Washington State Health Care Authority

Washington Apple Health (Medicaid)

Acute Physical Medicine & Rehabilitation (PM&R) Billing Guide

October 1, 2017

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.

About this guide*

This publication takes effect October 1, 2017, and supersedes earlier guides to this program.

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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
Fully Integrated Managed Care (FIMC)	**Effective January 1, 2018,** the agency is implementing a **second FIMC region**, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties. The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency's Managed Care webpage, the agency's Integrated physical and behavioral health care webpage, and the agency's Regional resource webpage.	Notification of new region moving to fully integrated managed care (FIMC)

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

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

*This publication is a billing instruction.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).

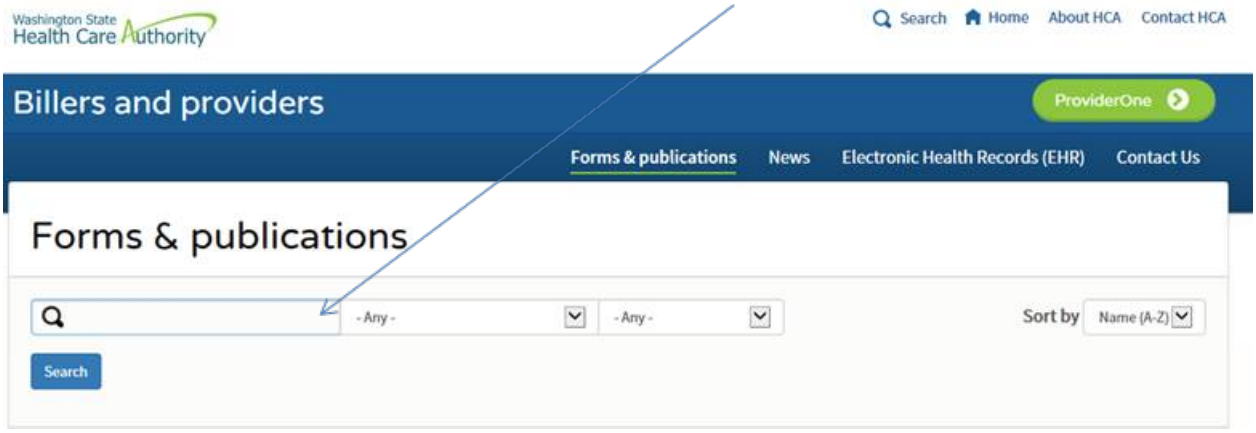

Table of Contents

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Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Accredit (or Accreditation) - A term used by nationally recognized health organizations, such as the Commission on Accreditation of Rehabilitation Facilities (CARF), to indicate a facility meets both professional and community standards of medical care. (WAC 182-550-1050)

Acute - An intense medical episode, not longer than three months. (WAC 182-550-1050)

Acute PM&R - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. (WAC 182-550-1050)

Administrative day - One or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. (WAC 182-550-1050)

Administrative day rate - The agency's statewide Medicaid average daily nursing facility rate. (WAC 182-550-1050)

Commission on Accreditation of Rehabilitation Facilities (CARF) – See http://www.carf.org/home/. (WAC 182-550-1050)

Family - People who are important to and designated by the client and need not be related.

Interdisciplinary team - A team that coordinates individualized Acute PM&R services at an agency-approved inpatient rehabilitation facility to achieve the following for the client:

- Improved health and welfare.
- Maximum physical, social, psychological, and vocational potential.

Noncovered service or charge – A service or charge the agency does not consider or pay for as a "hospital covered service." This service or charge may not be billed to the client, except under the conditions identified in WAC 182-502-0160. (WAC 182-550-1050)

Per diem – A hospital-specific daily rate for a service, multiplied by covered allowable days. (WAC 182-550-3000)

Short-term - Two months or less.

