Cost Avoidance

Suggestions

And

Helpful Hints

ProviderOne

September 12, 2016

THIS PACKET ONLY ADDRESSES SKILLED NURSING HOME ROOM AND BOARD CLAIMS. ANY APPROVED BILLING COMMENT IS TO BE USED ONLY FOR SKILLED NURSING HOME ROOM AND BOARD CLAIMS. THOSE COMMENTS CANNOT BE USED FOR ANY OTHER SERVICES PERFORMED IN THE FACILITY.

Please remember, Coordination of Benefits has 30 days in which to process a claim once a claim is forwarded from Claims Processing to COB. Please allow at least 30 days before faxing a request concerning the status of a claim.

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Quick Overview

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Quick Overview

Medicaid (Health Care Authority - HCA) is required by federal regulation to determine the liability of third-party resources available to Medicaid clients. All resources available to the client that are applicable to costs of medical care must be used. Once the applicable resources are applied, Medicaid may make reimbursement on the balance if the insurance payment is less than Medicaid's allowed amount. (see Section 2)

It is the provider's responsibility [WAC 182-501-0200] to bill Medicaid appropriately after pursing any potentially liable third-party resource when:

1. Health insurance is indicated on the Medicaid Remittance and Status Report (RA).
2. ProviderOne contains private insurance information.
3. Provider believes insurance is available.

Medicaid COB Nursing home toll-free number: 800-562-3022 Ext. 5-1191

COB Nursing Home Case Managers' fax number: 360-725-2114

Quick Overview

Denials not related to private insurance: change in participation, class, days, award letter, Medicare (Part C) advantage/complete/replacement plans, Healthy Options, etc. Direct your calls to the appropriate contact person in the Nursing Home Claims Processing Unit. If in doubt if a policy is a Medicare Part C plan, Healthy Options plan or private insurance, access client specific policy information through your ProviderOne Portal

Nursing Home Claims Processing Unit contacts are by the first letter of the name of the Skilled Nursing Facility. Nursing Home unit: Ext. 16820 Fax: 360-725-1214

Caseload Managers in the Nursing Home Claims Processing Unit:

A-B 360-725-2149

C-E 360-725-1081

G-L 360-725-1860

M-O 360-725-2147

P-R 360-725-1054

S-Z 360-725-5128

T-Z 360-725-1282

Supervisor: 360-725-1129

If your client is confined due to an accident and/or you have questions concerning accident insurance/coverage, L & I, crime victims, please contact the Casualty Unit at 1-800-562-3022 Ext. 15462.

Estate Recovery Excess questions need to be directed to OFR: 800-562-6114

Cost Avoidance Suggestion and Hints Draft

Section 1

Suggestions

1. Always fax a copy of the insurance Explanation of Benefits or complete all of the questions in Section 8 and attach a fax coversheet along with your

proposed billing comment to: 360-725-2114, attn: COB Nursing Home Case Manager. COB will respond

2. Report the cancellation of insurance to Medicaid and the Home and Community Service Office. That cancellation could increase the client's participation amount. The insurance cancellation date needs to be faxed to Medicaid: 360-725-2114, attn: COB Nursing Home Case Manager. COB will respond.

3. ALWAYS provide a proposed billing comment with your fax. **Medicaid – COB will not provide the initial billing comment.**

4. BE PREPARED to refund the participation and report that refund to the Home and Community Service Office – see Section 10.

5. BE PREPARED to re-verify insurance coverage. Policies can be renegotiated every year. Fax a copy of Section 8 or a current denial to: 360-725-2114, attn: COB Nursing Home Case Manager. COB will respond.

6. BE PREPARED to bill the insurance if requested by the COB Nursing Home Case Manager.

7. **ALWAYS perform your "Due Diligence"** prior to sending a request for assistance. Many issues can be resolved at facility level. Please insure you have completed the following before faxing a request for assistance:

   A. Client's file. Did you review the client's file for previous faxes? Have you complied with the previous fax request for information and/or is the facility using an approved COB comment?

   B. Corrections. Did you complete all previously requested updates/revisions?

   C. Incorrect Patient Status Code. Did the client discharge from your facility? If so, did you remember to change the patient status code.

   D. Change in Circumstance. Did the client have a change in circumstance? If so, did you fax COB a new Section 8 or a new insurance denial?

