Health and Recovery Services Administration (HRSA)

Long Term Acute Care (LTAC) Program

Billing Instructions

WAC 388-550-2565 through 2595

Copyright Disclosure

About this publication

This publication supersedes all previous DSHS Long Term Acute Care (LTAC) Program Billing Instructions published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use DSHS's toll-free lines for questions regarding its programs; however, DSHS's response is based solely on the information provided to the [DSHS] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern DSHS's programs.
[WAC 388-502-0020(2)].

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

- Click ***Sign up to be a DSHS WA state Medicaid provider***
- Click ***I want to sign up as a DSHS Washington State Medical provider***
- Click ***What happens once I return my application?***

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***I want to make a change to my provider information***

Payments, denials, claims processing, or DSHS managed care organizations?

Visit the Customer Service Center for Providers at:
http://hrsa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***Frequently Asked Questions***

or call/fax:

LTAC Program Manager
Division of Healthcare Services
1-360-725-2005
1-360-725-1966 Fax

If I don't have access to the Internet, how do I find information on…

Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
1-800-562-3022 (toll free)

or write to:

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on… (cont.)

Private insurance or third-party liability, other than DSHS managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136 (toll free)

Where do I send paper claims?

Claims Processing
PO Box 9248
Olympia, WA 98507-9248

How do I find out about Internet billing (electronic claims submission)?

Call the HRSA/HIPAA E-Help Desk at:
1-800-562-3022 (toll free) and choose option #2

or e-mail to:
hipaae-help@dshs.wa.gov

- or -

Visit DSHS at:
WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click ***Medicaid*** then ***Washington State***.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click ***Medicaid***, then ***Washington State***, then ***Enrollment***.

or call ACS EDI Gateway, Inc. at:
1-800-833-2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 1-800-833-2051.

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit:
http://hrsa.dshs.wa.gov

Click ***Billing Instructions/Numbered Memoranda***

How do I check on a client's eligibility status?

Call DSHS at:
1-800-562-3022 (toll free) option #2

You may also access the WAMedWeb Online Tutorial at:
http://hrsa.dshs.wa.gov/wamedwebtutor

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Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

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 388-550-1050]

Administrative Day Rate - The statewide Medicaid average daily nursing facility rate as determined by the DSHS.

Authorization - DSHS 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 DSHS 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 388-550-1050]

Client - An individual who has been determined eligible to receive medical or health care services under any DSHS program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Core Provider Agreement - The basic contract between DSHS and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

DSHS - Department of Social and Health Services.

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 388-550-1050]

Division of Healthcare Services (DHS) - A division within the Health and Recovery Services Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service programs.

Eligible Client – A DSHS client eligible for Level 1 or Level 2 LTAC services. [WAC 388-550-2570]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Family – Individuals who are important to and designated by the patient or client and need not be related. [WAC 388-550-2570]

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

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 388-550-2570]

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 DSHS-approved LTAC hospitals to eligible medical assistance clients who require Level 1 or Level 2 services.

LTAC Fixed Per Diem Rate- The daily rate DSHS reimburses for LTAC room and board and selected services.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

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 388-550-2570]

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About the Program

What Is the Long Term Acute Care (LTAC) Program?
[Refer to WAC 388-550-2565]

- The long term acute care (LTAC) program is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a DSHS-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).

- DSHS 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 a DSHS-approved LTAC facility to achieve improved health and welfare for a client.

- DSHS 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 DSHS-authorized length of 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.

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Client Eligibility

DSHS requires prior authorization for all long term acute care services. Refer to the Prior Authorization, Section D for instructions on requesting prior authorization. DSHS will verify the client's eligibility prior to authorizing services.

Who Is Eligible? [Refer to WAC 388-550-2575]

Clients presenting Medical Identification (ID) cards with the following program identifiers **are eligible** for LTAC services:

Note: To prevent claim denials, please check the client's Medical ID Card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the plan.

Medical ID Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP **SCHIP**	Categorically Needy Program – State Children's Health Insurance Program
CNP	Children's Health Program
CNP **Emergency Medical Only**	Categorically Needy Program – Emergency Medical Only
LCP-MNP	Limited Casualty Program – Medically Needy Program
AEM (CNP) or AEM (LCP-MNP) **Alien Emergency Medical Only**	Limited Casualty Program– Medically Needy Program - Alien Emergency Medical Only

Are Clients Enrolled in Managed Care Plans Eligible for LTAC Services?

Yes! Clients who have a Medical ID card that has an HMO identifier in the HMO column are enrolled in a DSHS contracted Healthy Options (HO) managed care plan.

- Clients are eligible for LTAC services through their (HO) 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.

DSHS does not process or reimburse claims for clients enrolled in a HO managed care plan when services provided are covered under the HO contract. You may contact the plan by calling the telephone number indicated on the clients Medical ID Card.

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 a DSHS contract. Clients enrolled in the WMIP program receive LTAC services the same as clients enrolled in Healthy Options (HO).