Survey – An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with Acute PM&R program requirements. (WAC 182-550-1050)

About the Program

(WAC 182-550-2501)

What is Acute Physical Medicine & Rehabilitation (PM&R)?

Acute PM&R is a 24-hour inpatient comprehensive program of integrated acute medical and rehabilitative services provided during the acute phase of a client's rehabilitation. The agency requires prior authorization for Acute PM&R services (see What are the requirements for prior authorization?).

An interdisciplinary team coordinates individualized Acute PM&R services at an agency-contracted rehabilitation facility for a client's:

- Improved health and welfare
- Maximum physical, social, psychological, and educational or vocational potential

The agency determines and authorizes a length-of-stay based on:

- The client's Acute PM&R needs
- Community standards of care for Acute PM&R services

When the agency's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client achieve maximum potential through other agency programs such as:

- Home health services
- Nursing facilities
- Outpatient physical, occupational, and speech therapies
- Neurodevelopmental centers

The agency's Acute PM&R program is regulated by:

- RCW 74.09.520, Medical Assistance-Care and services included--Funding limitations
- WAC 182-550-2501, 2511, 2521, 2531, 2541, 2551, 2561, and 3381 Acute PM&R
- The agency's Core Provider Agreement

How does a client qualify for Acute PM&R services?

(WAC 182-550-2551)

To qualify for Acute PM&R services, a client must have:

- All of the following extensive **or** complex:

  - ✓ Medical needs
  - ✓ Nursing needs
  - ✓ Therapy needs

AND

- A recent or new onset of a condition that causes an impairment in **two or more** of the following areas:

  - ✓ Mobility and strength
  - ✓ Self-care/ADLs (Activities of Daily Living)
  - ✓ Communication
  - ✓ Cognitive/perceptual functioning

AND

- A new or recent onset of **one** of the following conditions:

  - ✓ Brain injury caused by trauma or disease
  - ✓ Spinal cord injury resulting in:
    - ➢ Quadriplegia
    - ➢ Paraplegia
  - ✓ Extensive burns
  - ✓ Bilateral limb loss
  - ✓ Stroke or aneurysm with resulting hemiplegia or severe cognitive deficits, including speech and swallowing deficits
  - ✓ Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits
  - ✓ Skin flap surgery after severe pressure ulcers for a client who meets both of the following:
    - ➢ Requires close observation by a surgeon
    - ➢ Is ready to mobilize or be upright in a chair
  - ✓ Acute inflammatory demyelinating polyneuropathy (AIDP)

Provider Requirements

How does a hospital become an agency-approved Acute PM&R provider?

(WAC 182-550-2531)

The agency accepts applications from in-state and border hospitals only. To apply to become an agency-approved Acute PM&R facility, the agency requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Clinical Quality and Care Transformation (CQCT)
Medical and Dental Services
PO Box 45506
Olympia, WA 98504-5506

A hospital that applies to become an agency-approved Acute PM&R facility must provide the agency with documentation that confirms the facility is all of the following:

- A Medicare-certified hospital
- Accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO)
- Licensed by the Department of Health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010)
- Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a comprehensive integrated inpatient rehabilitation program or as a pediatric family-centered rehabilitation program, unless the facility has obtained a 12-month conditional approval from the agency (see Conditional approval when waiting for CARF accreditation)
- Contracted under the agency's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the agency

- **Operating per the standards set by DOH** (excluding the Certified Rehabilitation Registered Nurse (CRRN) requirement) in either:

  ✓ WAC 246-976-830, Level I Trauma Rehabilitation Designation
  ✓ WAC 246-976-840, Level II Trauma Rehabilitation Designation

> **Note:** Acute PM&R is **NOT** related to, nor does it qualify any facility for, the DOH Acute Trauma Rehabilitation Designation program.

For a list of CARF-approved providers, go to CARF International.