   E. Breaks/Gaps in Service. Do your records reflect an accurate representation of the client's stay?

F. **Incorrect Class Codes**: Did you use inappropriate Class Codes? Class 29/Class 24 **can only be used** for a Medicare stay. (See Section 5)

G. **Award Letter**. Did you begin billing with the first date covered by the Award Letter? COB needs a record of the client's complete stay in the facility.

H. **Non-TPL Denial Reason**. Was your claim denied for something other than COB? Did you review the RA for **ALL** denial code explanations? If denied for non-TPL reasons, call your contact in Claims Processing. See the Quick Overview Section for telephone numbers.

I. **Medicare Part C or State of Washington Healthy Options Plans**. Did you review the client's policies through your ProviderOne Portal? If the only policies reflected in ProviderOne are Medicare Part C plans or State of Washington Healthy Options plans, questions/issues need to be directed to your contact in Claims Processing. See the Quick Overview Section for telephone numbers.

J. **Claim(s) "Pending/In Process"**. Did you wait for the claim to finalize? Please remember that COB has 30 days to process a claim once it is forwarded from Claims Process to COB.

Section 2

Important Sources of Information

A. **ProviderOne Billing and Resource Guide** is a guide full of information on billing, rebilling and adjusting your claims.
http://www.hca.wa.gov/assets/billers-and-providers/Nursing-Facilities-20160701.pdf

B. **Nursing Facility Billing Instructions** is the Aging and Disability Services Administration (ADSA)/Medical Assistance Administration manual for billing Nursing Facility claims to Medicaid.

C. **Numbered Memos**

A. **ProviderOne Portal**

1. Review Claim Status online.
2. Review Client Eligibility online.
3. Review Client Insurance policies online.

Section 3

Client Service Card

This plastic "swipe" card replaces the paper Medical Assistance ID Card (MAID).

ALWAYS check ProviderOne Portal for Insurance. Refer to your ProviderOne Billing and Resource Guide.

http://www.hca.wa.gov/assets/billers-and-providers/Nursing-Facilities-20160701.pdf

1. If there is no insurance listed in ProviderOne and you are aware the client has insurance:

A. Fax a copy of the insurance card (front and back), a copy of Section 8 or insurance denial, a fax coversheet and your proposed comment to: 360-725-2114, attn: COB Nursing Home Case Manager. COB will respond.

You must notify Medicaid if you know of any third-party insurance.

Section 4

Billing Medicaid

ALWAYS bill Medicaid, it will:

1. Keep your award letter valid.
2. Medicaid needs the client's complete history while they are on Public Assistance even if there is a primary insurance.

A client's insurance company can be verified online through ProviderOne Portal.

If the client's insurance is one of the following, please use the comment that is provided and rebill:

AP01 – American Postal Workers Union
Comment: APWU – no SNF benefits

GE01 – Government Employees Health Association will pay the first 14 days at a SNF following transfer from acute inpatient confinement when skilled care is still required. **If your comment states there are no SNF benefits, it will be denied .** Please correct to one of the following comments depending on the client's circumstances:

If the client has a QHS and the **QHS is not** followed by a Medicare stay. 14 days will need to be billed to GEHC. Once payment is received, rebill Medicaid and place the insurance payment on the claim and in the billing comment per Section 10.

Section 4

If the facility is billing class codes 20/23/26/27/40/50/60 and there was no QHS use:
Comment: GEHC requires QHS – no QHS

If the facility is billing dates of service after 14 days that were paid by GEHC use:
Comment: GEHC requires QHS – no QHS.

If the client has a Medicare stay, GEHC will not pay the 14 days following the QHS. When billing Class 29/Class 24 claims use:
Comment: GEHC – 14 days paid by Medicare.

If the facility is billing dates of service after Medicare ceased paying use:
Comment: GEHC requires QHS – no QHS

MA21 – Mail Handlers Benefit Plan (MHBP)
Comment: Mail Handlers – no SNF benefits

Mail Handlers Exception: as of 1/1/2012 date of service: For non-Medicare members (client not enrolled in Medicare; no entitlement) Mail Handlers will cover 15 days of room and board with Qualifying Hospital Stay and with pre-authorization.
Comment: Mail Handlers 15 days billed (span of dates)

SE07 – State Employees Group Benefit Plan (SEGB)
Comment – SEGB – no SNF benefit

HI50 – Uniformed Services Family Health Plan (Pacific Medical Center) shown in DEERS as USFHP/Tricare Prime.

