

Washington Apple Health (Medicaid)

Long-Term Acute Care Program 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 guide¹

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

¹ This publication is a billing instruction.

Authorization

For additional information on requesting authorization, see the [Authorization for Services](#) webpage.

How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) web page.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

Where can I download agency forms?

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

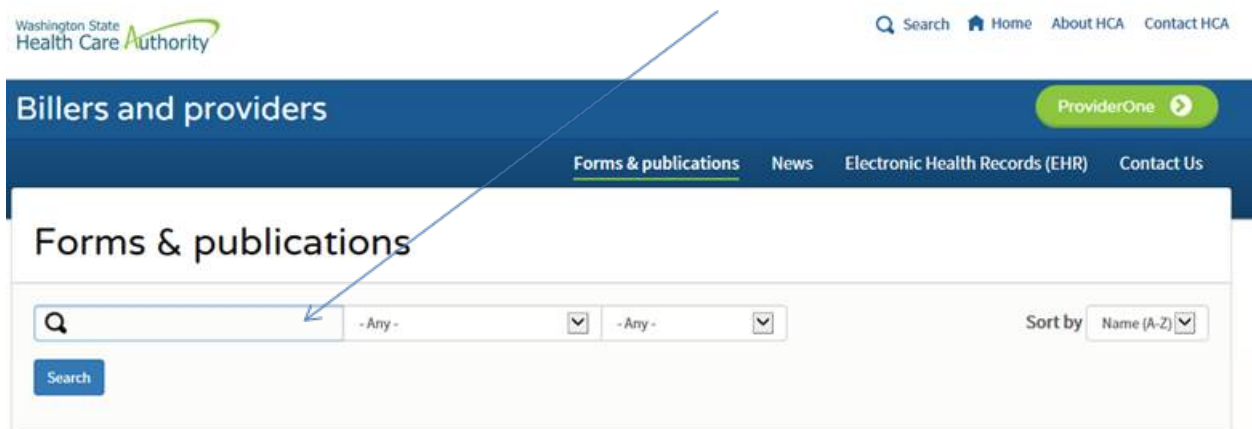


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Resources Available

Note: This section contains important contact information relevant to the Long-Term Acute Care Program. For more contact information, see the agency's [Billers and Providers](#) web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	<p>See the agency's ProviderOne Resources web page.</p>
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., provider guides, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Prior authorization, limitation extensions, or exception to rule	<ul style="list-style-type: none"> • Use the General Information for Authorization, form HCA 13-835. • Use the Long-Term Acute Care Authorization/Update Request, form HCA 13-890. Attach the LTAC intake form. • Attach the most recent hospital admission history and physical. <p>Forms can be found online Medicaid forms.</p> <p>The General Information for Authorization, form HCA 13-835 must be typed and must be the <i>cover sheet</i> when submitting the request for authorization.</p> <p>Fax the completed request to: 1-866-668-1214</p> <p>For information about downloading agency forms, see Where can I download agency forms?</p>

Definitions

This section 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.

Acute - An intense medical episode, not longer than three months.

Administrative day - A day of a hospital stay in which an acute inpatient level of care is no longer necessary, and non-inpatient hospital placement is appropriate. [\[WAC 182-550-1050\]](#)

Administrative day rate - The statewide Medicaid average daily nursing facility rate as determined by the agency.

Authorization - The agency's official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number - A nine-digit number assigned by the agency that identifies individual requests for approval of services. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied. [\[WAC 182-550-1050\]](#)

Diagnosis Related Group (DRG) - A classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or

complications, and other relevant criteria. [\[WAC 182-550-1050\]](#)

Level 1 Services - Long-term acute-care (LTAC) services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one (or both) of the following:

- Ventilator weaning care; or
- Care for a client who has:
 - Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and
 - At least one comorbid condition (such as chronic renal failure requiring hemodialysis).
 - **Level 2 services** - Long-term acute-care (LTAC) services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

- Ventilator care for a client who is ventilator-dependent and is not weanable, and has complex medical needs; or
- Care for a client who has a tracheostomy; and
 - ✓ Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and
 - ✓ Has at least one comorbid condition (such as quadriplegia.)

Long-term Acute Care (LTAC) - Inpatient intensive long-term care services provided in agency -approved LTAC hospitals to eligible medical assistance clients who require Level 1 or Level 2 services.

LTAC fixed per diem rate - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.
[WAC 182-550-1050]

Survey - An inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements. [WAC 182-550-1050]

About the Program

What is the Long-Term Acute Care (LTAC) Program?