Conditional approval when waiting for CARF accreditation

A hospital not yet accredited by CARF:

- May apply for or be awarded a 12-month conditional written approval by the agency if the facility meets both of the following:

  ✓ Provides the agency with documentation that shows it has started the process of obtaining full CARF accreditation

  ✓ Is actively operating under CARF standards

- Is required to obtain full CARF accreditation within 12 months of the agency's conditional approval date. If this requirement is not met, the agency sends a letter of notification to revoke the conditional written approval.

> **Note:** If a hospital is working with a CARF consultant, a letter of active intent showing time lines of facility operation under CARF standards must be submitted to the agency at the time of application. Full CARF accreditation must be:
> - Obtained within 12 months of the agency's conditional approval
> - Kept current

Final qualification criteria

A hospital qualifies as an agency-approved Acute PM&R facility when:

- The facility meets all the applicable requirements in this guide.
- The agency provides written notification that the facility qualifies to be paid for providing Acute PM&R services to eligible medical assistance clients.

> **Note:** Agency-approved Acute PM&R facilities must meet the general requirements in Chapter 182-502 WAC, Administration of Medical Programs--Providers.

Is notifying clients of their right to make their own health care decisions (Advance Directives) required?

(42 CFR, 489 Subpart I)

All Medicare and Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment
- Make decisions concerning their own medical care
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care

How does the agency ensure quality of care for the client?

(WAC 182-550-2541)

To ensure quality of care, the agency:

- May conduct reviews (post-pay or on-site) of any agency-approved Acute PM&R facility

- Requires a provider of Acute PM&R services to act on any report of substandard care or violation of the facility's medical staff bylaws and CARF standards. The provider must have and follow written procedures that meet both of the following:

  ✓ Provide a resolution to either a complaint or grievance, or both

  ✓ Comply with applicable CARF standards for adults or pediatrics as appropriate

  A complaint or grievance regarding substandard conditions or care may be investigated by one or more of the following:

  ✓ DOH

  ✓ JCAHO

  ✓ CARF

  ✓ The agency

  ✓ Other agencies with review authority for agency programs

Note: Being selected for an audit does **not** mean that the business has been predetermined to have faulty business practices.

Client Eligibility

(WAC 182-550-2521 (1))

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 Program Benefit Packages and Scope of Services webpage.

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

1. By visiting the Washington Healthplanfinder's webpage 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?

(WAC182-550-2521 (2))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted MCO, managed care enrollment will be displayed on the client benefit inquiry screen.

If a client is enrolled in an MCO at the time of acute care admission, that plan pays for and coordinates Acute PM&R services as appropriate. Clients can contact their agency-contracted MCO by calling the telephone number provided to them.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients were not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) program. For these clients, substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care webpage, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

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. See the agency's Regional Resources webpage.

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 replaced the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing 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)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted managed care organization (MCO). The Behavioral Health Organization (BHO) will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

> **Effective July 1, 2017, American Indian/Alaska Native (AI/AN)** clients living in an FIMC region of Washington must choose to enroll in one of the agency-contracted MCOs available in that region; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavior health services. For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on FIMC, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency's Managed Care webpage, the agency's Integrated physical and behavioral health care webpage, and the agency's Regional resource webpage.

FIMC Regions

North Central Region (NC) – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details, including information about mental health crisis services can be found on the agency's Managed Care webpage, the agency's Integrated physical and behavioral health care webpage, and the agency's Regional resource webpage.

Southwest Washington Region (SW WA) – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the SW WA region which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

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 automatically 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 is not a 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 be 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

How does this affect the Acute Physical Medicine and Rehabilitation Program?

The majority of eligible clients will be assigned to an MCO. If clients are newly eligible, their enrollment with the MCO will start on the first day of the month of enrollment.

Starting April 1, 2016, when a client or a client's representative applies for eligibility, the Healthplanfinder will determine if the client is eligible. If eligible, the client will be able to pick one of the managed care plans or be assigned to one. As a result, most clients will be in a managed care plan before admission to PM&R.