Section 4

If the SNF is contracted with USFHP, we will require either a denial or Section 8 completed and faxed to COB.
The five Skilled Nursing Facilities contracted with USFHP that would require a denial or section 8 completed are:

1. Washington Care Center
2. Anderson House
3. Queen Anne Care Center
4. Stafford Health Care
5. Madeleine Villa as of 1/1/2013
6. Cascade Vista no longer contracted as of 1/1/2013

If the SNF is not contracted with USFHP, use comment: USFHP – no SNF benefit

Class Codes

1. **ALWAYS USE THE CORRECT CLASS CODE.**

   See page B.1 of the Nursing Home Facility Billing Instructions. **These instructions are for clients with private insurance**. Clients with Medicare Part C replacement/advantage/complete plans or Healthy Options plans, call your contact in claims processing – see Quick Overview for telephone numbers. If unsure if a policy is a Medicare Part C plan or Healthy Options plan, review the client's policies through your ProviderOne Portal.

2. **DO NOT** use class 29 or class 24 when billing for a client who has insurance and **IS NOT** in a Medicare stay. If a facility did not or will not receive a Medicare EOMB showing Medicare made payment than **DO NOT** bill Class 29 or Class 24. The facility must be able to show an auditor a Medicare EOMB upon request.

   A. Class 29 is to be used for the first 20 days of a Medicare stay (days 1-20) where Medicare is paying the service in full.

   B. Class 24 is to be used for the next 80 days of a Medicare stay (days 21-100) where Medicare is making a partial payment.

3. Once the client is no longer in a Medicare stay or if the client was never in a Medicare stay, change to the appropriate non-Medicare class code, place the insurance payment on the claim and in the billing comment per Section 10.

4. See Section 9 Managing Your Insurance Comments Correctly.

For the Nursing Home Facility Billing Instructions:

http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx

Billing Private Insurance

1. Always be prepared to bill the insurance if requested by the COB Nursing Home Case Manager.

2. Insurance company timely filing limits vary. It is the provider's responsibility to meet the insurance carriers billing time limit prior to receiving payment by Medicaid.

3. Perform appropriate follow-up with the insurance company within a reasonable amount of time or access their website to check the status of the claim.
4. Bill your private rate. The private insurance is primary to Medicaid.
5. Comply with the insurance company's request for additional information.
6. Do not bill the private insurance using 210 in the Type of Bill box 4 on your UB claim form. Change to a 211, 212, 213, etc.

Rebilling Medicaid with an Insurance Denial

The definition of skilled care differs between Medicare, Medicaid and Insurance Companies.

1. If the insurance denies the room and board and **you are unsure what the insurance denial reason means, PLEASE CONTACT THE INSURANCE COMPANY for clarification.) Medicaid cannot interpret an insurance denial for the facility.**

Fax a copy of your insurance denial or complete all of the questions in Section 8 along with your fax coversheet and proposed comment to: 360-725-2114, attn: COB Nursing Home Case Manager. **Medicaid will not provide billing comments**. Coordination of Benefits must have something in writing for their files. COB will respond.

Some valid denials:

1. **Policy maxed/maximum benefit paid/maxed per calendar year**: give the date the policy maxed, how many days per calendar year it covers and when it ended, what criteria is required for the client to re-qualify or if it is maxed for a lifetime and the date it maxed.
2. **Elimination period**: give the elimination period dates.
3. **No qualifying hospital stay.**
4. **100 Medicare days required and not used**

Section 7

5. **Determined custodial/not medically necessary:** the SNF must provide a copy of the insurance EOB/letter that shows the insurance determined the care custodial/not medically necessary

Examples of Proposed Billing Comments: (**ALWAYS** include the name of the insurance company in your comments).

1. Cigna determined condition not medically necessary per review of medical records.
2. Uniform requires 100 Medicare days used – not used.
3. Aetna's review of medical records determined custodial.