Clients enrolled in WMIP will have the word "MINT." in the HMO column on their Medical ID card.

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.

DSHS does not process or reimburse claims for clients enrolled in WMIP when services are provided under the WMIP contract. You may contact the plan by calling the telephone number indicated on the clients Medical ID Card.

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

Primary Care Case Management (PCCM)

For the client that has chosen to obtain care with a PCCM the identifier in the HMO column will be "PCCM". DSHS requires prior authorization for LTAC Services. Prior authorization is obtained through the LTAC program manager not the PCCM provider.

Provider Requirements

What is Required to Become an LTAC Hospital?

[Refer to WAC 388-550-2580]

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

Submit a letter of request to:

LTAC Program Manager
Division of Healthcare Services
Health and Recovery Services Administration
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 DSHS as a Medicaid participating provider.

The hospital qualifies as a DSHS-approved LTAC hospital when:

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

DSHS may, in 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 department agreeing to the payment rates established for LTAC services in accordance with WAC 388-550-2595.

DSHS does not have any legal obligation to approve any hospital or other entity as an LTAC hospital.

Postpay/On-site Reviews **[WAC 388-550-2585]**

To ensure quality of care, DSHS may conduct postpay or on-site reviews of any DSHS approved LTAC hospital. See WAC 388-502-0240, "Audits and the audit appeal process for contractors/providers," for additional information about audits conducted by DSHS 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);
- DSHS; 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 their health care.

Prior Authorization

Does DSHS Require Prior Authorization (PA) for LTAC Services?

[WAC 388-550-2590]

YES!

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 388-550-2575; and
    - ➢ Require Level 1 or Level 2 LTAC services as defined in WAC 388-550-2570.
- Before admitting the client to the LTAC hospital the LTAC provider of services must:
  - ✓ Submit a request for prior authorization to DSHS by fax, electronic mail, or telephone, as published in the DSHS LTAC billing instructions;
  - ✓ Include sufficient medical information to justify the requested initial stay;
  - ✓ Obtain prior authorization from the DSHS medical director or designee, when accepting the client from the transferring hospital; and
  - ✓ Meet all the requirements in WAC 388-550-2580.

<u>TO REQUEST PRIOR AUTHORIZATION</u>
Send a fax to:
LTAC Program Manager
Division of Healthcare Services
360-725-1966 Fax

For any extensions of stay the LTAC provider of services must:

- Submit a request for the extension of stay to DSHS by fax or telephone;
- Include sufficient medical information to justify the requested extension of stay.

DSHS 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, DSHS may request additional information from the client and the facility, or both. After DSHS reviews the available information, the result may be:

- A reversal of the initial DSHS decision;
- Resolution of the client's issue(s); or
- A fair hearing conducted per chapter 388-02 WAC.

DSHS 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.

Reimbursement

What Does the LTAC Fixed Per Diem Rate Include?

[Refer to WAC 388-550-2595 (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, see page G.1, 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. DSHS reimburses for these services at DSHS'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 codes 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 E3.

Revenue Code	Description
100	**Your usual and customary charges for the following services are included and should be billed under revenue code 100. DSHS reimburses for these services at DSHS'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 388-550-2596 (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 DSHS fee and/or rate schedules:

Note: Bill your total usual and customary charges for revenue code 250 in the appropriate form locator field. (See page G.1) 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: DSHS uses the appropriate payment method described in DSHS's other billing instructions to reimburse providers other than LTAC facilities for services and equipment that are covered by DSHS but not included in the LTAC fixed per diem rate. The provider must bill DSHS directly and DSHS reimburses the provider directly. **[Refer to WAC 388-550-2596 (2)]**

How Does DSHS Determine Reimbursement for LTAC Services?

[WAC 388-550-2595 (2)]

DSHS 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: DSHS may make annual rate increases to the LTAC fixed per diem rate by using a vendor rate increase. DSHS may rebase the LTAC fixed per diem rate periodically.

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

Does DSHS Reimburse for Ambulance Transportation?

[WAC 388-550-2596 (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 reimbursed through the LTAC fixed per diem rate;
- Are not payable directly to the LTAC hospital;
- Are subject to the provisions in Chapter 388-546 WAC; and
- Must be billed directly to:

  - ✓ DSHS by the transportation company to be reimbursed if the client required ambulance transportation; or

  - ✓ DSHS's contracted transportation broker, subject to the PA requirements and provisions described in Chapter 388-546 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: DSHS 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 388-501-0165 and 388-501-0169.

When DSHS 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 DSHS.

Billing

What are the General Billing Requirements?

Providers must follow the general billing requirement in **DSHS's *General Information Booklet*** (http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf).

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case Manager (PCPM) 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 DSHS Allow Interim Billing?

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

Completing the CMS-1500 Claim Form

Refer to **DSHS's General Information Booklet** (http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) for 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	Field Required	Entry	
24B	Place of Service	Yes	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.

For more information, read # Memorandum 06-84.

To see a sample of the UB-04 Claim Form, see the *General Information Booklet*.