Washington State Health Care Authority

Washington Apple Health (Medicaid)

Nursing Facilities Billing Guide

October 17, 2018

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect October 17, 2018, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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
Bariatric Nursing Home Pilot Program - Authorization	Removed incorrect authorization form information	Correction

How can I get agency provider documents?

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

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

*This publication is a billing instruction.

Where can I download agency forms?

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

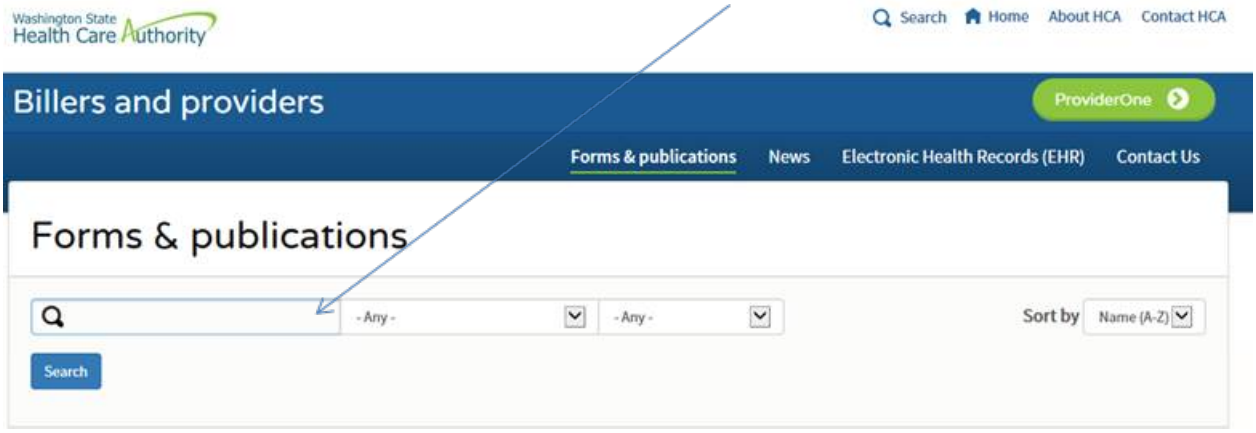

Table of Contents

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Resources

Topic	Resource
Becoming a provider or submitting a change of address or ownership	Aging and Long-Term Support Administration Business Analysis and Applications Unit (BAAU) 360-725-2573 or baau@dshs.wa.gov
Questions about what is included in the nursing facility per diem or general rate	Aging and Long-Term Support Administration (ALTSA) Office of Rates Management 360-725-2448 or nfrates@dshs.wa.gov
Prospective ALTSA payment rates	See ALTSA's Nursing Facility Rates and Reports page and WAC 388-96-704
Questions about payments, denials, claims processing, or agency managed care organizations	Claims Processing Nursing Facilities Unit 1-800-562-3022 ext. 16820 Fax: 1-866-668-1214 HCANursingHomeClaims@hca.wa.gov
Coordination of benefits for clients with private insurance and Medicaid as secondary insurance	Coordination of Benefits 1-800-562-3022 Fax: 360-586-3005
Electronic billing	See the agency's Billers and Providers webpage. See the Webinars webpage for additional training.
Finding agency documents such as billing guides and fee schedules	
Accessing provider alerts	See the agency's Provider Alerts webpage.

