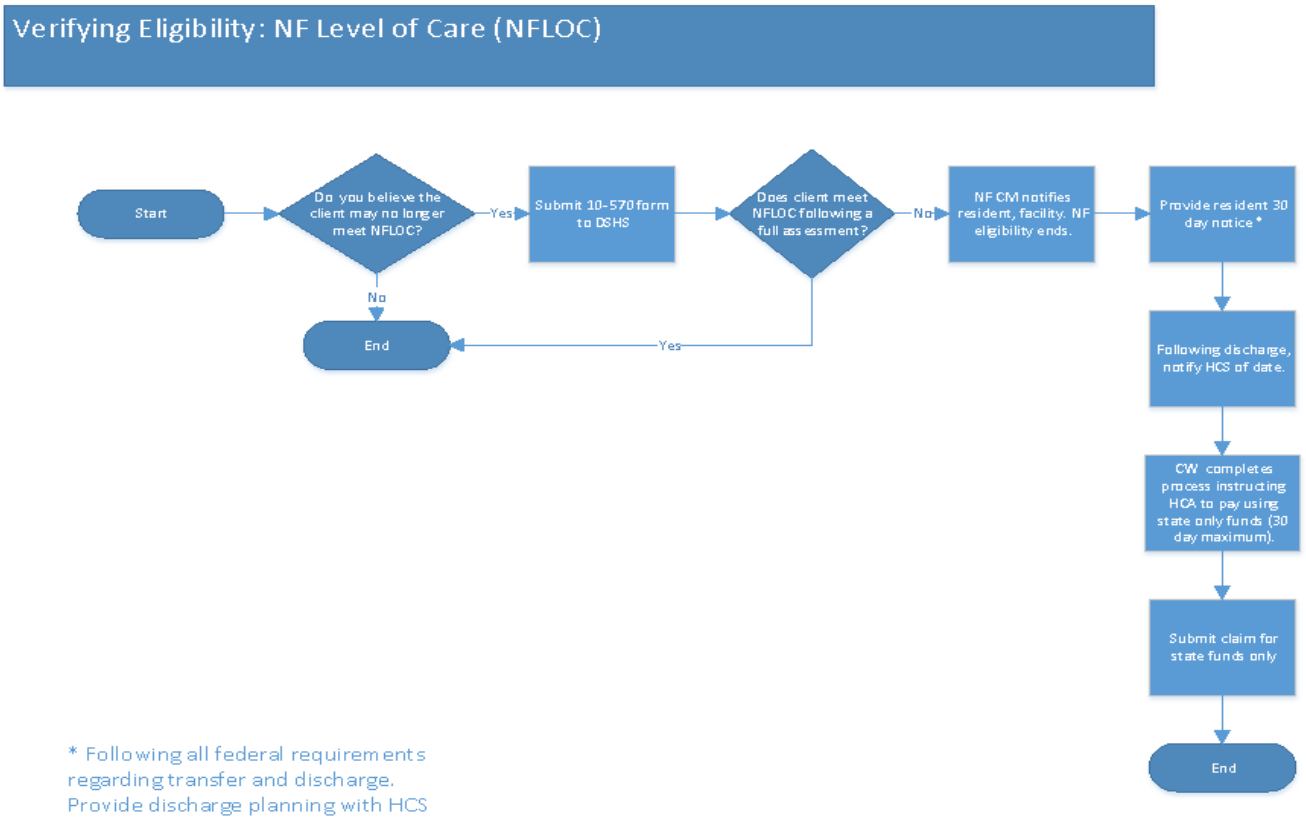
Patient Class Code ProviderOne (P1) Payment	Description A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories to bill for an identified service authorized and provided.	Billing Requirements
		This patient class code will pay out at $0.00 for all appropriately billed claims.
56: QMB Cost Sharing (Non-Medicaid contracted)	Qualified Medicare Beneficiaries (QMB) Cost Sharing.	SNF providers not enrolled to bill through Medicaid bill patient class code 56 instead of 24. Patient class code 56 is not entitled to secondary Medicaid payment. Like patient class code 24, this code only pays the difference if the Medicaid rate is greater than the Medicare rate. The average swing bed rate is used as a proxy for the comparison.
60: Community Home Project	Medicaid NH Rate patient class code 20 daily rate plus additional costs for skilled nursing and skilled therapy and rehabilitation supplies and services. The Community Home Project (CHP) is a limited duration authorization to assist clients in an inpatient hospital setting whose goal is to transition to a community home setting. CHP provides services in a SNF that are not included in a daily rate and not payable through other means. The client needs to be approved for this type of care by HCS before payment will be authorized.	Residents must be preapproved for this program through ALTSA and HCA, and the facility must receive an approval letter from both ALTSA/HCS and HCA.
62: EBS Plus (Behavioral Support Plus)	Medicaid NH patient class code 20 daily rate plus $175. EBS Plus means: A level of intensive behavior support service provision which includes dedicated staffing on site behavior support consultation and training in a skilled nursing environment. Requires HCS contract approval.	SNFs awarded a contract from ALTSA allowing EBS services can bill for this patient class code. Residents must be preapproved for this program through the ALTSA/HCS