The managed care plan assignment can be found in ProviderOne.

Are Primary Care Case Management (PCCM) clients eligible?

Yes. Providers must follow the agency's *ProviderOne Billing and Resource Guide*. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record-keeping requirements.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Prior Authorization

Is prior authorization (PA) required for Acute PM&R services?

(WAC 182-550-2501)

Yes. The agency requires PA for Acute PM&R services.

What are the requirements for PA?

(WAC 182-550-2561)

> **Note:** Authorization of services does not guarantee payment. Providers must meet administrative requirements (client eligibility, claim timeliness, third-party insurance, etc.) before the agency pays for services.

The Acute PM&R provider must obtain prior authorization:

- Before admitting a client to the rehabilitation unit
- For an extension of stay, before the client's current authorized period of stay expires

> **Note:** Retroactive authorization requests are approved on a case-by-case basis only.

Initial PA

For an initial admission:

- A client must:
  - ✓ Be eligible for Acute PM&R services (see Client Eligibility)
  - ✓ Require Acute PM&R services (see How does a client qualify for Acute PM&R services?)
  - ✓ Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program
  - ✓ Be willing and capable to participate at least three (3) hours per day, seven (7) days per week, in Acute PM&R activities

- The Acute PM&R provider must:

  ✓ Submit a typed and signed request for prior authorization (PA) to the agency. You must use the current version of the *Acute Physical Medicine and Rehab Admit/Extension Request* (HCA 13-838) form. See Where can I download agency forms? Older versions submitted will not be accepted. You must use a correct Acute PM&R billing provider NPI on the request form.

  ✓ Include sufficient medical information to justify that all of the following apply:

    ➢ Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care or independence, or both.

    ➢ The client's medical condition requires intensive 24-hour inpatient comprehensive Acute PM&R services in an agency-approved Acute PM&R facility.

    ➢ The client suffers from severe disabilities including, but not limited to, neurological or cognitive deficits, or both.

Extension of PA

For an extension of stay:

- A client must meet all of the following:

  ✓ Be eligible for Acute PM&R services (see Client Eligibility)

  ✓ Require Acute PM&R services

  ✓ Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program

  ✓ Be willing and capable to participate at least three (3) hours per day, seven (7) days per week, in Acute PM&R activities

  ✓ Have observable, documented evidence of significant improvement

- The Acute PM&R provider must do both of the following:

  ✓ Submit a typed and signed request for the extension of stay to the agency before the current authorization expires. You must use the current version of the *Acute Physical Medicine and Rehab Admit/Extension Request* (HCA 13-838) form. See Where can I download agency forms? Older versions submitted will not be accepted. You must use a correct Acute PM&R billing provider NPI on the request form.

  ✓ Include documented medical evidence to justify the extension; include all pertinent medical records that substantiate the client's condition has observably and significantly improved.

If the agency denies the request for extension of stay, the client must be transferred to an appropriate lower level of care (see What is Acute Physical Medicine & Rehabilitation (Acute PM&R?).)

Note: To request authorization (either initial or an extension), complete the *Acute Physical Medicine and Rehab Admit/Update* (HCA 13-838) form (current version). See Where can I download agency forms? Fax it to the agency at: 360-725-1966.

Note: See the agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

What happens after prior authorization is requested?

A facility intending to transfer a client to an agency-approved Acute PM&R facility or an Acute PM&R facility requesting an extension of stay for a client must do both of the following:

- Discuss the agency's authorization decision with the client or the client's legal representative, or both

- Document in the client's medical record that the agency's decision was discussed with the client or the client's legal representative, or both

When does the agency authorize administrative days?

The agency may authorize administrative days for a client who meets one of the following:

- Does not meet the "extension" authorization requirements described in this section
- Stays in the facility longer than the community standard length-of-stay
- Is waiting for a discharge destination or a discharge plan

When does the agency not authorize Acute PM&R services?