[\[WAC 182-550-2565\]](#)

- The Long-Term Acute Care (LTAC) Program is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in an agency - approved LTAC facility during the acute phase of a client's care. These facilities specialize in treating patients that require intensive hospitalization for extended periods of time. Patients transferred to these hospitals are typically in the intensive care unit of the traditional hospital that initiated their medical care. Under federal guidelines, only a few hospitals have been designated as specialists in treating patients requiring intensive medical care for extended periods. Medicare calls these hospitals "long-term acute care hospitals" (LTAC).
- The agency requires prior authorization for all LTAC stays. The agency determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in [PA Requirements for Level 1 and Level 2 LTAC Services](#).
- A multidisciplinary team coordinates individualized LTAC services at an agency - approved LTAC facility to achieve improved health and welfare for a client.
- When the agency-authorized stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

Client Eligibility

Note: The agency requires prior authorization for all long-term acute care services. See [Prior Authorization](#) for instructions on requesting prior authorization. The agency will verify the client's eligibility prior to authorizing services.

Who is eligible?

[\[WAC 182-550-2575\]](#)

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the patient'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 current [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](#) web page.

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

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

In-person application assistance is also available. For information about local in-person application assistance available, see www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in managed care plans eligible for LTAC services?

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen.

- Clients are eligible for LTAC services through their managed care plan when the client is enrolled in the plan at the time of acute care admission.
- The plan pays for, coordinates, and authorizes LTAC services when appropriate.

The agency does not process or pay claims for clients enrolled in a managed care plan when services provided are covered under the managed care contract. Clients can contact their managed care plan 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**. For more information on how to verify a client's eligibility, see the agency [ProviderOne Billing and Resource Guide](#).

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 BHO/FIMC/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 web page](#), 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 the agency's [Regional Resources web page](#).

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, 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 web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

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 web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

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 an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to a person 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
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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Primary care case management (PCCM)

The Client Benefit Inquiry screen in ProviderOne will display the PCCM provider when a client who has chosen to obtain care with a PCCM provider. The agency requires prior authorization for LTAC Services. Prior authorization is obtained through the LTAC program manager not the PCCM provider.

Note: To prevent billing denials, please 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. Please see the agency [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Provider Requirements

What is required to become an LTAC hospital?

[\[WAC 182-550-2580\]](#)

To apply to become an agency-approved, long-term acute care (LTAC) hospital, the agency requires a hospital to:

Submit a letter of request to:

LTAC Program Manager
Healthcare Services
The Health Care Authority
P.O. Box 45506
Olympia WA 98504-5506

And

Include in the letter documentation that confirms the hospital is all of the following:

- Medicare-certified for LTAC
- Accredited by the joint commission on accreditation of healthcare organizations (JCAHO)
- For an in-state hospital, licensed as an acute care hospital by the Department of Health (DOH) under [WAC 246-310-010](#) and [Chapter 246-320 WAC](#)
- For an out of state hospital licensed as an acute care hospital by the state where the hospital is located
- Enrolled with the agency as a Medicaid participating provider

The hospital qualifies as an agency-approved LTAC hospital when all of the following are met:

- The hospital meets all the requirements in this section
- The agency has conducted an on-site visit and recommended approval of the hospital's request for LTAC designation
- The agency provides written notification to the hospital that it qualifies for payment when providing LTAC services to eligible medical assistance clients

The agency may, at its sole discretion, approve a hospital located in Idaho or Oregon that is not in a designated bordering city as an LTAC hospital if both of the following are met:

- The hospital meets the requirements of this section
- The hospital provider signs a contract with the agency agreeing to the LTAC criteria for services in accordance with [WAC 182-550-2595](#)

The agency does not have any legal obligation to approve any hospital or other entity as an LTAC hospital

Postpay or on-site reviews

[\[WAC 182-550-2585\]](#)

To ensure quality of care, the agency may conduct postpay or on-site reviews of any agency-approved LTAC hospital. See [WAC 182-550-2585](#), “Audits and the audit appeal process for contractors/providers,” for additional information about audits conducted by agency staff.

To ensure a client’s right to receive necessary quality of care, a provider of LTAC services is responsible to act on reports of substandard care or violations to the hospital’s medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or a grievance or both. A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- The Department of Health (DOH)
- [The Joint Commission on Accreditation of Healthcare Organizations \(JCAHO\)](#)
- The agency
- Other agencies with review authority for medical assistance programs

Notifying clients of their rights (advance directives)

[\[42 CFR, Subpart I\]](#)

All Medicare-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 all of the following:

- 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 health care

Prior Authorization

Does the agency require prior authorization (PA) for LTAC services?

[\[WAC 182-550-2590\]](#)

YES.