Patient Class Code ProviderOne (P1) Payment	Description A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories to bill for an identified service authorized and provided.	Billing Requirements
		Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.
63: ECS Respite **(Behavioral Support Respite)**	Medicaid NH patient class code 20 daily rate plus $175. The length of stay in the ECS Respite bed will be 20 days or less for any particular episode of service for any particular ECS residential client unless an exception is provided by the HCS Field Services Administrator or his/her designee. ECS Respite means a short-term medically based SNF admission as an intervention for ECS or SBS residential clients experiencing an escalation in behavioral challenges that does not fit the definition for mental health voluntary or involuntary detention but that jeopardizes the ECS client's residential living as determined by HCS.	SNFs that have been awarded a contract from ALTSA allowing ECS services can bill for this patient class code. Residents must be preapproved for this program through the ALTSA/HCS Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.
66: Ventilator	Medicaid NH patient class code 20 daily rate plus $192. The SNF must have a Medicaid approval for vent/trach client services in this setting.	SNFs are preapproved by ALTSA to admit these clients and provide services.
67: Tracheotomy	Medicaid NH patient class code 20 daily rate plus $123. The SNF must have a Medicaid approval for vent/trach client services.	SNFs are preapproved by ALTSA to admit these clients and provide services.
68: Ventilator wrap-around only	SNF will bill this class code when a Medicaid client has TPL insurance that covers room and board but not the wrap-around rate for ventilator services. Must be pre-approved to bill this class code by ALTSA.	SNFs have been preapproved by ALTSA to admit these clients and provide services.
69: Trach wrap-around only	SNF will bill this class code when a Medicaid client has TPL insurance that covers room and board but not the wrap-around rate for tracheotomy services. Must be pre-approved to bill this class code by ALTSA.	SNFs have been preapproved by ALTSA to admit these clients and provide services.

Patient Class Code ProviderOne (P1) Payment	Description A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories to bill for an identified service authorized and provided.	Billing Requirements
87: Tribal Enhancement	SNF will bill this class code when a tribal member is being served in an eligible tribally owned and operated SNF. This is an enhanced rate negotiated with the tribal operator and receives 100% FMAP. Cannot bill for non-tribal clients, even in tribally owned/operated facilities. Must be pre-approved to bill this class code by ALTSA.	The tribal owner/operator must have engaged in rate negotiations with ALTSA and approved by CMS before billing.
88: Intermediate/ Intellectual Disability Services	Intermediate/Intellectual Disability Services. This patient class is restricted and only used by a very few homes.	Any Intermediate Care Facility - Intellectually Disabled (ICF-ID) will bill this patient class code for all Medicaid residents.
92: State Funded Medical Care Services (MCS) Programs	State-funded Medical Care Services (MCS) programs. SNF will bill this class code for ACES medical coverage groups A01, A05, and A24.	Pre-approved by Home and Community Services (HCS) before admission is not required as long as the client meets nursing facility level of care (NFLOC). The SNF is required to request an HCS intake for NFLOC. No SNF participation is applied to this group. No SNF award letter is needed for a claim.