The agency does not authorize Acute PM&R services for a client who meets one of the following:

- Is deconditioned by a medical illness or by surgery
- Has loss of function primarily as a result of a psychiatric condition(s)
- Has had a recent surgery and has no complicating neurological deficits

  Examples of surgeries that do not qualify a client for Acute PM&R services without extenuating circumstances are:

  - ✓ Single amputation
  - ✓ Single extremity surgery
  - ✓ Spine surgery

Payment

What is included in Acute PM&R room and board?

(WAC 182-550-3381 (2))

Acute PM&R **room and board** includes, but is not limited to:

- Facility use
- Medical social services
- Bed and standard room furnishings
- Dietary and nursing services

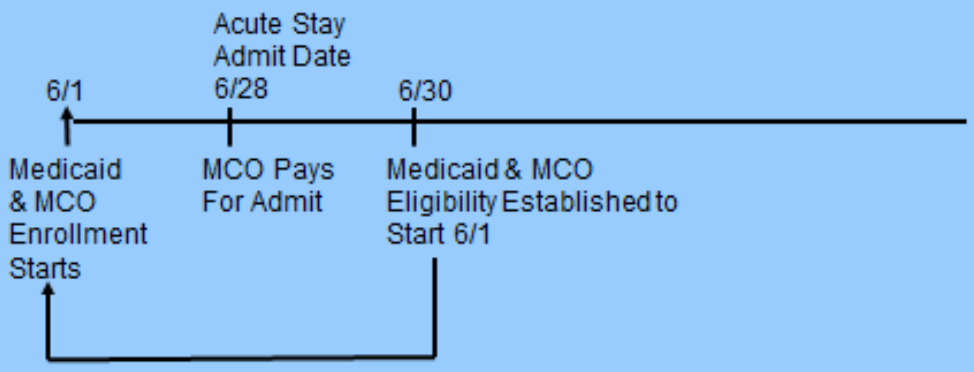
Who pays for care when a client enrolls in an agency-contracted managed care organization (MCO) during an admission?

In situations when a patient receives care from an acute medical care facility and is then transferred to a rehabilitation setting (e.g., an acute physical medicine and rehabilitation (acute PM&R) facility, a long term acute care (LTAC) facility, or a skilled nursing facility, (SNF)), each of these admissions is considered a separate event. Whether the agency or the managed care organization (MCO) pays depends on the date of admission compared to the date of Medicaid eligibility, and the date of enrollment with MCO.

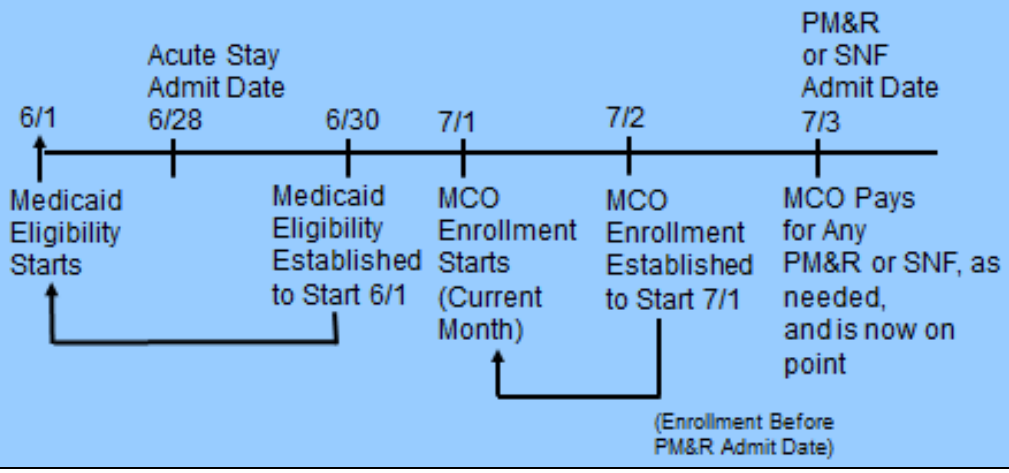
The agency does not pay:

- For an admission to an acute PM&R facility, LTAC facility, or SNF, if the MCO enrollment is effective the same month as the date of admission to this facility.
- For a covered service that is the responsibility of the agency-contracted MCO.