4. CNA elimination period 5-1-12 to 6-30-12
5. UHC requires QHS – no QHS.

Some invalid denial

1. **Not covered/not covered under contract/not a contract provision** – provider will need to call the insurance to clarify why the service is not covered/not a provision. They may find that additional information is required. That is not a valid denial. Any information requested by the insurance must be provided. If the insurance company states the services are not covered/not a contract provision, COB needs to know why the room and board is not covered.
2. **Need a Medicare denial.**
3. **Need medical records.**
4. **Additional information required.**
5. **Bill primary carrier.**

Section 7

6. **Pre-certification/Pre-authorization/Referral required or requirement not completed in a timely fashion.**
7. **Claim form needs to be completed.**
8. **Custodial/not medically necessary:** Medicaid will need to see the custodial/not medically necessary denial from the insurance company.

Section 8

Please make sure the facility performs their "Due Diligence" prior to faxing a request for assistance. See Section 1 "Suggestions" number 7.

Questions to Ask an Insurance Company

If you have a current valid insurance denial on file, please fax it with your proposed comment to: 360-725-2114, attn: COB Nursing Home Case Manager. If not, please complete Section 8 and fax it to 360-725-2114, with your comment. Please provide either a denial or completed Section 8. Medicaid will not provide the initial billing comment.

Your fax needs to contain:

A. Client's Name and ProviderOne WA Client ID Number

B. TCN Number(s)

C. Date of call.

D. Name of Insurance Company

E. Name of Contact @ Insurance Company

F. Telephone number of Insurance Company.

G. Policy number

Section 8

Please ask the insurance company the following questions:

A. **What is the benefit for a stay in a skilled nursing facility?**

If the client is not enrolled in Medicare **and** does not have a Medicare HIC number, skip to number 4, but please indicate the client does not have a Medicare HIC number.

1. "Does the policy cover any Medicare days?"
2. "Will the policy pay past the 100th Medicare day?"
3. "If the policy pays past the 100th Medicare day, how many more days will the policy pay?" (Get the number of days).

4. **AND/OR** "Does this policy pay a certain number of days per calendar year"? (Get the number of days).
5. "Does the policy follow Medicare's guidelines"?
6. "Would the policy possibly pay with a Medicare denial? **And/or** what would be required for adjudication? Review of Chart notes/Medical records? What would the insurance need as proof of medical necessity?"

B. If the policy covers skilled nursing facility days ask:

What would be required in order to have a claim adjudicated for possible payment?"

1. "Does the policy require a qualifying hospital stay? If so, how many days?"
2. "Would it need pre-authorization/certification? If so, would they retro-authorize/certify?" (Would additional days require pre-authorization?).

3. "Would it need a referral? Is so, would they retro-refer?"
4. "Will the insurance pay an in-network provider? Will they pay a non-network provider?"
5. Would they need a hospital billing showing proof of a hospital stay

C. Is Custodial care covered? Fax a copy of the current insurance "custodial" denial to Medicaid.

If there is no current insurance denial on file at the facility, Medicaid cannot approve a "custodial" comment.

D. Services not Covered? <u>Medicaid needs to know what criteria the INSURANCE COMPANY used to determine the care was not covered.</u>

If the insurance company states the services are "not covered", the facility will need to contact the insurance company for clarification as to why the services are not covered. Additional information may be requested from the insurance company in order for them to consider payment. Failure to provide the requested information to the insurance company is not a valid denial.

<u>EXAMPLE FAX COVER SHEET FOLLOWS</u>

Nursing Facility Name:
NPI Number:
Address:

Phone Number:
Fax Number:

COB Fax #: 360-725-2114

Attn: COB Nursing Home Case Manager From:
ACES ID #: Pages:
Client WA ID #: Date:
Client Name: CC.
TCN (claim number(s) for our review)

See Attached: Completed Section 8: Valid Insurance Denial:

If the client had a Medicare stay, include a copy of the Notice of Medicare Non-Coverage form and the name and title of the qualified Skilled Nursing Facility representative who made the determination that the client was no longer skilled according to Medicare guidelines.

Briefly state the reason why insurance company will not cover the room and board. If proposing a custodial comment, **attach a copy of the current insurance company denial.**

My proposed billing comment will read:

Name: Title:
Signature: Date:

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Section 9

Managing Your Insurance Comments

Providers will manage the client's insurance comments. Once the COB Nursing Home Case Manager has faxed an approved billing comment, re-submit your claim on-line with the approved comment.