Note: Please see the agency [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

PA requirements for Level 1 and Level 2 LTAC services

The prior authorization process includes all of the following:

- **For an initial thirty-day stay:**
 - ✓ The client must meet both of the following:
 - Be eligible under one of the programs listed in [WAC 182-550-2575](#)
 - Require Level 1 or Level 2 LTAC services as defined in [WAC 182-550-1050](#)
- **Before admitting the client to the LTAC hospital the LTAC provider of services must:**
 - ✓ Submit a request for prior authorization to the agency using the following process:
 - Use the General Information for Authorization form, HCA 13-835
 - Use the Long-Term Acute Care Authorization/Update Request form, HCA 13-890
 - Attach your LTAC intake form
 - Attach the most recent hospital admission history and physical
 - Forms can be found at [Medicaid forms](#), see [Where can I download agency forms?](#)
 - The General Information for Authorization form must *be typed* and must be the *cover sheet* for your request
 - Your complete request must be faxed to: 1-866-668-1214
 - Call 360-725-5144 and leave a message that a request has been sent and include the client information (the client ID ending in WA) and a call back number

Long-Term Acute Care Services

- Include sufficient medical information to justify the requested initial stay
- Obtain prior authorization from the agency medical director or designee, when accepting the client from the transferring hospital
- Meet all the requirements in WAC [182-550-2580](#).

Note: Contact the agency to request prior authorization (see [Resources Available](#)).

To request an extension for LTAC days, please use the following instructions:

Go to [Document submission cover sheets](#):

- Scroll down and click on number 7. PA (Prior Authorization) Pend Forms.
- When the form appears on the screen, insert the Authorization Reference number (ProviderOne authorization number) in the space provided and press enter to generate the barcode on the form.

TIP: The ProviderOne authorization number for this type of request can be found using the ProviderOne authorization inquiry feature. The ProviderOne authorization number is listed above the client's ID number on the PA Utilization screen.

- Print the Pend form and use it as the cover sheet and attach the additional information behind it.
- Fax pages to the agency using the fax number on the bottom of the Pend Form.

Note: The Pend form MUST be the first page of the fax.

- Use the LTAC Request, form HCA 13-890. See [Where can I download agency forms?](#)
- Include sufficient medical information to justify the requested extension of stay.

The agency authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received.

Long-Term Acute Care Services

A client who does not agree with a decision regarding a length of stay has a right to a fair hearing under chapter [182-526](#) WAC. After receiving a request for a fair hearing, the agency may request additional information from the client and the facility, or both. After the agency reviews the available information, the result may be:

- A reversal of the initial agency decision;
- Resolution of the client's issue(s); or
- A fair hearing conducted per Chapter 182-526 WAC.

The agency may authorize an administrative day rate payment for a client who meets one or more of the following:

- Does not meet the requirements for Level 1 or Level 2 LTAC services;
- Is waiting for placement in another hospital or other facility; or
- If appropriate, is waiting to be discharged to the client's residence.

Payment

What does the LTAC fixed per diem rate include?

[\[WAC 182-550-2595 \(1\)\]](#)

In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the services and equipment in the table below. Use revenue code 100 in the appropriate field of the institutional claim when billing for the services included in the fixed per diem rate. The amount billed must be the usual and customary charges for the services included in the per diem rate. The agency pays for these services at the agency's LTAC fixed per diem rate.

Note:

- Bill the usual and customary charges for all charges incurred for services included in the fixed per diem rate under revenue code 100.
- Do not bill separately for any of the revenue codes listed below as these charges should be included in your charges for revenue code 100. **Exception: Revenue code 250.**

Revenue Code	Description
100	Your usual and customary charges for the following services are included and should be billed under revenue code 100. The agency pays for these services at the agency's LTAC fixed per diem rate.
128	Room and Board – Rehabilitation
200	Room and Board – Intensive Care
250	Pharmacy - Up to and including \$200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
270	Medical/Surgical Supplies and Devices
300	Laboratory – General
301	Laboratory – Chemistry
302	Laboratory – Immunology
305	Laboratory – Hematology
306	Laboratory – Bacteriology and Microbiology
307	Laboratory – Urology
309	Laboratory – Other Laboratory Services
410	Respiratory Services
420	Physical Therapy
430	Occupational Therapy
440	Speech-Language Therapy

Who pays for continuous care events when a client enrolls in an agency-contracted managed care organization?