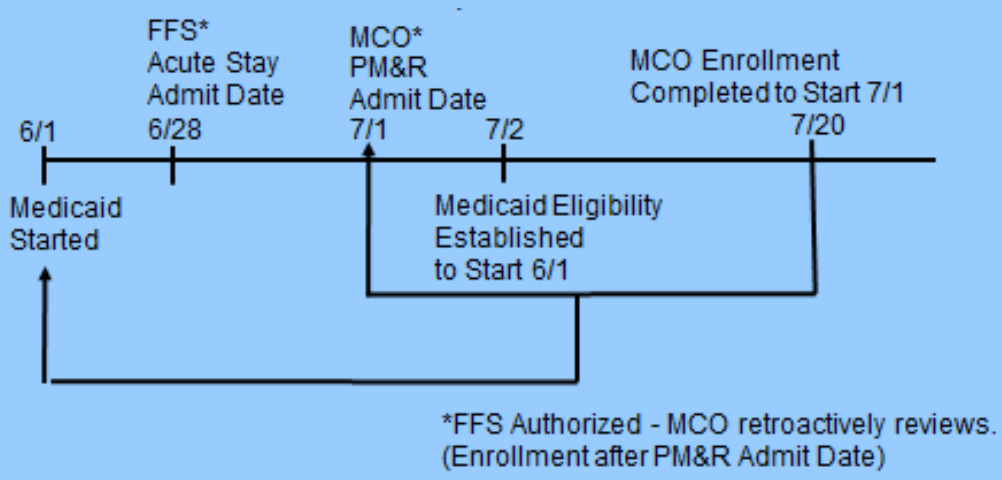
Scenario 1:
If the effective date for the client's Medicaid eligibility and MCO enrollment is *before* an acute care admission date, the MCO is responsible.



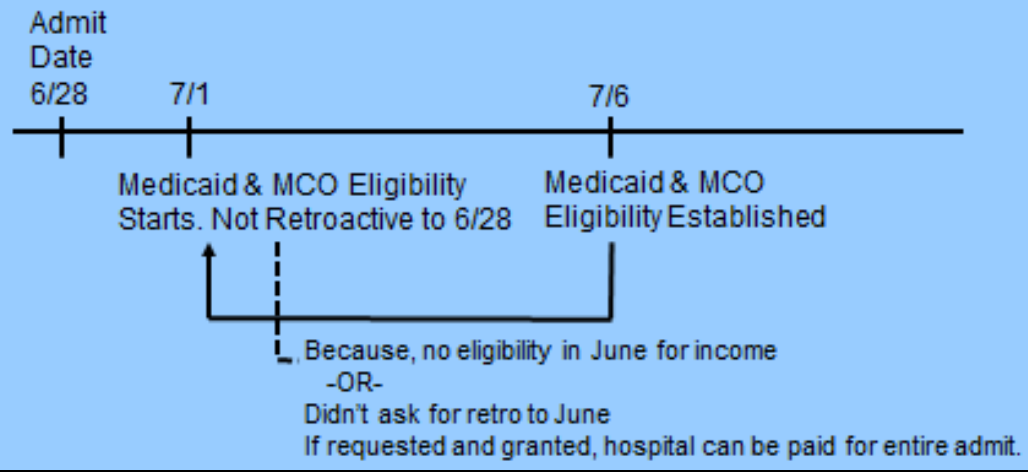
Scenario 2:
If the MCO enrollment effective date is *after* an acute care admission date, the agency fee-for-service (FFS) program is responsible for the acute care admission. The MCO is responsible for any subsequent admissions for PM&R, LTAC, or SNF services occurring after the MCO enrollment effective date.