1. **Do not use a comment for Medicare supplement plans A through N, unless there is an Class 24 insurance payment**. (see Section 10)

2. Questions concerning State of Washington Healthy Option plans or Medicare (Part C) replacement/advantage/complete plans, should be directed to the Nursing Home Claims Processing Unit – telephone numbers can be found in the Quick Overview and in the Nursing Facility Billing Instructions.

3. If the insurance is cancelled and Medicaid has been notified, no comment is necessary after the termination date of the insurance. To verify if the insurance has been terminated by Medicaid, review the policy through your ProviderOne Portal.

4. Medicaid will periodically require an updated Section 8/current denial.

5. If there is a change in circumstance, Medicaid will need to see a new denial/Section 8.

6. If there is a change in insurance, fax the new insurance information to Medicaid and remove your comment. Once a denial/Section 8 is received/completed, fax that along with a coversheet and your proposed comment to: 360-725-2114, attn: COB Nursing Home Case Manager. **Medicaid will not provide a comment**. COB will respond.

7. Change your comment for Class 29 days. **Example:** Medicare paid in full, BC Fed paid 0.

8. When an insurance ceases paying, fax a copy of the denial along with a fax coversheet and your proposed comment to: 360-725-2114, attn: COB Nursing Home Case Manager. **Medicaid will not provide a comment.** Cob will respond.

Rebilling Medicaid with Insurance Payment and Refunding Participation

For instructions as to how to place an insurance payment on your claim:

Provider relations has produced and posted an insurance webinar and presentation slides on web page http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx under the "SUBMIT FEE FOR SERVICE CLAIMS (PROFESSIONAL, DENTAL, INSTITUTIONAL" link. Expand the link and go to the Institutional subsection titled: Submit an Institutional Claim with Primary Insurance other than Medicare". Click on presentation slides and Q & A. The presentation slides contain shots of "pictures" about how to bill the commercial insurance secondary claims with or without sending the EOB.

ProviderOne Billing and Resource Guide:

1. http://www.hca.wa.gov/billers-providers/providerone-resources
2.
3. If the insurance paid for room and board:

   A. **Apply the insurance payment to the claim (review the Provider Relations website listed above) and place the insurance paid amount and name of the insurance in your billing comment.**
   The two amounts must match.

   B. If Medicaid has conflicting insurance information, your claim will be denied until the conflict is resolved.

   C. Since the insurance company was billed the Skilled Nursing Facility private rate, it is possible that you will need to refund all/part of the client's participation and report that refund to the Home and Community Service Office (HCS). [WAC 388-96-803 See attached.]

HOW TO DETERMINE EXCESS PARTICIPATION FOLLOWS:

HOW TO DETERMINE EXCESS PARTICIPATION

These examples will be using an example private rate when billing the insurance company.

Example:

If the private rate is $200.00 per day for a 30 day month the billed amount would be $6000.00.

If the Medicaid rate for the same month is $150.00 per day for a 30 day month the Medicaid billed amount would be $4500.00

If the client participation is $1500.00 per month, the SNF would collect the client participation of $1500.00 and bill the insurance company the private rate of $200.00 per day

First Example:

$6000.00 Private rate billed to insurance company
$2000.00 Paid by the insurance company

Take the:

$4500.00 Medicaid rate Minus
$2000.00 Amount paid by insurance company Leaves:

$2500.00 Still due for the client's care Minus
$1500.00 Client Participation for the month Leaves

$1000.00 Still due from Medicaid. Re-bill Medicaid. There is no excess to refund and report.

Second Example:

$6000.00 Private rate billed to insurance company
$3500.00 Paid by insurance company

Take the:

$4500.00 Medicaid rate Minus
$3500.00 Amount paid by insurance company Leaves

$1000.00 Still due for the client's care Minus
$1500.00 Client Participation for the month Leaves

$500.00 of the client's participation **needs to be refunded** to the client and reported to the HCS office per attached WAC.

Third Example:

$6000.00 Private rate billed to insurance company
$4500.00 Paid by insurance company
Take the:

$4500.00 Medicaid rate Minus
$4500.00 Paid by insurance company Leaves

$0 Due for the client's care Minus
$1500.00 Client Participation for the month Leaves

$1500.00 of the client's participation **needs to be refunded** to the client and reported to the HCS office per attached WAC.