Topic	Resource
Contacting the managed care organizations (MCO)	• **Amerigroup Washington, Inc. (AMG)** Provider line: 1-800-454-3730 • **Community Health Plan of Washington (CHPW)** Provider line: 1-800-440-1561 • **Coordinated Care Corporation (CCC)** Provider line: 1-877-644-4613 • **Molina Healthcare of Washington, Inc. (MHC)** Provider line: 1-800-869-7175 • **United Healthcare Community Plan(UHC)** Provider line: 1-877-542-9231
Department of Social and Health Services (DSHS) nursing facilities forms	• Information for Nursing Home Professionals • Electronic DSHS Forms • Nursing Facility Notice of Action (DSHS 15-031) form • Intake and Referral (DSHS 10-570) form
Find a local HCS office	See the ALTSA Contact Information page See the Find Local Services, Information and Resources for the HCS office in each county: https://www.dshs.wa.gov/ALTSA/resources
Community Services Office	• Department of Social and Health Services Community Services Office Customer Connection • 1-877-501-2233
ALTSA provider updates	See the ALTSA listserv page
Nursing facility rates for ALTSA payment	See WAC 388-96-704

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a list of definitions for Washington Apple Health and WAC 182-513-1100 for definitions for long-term services and supports (LTSS).

Per Diem Costs - (Per patient day or per resident day) Total allowable costs for a fiscal period divided by total patient or resident days for the same period. (WAC 388-96-010)

Qualified Medicare Beneficiary (QMB) Program – This program pays for Medicare Part A and Part B premiums, and deductibles, coinsurance and copayments, under Part A, Part B, and Part C, with limitations.

QMB Only – A person who is eligible for the QMB program but is not enrolled in a Categorically Needy (CN) or Medically Needy (MN) Medicaid program.

Record – Dated reports supporting claims submitted to the agency for medical services provided in a client's home, a physician's office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Resident – A person residing in a nursing facility. The term resident excludes outpatients and people receiving adult day or night care, or respite care.

Skilled Care* – Skilled care in a nursing facility is care provided by trained individuals (registered nurses, physical therapists, occupational therapists, speech therapists, or respiratory therapists) and typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (rehabilitation, for example) or due to chronic or acute medical conditions or disabilities.**

Skilled care is:

- Rehabilitative: Care provided for or after an acute illness or injury with the intent of restoring or improving lost or impaired skills or functions.
- Skilled medical: Care provided daily and includes, but not limited to, intravenous therapy, intramuscular injections, indwelling and suprapubic catheters, tube feeding, total parenteral nutrition, respiratory therapy, or wound care.

*Any services or equipment reimbursed as skilled care is unallowable on the Medicaid cost report.

** Once improvement is no longer evident, it is no longer covered under the rehabilitative/skilled care benefit.

About the Program

What is the purpose of the Nursing Facilities program?

The purpose of the Nursing Facilities program is to pay for medically necessary nursing facility (NF) services provided to eligible Apple Health clients. The NF billing process for Health Care Authority (agency) clients was developed by the Aging and Long-Term Support Administration (ALTSA) and the agency. See Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and Title 71A RCW (Developmental Disabilities) for further information.

When does the agency pay for services?

The agency pays nursing facilities for costs only when the client is not covered by Medicare, a managed care organization, or third party insurance. Apple Health covers only those services that are ordinary, necessary, related to the care of Apple Health clients, and not expressly unallowable. See RCW 74.46 and WAC 388-96-585 for examples of unallowable costs.

Client Eligibility

Who is eligible for Skilled Nursing Facility (SNF) Services?

The implementation of the Affordable Care Act and the expansion of Washington Apple Health means eligibility for skilled nursing facility (SNF) care has changed. Clients in certain ACES (Automated Client Eligibility System) coverage groups are eligible for SNF care, and the SNF can bill for that care when all other billing criteria are met.

Nursing facilities must always verify that a patient has Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. If the payer is an agency-contracted MCO (see Managed Care), the SNF must obtain prior authorization from the MCO before admission. The coverage groups eligible for SNF care are identified in the ProviderOne Billing and Resource Guide, Section 3 and Appendix E.

Note: Clients enrolled in state-funded medical care service programs (A01 and A05) are not enrolled in an agency-contracted MCO; this is a state-funded Medical Care Services (MCS) program. A pre-approval by home and community services (HCS) before admission is not required as long as the client meets nursing facility level of care (NFLOC). Submit an *Intake Request* (DSHS 10-570) form to HCS for a determination of NFLOC. The fax number is located on the form.