Scenario 3:
If the MCO enrollment is effective the month following the acute care admission date, but Medicaid eligibility is established back to the first of the month in which the admission occurred, the agency FFS program is responsible for the acute care stay and any other admissions (PM&R, LTAC, SNF) that begin *before* the MCO enrollment effective date. The MCO pays for any PM&R, LTAC, or SNF admissions that begin after the MCO enrollment effective date.



Scenario 4:
If the effective dates for the client's Medicaid eligibility and MCO enrollments are *after* the acute medical, PM&R, LTAC, or SNF admission date and no retroactive eligibility is granted back to the date of admission, the agency FFS program is responsible for the admission and all days until the client's discharge. However, the agency will prorate and pay only for those dates the client is eligible for Medicaid.



How does the agency determine payment?

The agency's payment for Acute PM&R services provided by Acute PM&R facilities is described below:

- The agency pays a rehabilitation facility a per diem rate as described in WAC 182-550-3000. Payment is calculated based on client length of stay and the provider specific rehab per diem rate.

- The agency pays the per diem rate in effect at the time services are provided, minus the sum of the following:

  - ✓ Client liability, whether or not collected by the contracted provider

  - ✓ Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from the following:

    - ➢ Insurers and indemnitors;

    - ➢ Other federal or state medical care programs;

    - ➢ Payments made to the provider on behalf of the client by people or organizations not liable for the client's financial obligations; and

    - ➢ Any other contractual or legal entitlement of the client, including but not limited to the following:

      - ☐ Crime victim's compensation

      - ☐ Worker's compensation

      - ☐ Individual or group insurance

      - ☐ Court-ordered dependent support arrangements

      - ☐ The tort liability of any third party

The agency may authorize administrative days for a client who meets one of the following:

- Does not meet "extension" authorization requirements (see Prior Authorization)
- Stays in the facility longer than the **community standards length-of-stay**
- Is waiting for a discharge destination or a discharge plan. (WAC 182-550-2561(8))

How does the agency pay for administrative day(s)?

(WAC 182-550-3381(3))

When the agency authorizes administrative day(s) for a client, the agency pays the facility for both of the following:

- The administrative day rate
- Pharmaceuticals prescribed for the client's use during the administrative portion of the client's stay

How does the agency pay for ambulance transportation services provided to clients receiving Acute PM&R Services?

(WAC 182-550-3381(4))

The agency pays for transportation services provided to a client receiving Acute PM&R services in a rehabilitation facility according to Chapter 182-546 WAC.

Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

What revenue codes should I use when billing the agency for services provided in an agency-approved Acute PM&R facility?

Bill the agency using any applicable revenue code with the following exceptions:

- For Acute PM&R room and board services, bill only revenue code 0128.

- For administrative days, bill only revenue codes 0169 (Room and Board - Other) and 025x (Pharmacy).

The agency pays for covered revenue codes only. See the agency's Inpatient Hospital Services Billing Guide for a complete list.

How do I bill the agency for noncovered days?

Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	$xx.xx	
0xx4		$xx.xx

How do I bill the agency for administrative day(s)?

To receive payment for medical administrative days the hospital must bill administrative days with revenue code 0169 and all associated charges for those days on a claim separate from the acute care stay.

For the acute care stay claim the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for administrative days.

Bill the administrative day portion of the client's stay:

- On a separate claim from the Acute PM&R portion of the stay
- Using the authorization number assigned by the agency
- Using the facility's Acute PM&R provider NPI

How do I update the ProviderOne client ID number and verify the length-of-stay on an authorization number?

Fax your completed *Acute Physical Medicine and Rehabilitation (PM&R) Update* (HCA 13-839) form (current version) to the agency at: 360-725-1966. See Where can I download agency forms?