REMEMBER: If the insurance payment is the same or greater than the Medicaid billed amount, the full participation must be refunded to the client and reported to the Home and Community Service Office as a change in circumstance.

Fourth Example:

$6000.00 Private rate billed to the insurance company
$5500.00 Paid by the insurance company

Take the:

$4500.00 Medicaid rate Minus
$5500.00 Paid by insurance company Leave

$1000.00 Paid by the insurance company over the Medicaid billed amount and the client paid

$1500.00 in participation. That participation will **need to refunded** to the client and reported to the Home and Community Service Office per the attached WAC as a change in circumstance.

DO NOT refund $2500.00 ($1000.00 additional paid by insurance company plus $1500.00 client participation). The SNF is only concerned with repaying the client's participation amount. The SNF may keep the $1000.00 over the Medicaid rate.

REMEMBER: If the insurance payment is the same or greater than the Medicaid rate it is possible that part/all of the participation would need to be refunded to the client and reported to the HCS office.

TITLES >> WAC 288 TITLE >> WAC 388 – 96 CHAPTER

WAC 388-96-803 When a nursing facility (NF) contractor becomes aware of a change in the Medicaid resident's Income and/or resources, must he or she report it? Yes, within seventy-two hours of becoming aware of a change in the Medicaid resident's income and/or resources, the NF contractor will report the change in writing to the home and community services office serving the area in which the NF is located. When reporting the change, the NF contractor will include copies of any available documentation of the change in the Medicaid resident's income and/or resources.

[Statutory Authority: RCW 74.46.800 01-12-037 388-96-803, filed 5/29/01, effective 6/29/01]

Section 11

Home and Community Service

Good Cause Policy

Section 11

Why did Medicaid deny my claim after the insurance company denied it for non-network/non-participating./non-contracted provider?

When the insurance information is reflected in ProviderOne, Medicaid normally does not pay for services performed out of network. (ProviderOne Portal should be checked for insurance information).

Home & Community Services Private Health Insurance and Good Cause Determinations

Medicaid clients are required to cooperate in the identification and use of third party liability (insurance carriers) that may be responsible for paying for nursing facility care and other long-term care services. Clients may object to the options offered by their private insurance for a variety of reasons, including the location of the facility. The Department is allowed to exempt the client from cooperation if we have determined that there is "good cause" for the exemption.

If a client has third party liability (TPL) and resides in a facility that is a non-participating/non-network/non-contracted provider of the plan, the following process will occur:

1. The nursing facility will contact the insurance carrier to determine if they will pay a non-participating/non-network/non-contracted provider, or can decide to become a participating/network/contracted provider, if possible.
2. If the TPL has denied coverage and the nursing facility believes good cause exists, the nursing home must contact the client's NFCM through the local HCS office.
3. The local NFCM determines if a client should be exempted from using their TPL if there is no DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes from the client's current residence.
4. If there is a DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes of the client's current residence, the NFCM will talk with the client and/or the client's representative about the possibility of moving to a facility that is in the insurance carrier's network.
5. The local NFCM in coordination with their supervisor will determine if good cause exists.

The final decision regarding good cause is made by the local HCS office. To determine good cause, the local NFCM will evaluate the reasons why the client does not want to transfer to a participating network provider. Good cause can include a variety of reasons such as location, physical or emotional harm, or that a move to a different NF will cause transfer trauma. The NFCM will document in the SER if good cause is approved or denied. If approved, the NFCM must inform the HCA-Coordination of Benefits Unit (nursing home desk) by calling the following number and extension.

1-800-562-3022 ext. 5-1191

If the client is deceased, no longer a resident at the facility, or no longer has the insurance, a local exception to policy to WAC 182-501-0200 may be submitted by the nursing facility directly to ALTSA headquarters to the NFCM Program Manager.

Note: The Veterans Affairs Registered Nurses (VARN) or other designee of the Washington Department of Veterans Affairs shall complete all good cause determinations for all state Veteran's home placements.

*****Any questions by the NFCM at the HCS office concerning this policy will need to be directed to Home and Community Services in Olympia. Please call 360-725-2561 or 360-725-2318 with your questions. IMR/ICF (see below). IMR/ICF facilities please contact DDD - 360-725-3206.**