Note: State-funded long-term care coverage for non-citizens program. Coverage groups L04 and K03 require a pre-approval by ALTSA.

Note: An award letter is issued to all clients who are eligible to receive institutional Aged, Blind or Disabled Apple Health and meet nursing facility level of care (NFLOC). An institutional benefits award letter does not guarantee payment for clients. Apple Health is the payer of last resort. If there is another payer available, Apple Health will not pay.

When are clients not eligible for long-term care under the fee-for-service program?

Clients covered under an agency-contracted managed care organization (MCO) or Medicare are not eligible to receive payment under the long-term care fee-for-service program until rehabilitation or skilled nursing services authorized by the MCO or Medicare has ended.

Some Apple Health clients are eligible for stays of 29 days or fewer, but are not eligible for periods longer than that because they do not meet the eligibility criteria for long-term care programs.

SNF services are not covered under the Alien Emergency Medical (AEM) (non-citizen) program. ALTSA has a limited state-funded non-citizen SNF program that requires prior approval. Contact Sandy Spiegelberg at (360) 725- 2576 for more information.

How do I verify a client's eligibility?

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

Check the client's Services Card or follow the two-step process below to verify that a client has 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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not 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.

Backdated eligibility

Financial institutional eligibility may be backdated up to three months before the date of application as long as the client is otherwise eligible. As soon as it is determined that a current resident will likely need custodial care funded by the state and the resident begins the application for Apple Health, the SNF must request a NFLOC assessment to verify functional eligibility by faxing a completed *Intake and Referral* (DSHS 10-570) form to DSHS/Home and Community Services (HCS). The fax number is located on the form by region.

Note: Program eligibility for hospice **cannot** be backdated to more than five business days before the agency's receipt of the *HCA/Medicaid Hospice Notification* (HCA 13-746) form.

Award letter

When is an institutional benefits award letter issued?

Note: For Aged, Blind or Disabled Apple Health clients, the agency issues an institutional benefits award letter to clients who have been verified eligible and approved for long-term care services. These approval letters are required for classic Medicaid clients only. They are not required for MAGI-based clients or QMB only cases. MAGI-based ACES coverage groups are: N01, N02, N03, N05, N10, N11, N13, N23, N31, and N33. Excluded coverage groups are N21 and N25.

Note: Medically-fragile children who are Washington residents and placed in the Providence Child Center in Portland, Oregon, do not require a NFLOC assessment by DSHS staff for payment. Children placed in this facility meet NFLOC. All other billing conditions apply.

Note: The nursing facility (NF) may bill under QMB with no award letter. An award letter may exist for the client's Medicaid coverage but is not necessary for Medicare days in the NF.

When is an institutional award letter not issued?

If the client is eligible to receive health care coverage in a MAGI program, regardless of setting, the client will **not** contribute to the cost of care and **no** institutional benefits award letter will be sent. However, for claims to pay, the skilled nursing facility (SNF) must request a NFLOC assessment for a MAGI client when:

- It is determined the client will likely no longer meet rehabilitation or skilled nursing criteria, or
- The client is not enrolled in managed care.

MAGI-based clients are identified in the ProviderOne client benefit inquiry screen with the following codes: See medical coverage chart for MAGI programs.

Note: Receipt of an award letter **does not guarantee payment** of the service if the client is enrolled in managed care, or has primary coverage under Medicare or other primary health insurance.

Note: Medically-fragile children who are Washington residents and placed in the Providence Child Center in Portland, Oregon, do not require a NFLOC assessment by DSHS staff for payment. Children placed in this facility meet NFLOC. All other billing conditions apply.

Provider Responsibilities

Are providers responsible to verify a client's coverage?

Yes. Providers must verify the client's eligibility in ProviderOne before providing services. If ProviderOne indicates the client is enrolled in an agency-contracted managed care organization (MCO), contact the client's MCO for all coverage conditions and limits on services. (See Managed Care).