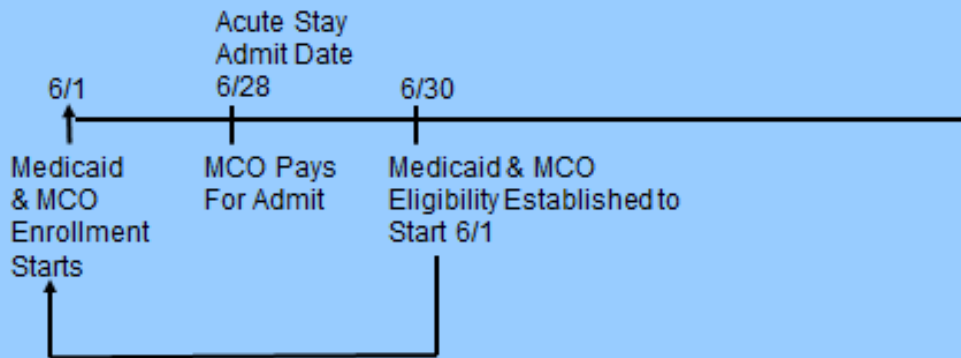
When a patient transfers from acute care to a rehabilitation setting (e.g., an acute physical medicine and rehabilitation (acute PM&R) facility, a long-term acute care (LTAC) facility, or a skilled nursing facility (SNF)), the agency considers each stay a separate event. Whether the agency of the managed care organization (MCO) pays depends on the date of admission compared to the date of Medicaid eligibility and the date of enrollment with the MCO.

The agency does not pay:

- For an admission to an acute PM&R facility, LTAC facility, or SNF, if the admission started on or after the effective date of enrollment in an MCO.
- For a covered service that is the responsibility of the agency-contracted MCO.

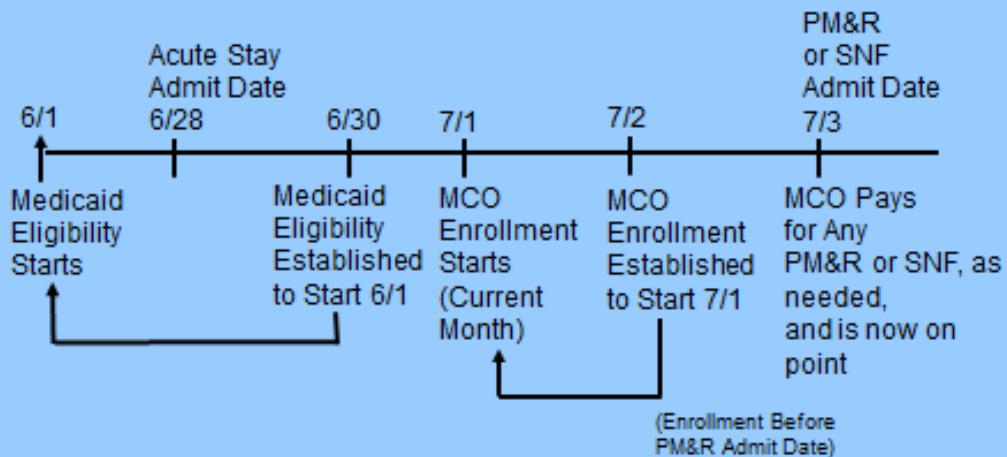
Scenario 1:

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



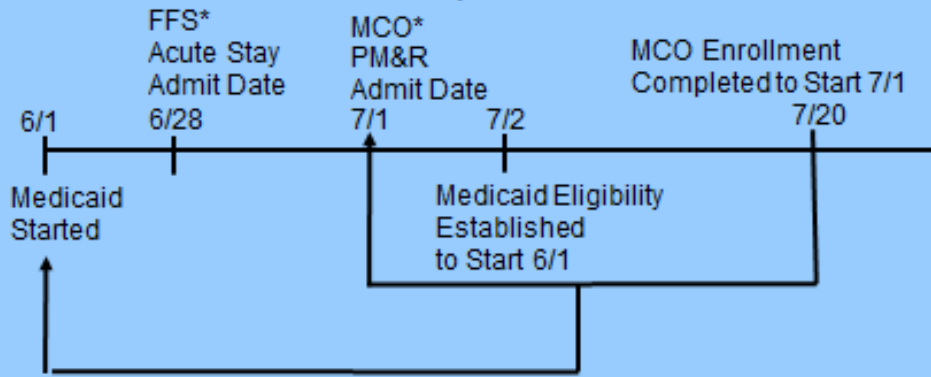
Scenario 2:

If the MCO enrollment effective date is *after* the 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:

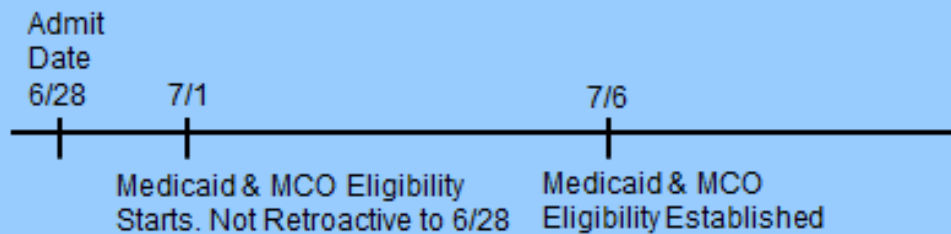
If the MCO enrollment is effective the month following the acute care admission date, but Medicaid eligibility is established back to the first of the month in which the admission occurred, the agency FFS program is responsible for the acute care stay and any other admissions (PM&R, LTAC, SNF) that begin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



*FFS Authorized - MCO retroactively reviews. (Enrollment after PM&R Admit Date)

Scenario 4:

If the effective dates for the client's Medicaid eligibility and MCO enrollments are *after* the acute care, 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 until discharge. However, the agency will prorate and pay only for those dates the client is eligible for Medicaid.



Because, no eligibility in June for income
-OR-
Didn't ask for retro to June
If requested and granted, hospital can be paid for entire admit.

What is not included in the LTAC fixed per diem rate?

[\[WAC 182-550-2596 \(1\)\]](#)

The following specific services and equipment are excluded from the LTAC fixed per diem rate and may be billed by providers in accordance with applicable agency fee or rate schedules:

Note: Bill your total usual and customary charges for revenue code 250 in the appropriate form locator field. Enter the first \$200 per day in locator 48 as noncovered.

Revenue Code	Description
250	Pharmacy - After the first \$200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
255	Drugs/Incidental Radiology
260	IV Therapy
320	Radiology
340	Nuclear Medicine
350	Computered Tomographic (CT) Scan
360	Operating Room Services
370	Anesthesia
390	Blood and Blood Component, Processing and Storage
391	Blood and Blood Component, Administration
402	Other Imaging Services – Ultrasound
460	Pulmonary Function
480	Cardiology
710	Recovery Room
730	EKG/ECG
750	Gastro-Intestinal Services
801	Inpatient Hemodialysis
921	Peripheral Vascular Lab

Note: The agency uses the appropriate payment method described in the agency’s other billing instructions to pay providers other than LTAC facilities for services and equipment that are covered by the agency but not included in the LTAC fixed per diem rate. The provider must bill the agency directly and the agency pays the provider directly. See [WAC 182-550-2596 \(2\)](#).

How does the agency determine payment for LTAC services?

[\[WAC 182-550-2595 \(2\)\]](#)

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

- Client liability, whether or not collected by the provider
- Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:
 - ✓ Insurers and indemnitors
 - ✓ Other federal or state medical care programs
 - ✓ Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations
 - ✓ Any other contractual or legal entitlement of the client, including, but not limited to:
 - Crime victims' compensation
 - Workers' compensation
 - Individual or group insurance
 - Court-ordered dependent support arrangements
 - The tort liability of any third party

Note: The agency may make an annual vendor rate increase to the LTAC fixed per diem rate. The agency may rebase the LTAC fixed per diem rate periodically.

When the agency establishes a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the agency.

Does the agency pay for ambulance transportation?

[\[WAC 182-550-2596 \(3\)\]](#)

Transportation services to transport a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC hospital, or related to transporting a client to another facility after discharge from the LTAC hospital:

- Are not covered or paid through the LTAC fixed per diem rate
- Are not payable directly to the LTAC hospital
- Are subject to the provisions in [Chapter 182-546 WAC](#)
- Must be billed directly to one of the following:
 - ✓ The agency by the transportation company to be paid if the client required ambulance transportation
 - ✓ The agency's contracted transportation broker, subject to the PA requirements and provisions described in Chapter 182-546 WAC, if the client meets one of the following:
 - Required non-emergency transportation
 - Did not have a medical condition that required transportation in a prone or supine position

Note: The agency evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions under the provisions of WAC 182-546-0400.

When the agency establishes a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the agency.

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 agency [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
- Record keeping requirements

Exception: If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

Does the agency allow interim billing?

The agency allows interim billing for hospital stays extending to 60 days. After the 60-day period is exceeded, the agency allows interim billing more frequently.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) web page, under [Webinars](#).

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 \(EDI\)](#) web page.

The following claim instructions relate to the long-term acute care program:

Name	Entry	
Place of Service	These are the only appropriate code(s) for this billing instruction:	
	Code	To Be Used For
	12	Client's residence
	13	Assisted living facility
	32	Nursing facility
	31	Skilled nursing facility
99	Other	