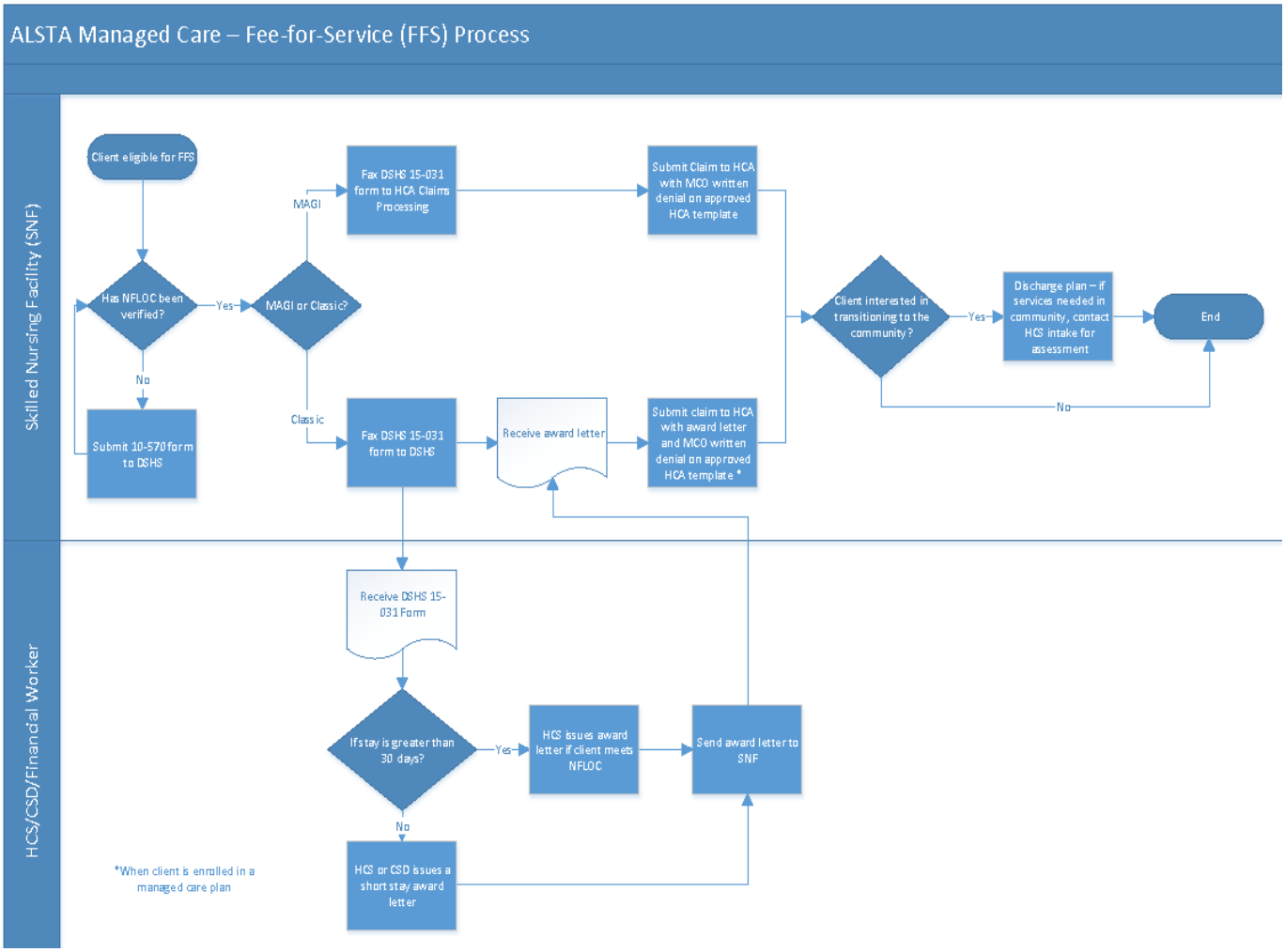
Washington State Health Care Authority

Verifying eligibility flow chart



Washington State Health Care Authority

Managed care billing flow chart



Washington State Health Care Authority

Managed care enrollee process flow chart