Is a completed Preadmission Screening and Resident Review (PASRR) required?

42 CFR 483.100 – 483.138, WAC 388-97-1920 and 388-97-1940

Yes. Under state and federal law, all people referred for care in a Medicaid licensed nursing facility (NF), regardless of payment source, are required to have a Preadmission Screening and Resident Review Level I screening performed by the professional making the referral (usually a doctor, registered nurse practitioner, or hospital social worker). The Level I screening looks for indicators that a person may have an intellectual disability or related condition, or a serious mental illness. A Level II screening is required prior to admission when indicated by the Level I screen. The NF is responsible for ensuring that the entire PASRR process is complete and accurate prior to admission to their facility (the Level I for every person and the Level II if indicated).

More information regarding the PASRR process can be found on the DSHS website. For clients whose Level I screen indicated intellectual disabilities or related conditions with a referral to a DDA PASRR Coordinator, information can be found on DSHS's PASRR Program webpage. For clients whose Level I screen indicated serious mental illness and a referral to a BHA PASRR contractor information can be found on DSHS's PASRR webpage.

Note: The PASRR is subject to post-payment review and audit by the agency or its designee. The agency may deny payment to the skilled nursing facility (SNF) if the SNF is unable to prove that the required PASRR process was timely completed.

Note: There are some exceptions to the PASRR requirement. These exceptions are listed on the PASRR Level I form.

When must the skilled nursing facility (SNF) notify the state of an admission or status change?

See the *Notice of Action – Adult Residential Services* (DSHS 15-031) form for instructions on how and when to notify the state of an admission, discharge, or status change. Instructions are printed on the back of the form.

After an Aged, Blind or Disabled Medicaid client has been admitted to the skilled nursing facility (SNF), the SNF must complete the *Notice of Action – Adult Residential Services* (DSHS 15-031) form, by following the instructions on the back of the form.

Nursing facility (NF) limitations on billing:

- For recipients with Apple Health coverage, the NF cannot bill a person who applies for or receives institutional services for the days between admission and the date the facility first notified DSHS of the admission. See RCW 74.42.056.

- For applicants, the agency will back date NF payment authorization for up to three months as long as the person is otherwise eligible for Apple Health.

What steps are necessary at admission, conversion, or application of an Apple Health Medicaid client (classic and MAGI-based) to ensure timely payment?

After an Apple Health client (classic and MAGI-based) has been admitted to the skilled nursing facility (SNF) and converted from a medical benefit or submitted a Medicaid application, the SNF must:

- Submit a *Notice of Action – Adult Residential Services* (DSHS 15-031) form. The form must include the date of admit and the date the client's status changed (if applicable).

  - ✓ For classic Apple Health clients: fax to DSHS at 855-635-8305
  - ✓ For MAGI Apple Health clients: fax to the Health Care Authority at 1-866-841-2267.

- For a client who will likely receive long-term-care services in the facility, fax a *Home and Community Services (HCS) Intake and Referral* (DSHS 10-570) form to the HCS office in

your region to request a nursing facility level of care (NFLOC) assessment through the HCS social service intake process. The fax numbers and region information are located on the form. A NFLOC assessment must be in place to receive payment through fee-for-service. Medicaid payment begins either on the date of the request for a NFLOC assessment or the date of admission to the SNF, whichever is later.

- ✓ For classic Apple Health clients, the date of request for NFLOC will be recorded on the *Financial/ Social Services Communication* (DSHS 14-443) form, which is completed by the HCS nursing facility case manager.

- ✓ For MAGI-based Medicaid clients, the date that determines the payment start date for clients who meet NFLOC will be recorded on a *NFLOC Determination Modified Gross Income (MAGI) Clients* (DSHS 15-442) form which is completed by the HCS nursing facility case manager.

Clients must continue to meet nursing facility level of care (NFLOC) in order for the SNF to receive payment.

