Washington State Health Care Authority

Medicaid Provider Guide

Long Term Acute Care (LTAC) Program
[WAC 182-550-2565 through 2595]

July 1, 2012

A Billing Instruction

About This Guide

This Guide supersedes all previous Agency *Long Term Acute Care Program Billing Instructions* published by the Health and Recovery Services Administration, Washington State Health Care Authority.

> **Note:** The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

This companion document applies to the Long Term Acute Care (LTAC) program. Please refer to the ProviderOne Billing and Resource Guide online for valuable information to help you conduct business with the Agency.

Authorization Section

For additional information on requesting authorization, please go to the Authorization for Services webpage.

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
PN 12-50	7-1-12	Prior Authorization Page D.1	PA Requirements for Level 1 and Level 2 LTAC Services	New process for submitting prior authorization request before admission to an LTAC hospital.
	7-1-12	Prior Authorization Page D.2	PA Requirements for Level 1 and Level 2 LTAC Services	New process for submitting requests for an extension of LTAC days.

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print Agency Provider Notices and Medicaid Provider Guides, go to the Agency's Provider Publications website.
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Table of Contents

Important Contacts

Note: This section contains important contact information relevant to the Long Term Acute Care Program. For more contact information, see the Agency *Resources Available* web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency *Resources Available* web page
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Prior authorization, limitation extensions, or exception to rule	• 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. Forms can be found online Medicaid forms. The General Information for Authorization, form HCA 13-835 must be typed and must be the ***cover sheet*** when submitting the request for authorization. Fax the completed request to: 1-866-668-1214

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Agency *ProviderOne Billing and Resource Guide* for a more complete list of definitions.

Acute - An intense medical episode, not longer than two 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, pended, 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]

Eligible Client – An Agency client eligible for Level 1 or Level 2 LTAC services. [WAC 182-550-2570]

Family – Individuals who are important to and designated by the patient or client and need not be related. [WAC 182-550-2570]

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). [WAC 182-550-2570]

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 or Review - An inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements. [WAC 182-550-2570]

About the Program

What Is the Long Term Acute Care (LTAC) Program?

[Refer to 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. See the "*What are the requirements for prior authorization?"* on page D.1.

- A multidisciplinary team coordinates individualized LTAC services at an Agency -approved LTAC facility to achieve improved health and welfare for a client.

- 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 the "*Is Prior Authorization(PA) Required for LTAC Services?*" on page D.1.

- 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. Refer to the Prior Authorization, Section D for instructions on requesting prior authorization. The Agency will verify the client's eligibility prior to authorizing services.

Who Is Eligible? [Refer to WAC 182-550-2575]

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 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 Health Care Coverage—Program Benefit Packages and Scope of Service Categories 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. 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 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, please 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, please see the Agency *ProviderOne Billing and Resource Guide*.

Are Clients Enrolled in the Washington Medicaid Integration Partnership (WMIP) Program Eligible for LTAC Services?

The Washington Medicaid Integration Partnership (WMIP) is a managed care plan with an Agency contract. Clients enrolled in the WMIP program receive LTAC services the same as clients enrolled in Healthy Options (HO).

Please see the Agency *ProviderOne Billing and Resource Guide* for instructions on how to verify a WMIP client's eligibility.

Clients are eligible for LTAC services when enrolled in WMIP at the time of acute care admission. WMIP will pay for, coordinate, and authorize LTAC services when appropriate.

The Agency does not pay claims for clients enrolled in WMIP when services are provided under the WMIP contract. Clients can contact their managed care plan by calling the telephone number provided to them.

> **Note:** Clients on General Assistance - Unemployable (GA-U) are **not** eligible for LTAC services.

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?

[Refer to 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:

  - ✓ 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 chapter 246-320 WAC; or
  - ✓ For an out of state hospital licensed as an acute care hospital by the state where the hospital is located, and
  - ✓ Enrolled with the Agency as a Medicaid participating provider.

The hospital qualifies as an Agency-approved LTAC hospital when:

- 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; and
- 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:

- The hospital meets the requirements of this section; and
- The hospital provider signs a contract with the Agency agreeing to the payment rates established for LTAC 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/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 182-502-0240, "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; or
- 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:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- 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:
    - ➢ Be eligible under one of the programs listed in WAC 182-550-2575; and
    - ➢ Require Level 1 or Level 2 LTAC services as defined in WAC 182-550-2570.
- 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.

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.

- 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; and
- Meet all the requirements in WAC 182-550-2580.

> **Note:** Contact the Agency to request prior authorization (see the *Important Contacts* section).

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
- 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.

A client who does not agree with a decision regarding a length of stay has a right to a fair hearing under chapter 388-02 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 388-02 WAC.

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

The client:

- 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?

[Refer to 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 form locator field on the UB-04 claim form 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, see instruction in note on E.3.

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

What Is Not Included in the LTAC Fixed Per Diem Rate?

[Refer to 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 and/or rate schedules:

Note: Bill your total usual and customary charges for revenue code 250 in the appropriate form locator field. Enter the first $200.00 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. **[Refer to 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:

- Client liability, whether or not collected by the provider; and
- 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; and
  - ✓ 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; and
    - ➢ 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; and
- Must be billed directly to:
  - ✓ The Agency by the transportation company to be paid if the client required ambulance transportation; or
  - ✓ The Agency's contracted transportation broker, subject to the PA requirements and provisions described in Chapter 182-546 WAC, if the client:
    - ➢ Required non-emergency transportation; or
    - ➢ 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 182-501-0165 and 182-501-0169.

When the Agency established 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 and Claim Forms

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; and
- 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.

Completing the CMS-1500 Claim Form

Note: Refer to the Agency *ProviderOne Billing and Resource Guide* for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to the Long Term Acute Care program:

Field No.	Name	Entry	
24B	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

Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.