> **Note:** Clients who are eligible for MAGI-based ACES coverage groups do not contribute towards the cost of care—SNFs cannot collect participation for these clients. An award letter is not needed to submit a claim.

What are the requirements at the time of discharge?

The provider must bill the discharge date. The provider must meet all federal and state discharge/transfer requirements (see 42 CFR 483.15; RCW 74.42.450; WACs 388-97-0120, 388-97-0140 and 388-97-0160).

> **Note:** Billing for the date of discharge ensures that other providers can bill as necessary.
>
> **Example:** Client discharges on July 2nd from the skilled nursing facility and the facility has not billed for the discharge date. On July 15th, the client tries to fill a prescription at a pharmacy, but the pharmacy claim is denied. The client will not be able to fill the prescriptions until the nursing facility has billed for the discharge date, which updates the client profile in ProviderOne. This affects the client and does not allow other providers to successfully bill their claims.

Managed Care

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible for skilled nursing facility (SNF) coverage?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency-contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. MCOs pay for medically necessary skilled nursing facility (SNF) stays for rehabilitation or skilled medical care when the MCO determines that nursing facility care is more appropriate than acute hospital care. These services require prior authorization (PA) by the MCO. SNFs must check Apple Health client eligibility and work with hospital staff and MCO staff to ensure authorization is obtained for skilled rehabilitation or nursing services for clients transferring from a hospital. Once admitted to a SNF, it is the responsibility of the SNF to obtain additional authorization from an MCO for ongoing skilled rehabilitation or nursing services. Clients remain enrolled in managed care even when the MCO is not responsible for payment of the client's nursing facility stay.

Note: If the client is enrolled in managed care, contact the MCO prior to admittance to determine what services have been authorized and for how long.

Who is not enrolled in managed care?

Most people receiving long-term care are Medicare-eligible and are not enrolled in managed care. Clients who meet the following criteria are not enrolled in managed care:

- Clients with Medicare coverage
- Clients in the Medically Needy program

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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.

Checking eligibility

- 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 policies.

Behavioral Health Organization (BHO)

Effective July 1, 2018, the Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

See the agency's Mental Health Services Billing Guide for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The 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 may 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 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 behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on FIMC, see the agency's Changes to Apple Health managed care webpage.

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's Apple Health managed care webpage.

North Central Region – Douglas, Chelan and Grant Counties
Effective January 1, 2018, the agency implemented the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties
Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington 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.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

See the agency's Apple Health managed care page, Apple Health Foster Care for further details.

What should the SNF do before admitting an MCO client?

Prior to any admission, the SNF must request authorization from the client's agency-contracted managed care organization (MCO). The payer that is financially responsible for the client at the time of admission is responsible for rehabilitation or the skilled nursing facility stay. This applies to any transfer of care from an MCO to another MCO, and to transfers from an MCO to fee-for-service.

What should the SNF do before admitting an MCO client from a transferring SNF?

Prior to any admission, the receiving SNF must request authorization from the MCO. If the authorization is approved, the SNF must bill the MCO. If the authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met.

What are the SNF's options if the authorization is denied by the MCO for skilled or rehabilitative care?

If the MCO denies the authorization for skilled or rehabilitative care and the skilled nursing facility (SNF) disagrees with this determination, the SNF may file an appeal through the MCO and provide additional documentation supporting the need for skilled or rehabilitative care.

What should the SNF do when an MCO client's hospice election ends?

Prior to any admission of a hospice client (or for clients who have ended their hospice election) the receiving SNF must ask the discharge planner at the hospice agency which agency-contracted managed care organization (MCO) authorized the stay. Prior to any admission to the SNF (or transfer from hospice), the SNF must request authorization from the MCO. If the authorization is approved, the SNF must bill the MCO. If the authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met.

How does the SNF admit and bill for a patient who is authorized for rehabilitation or skilled nursing services by an MCO?

Prior to any admission, it is essential that the SNF coordinate with the agency-contracted managed care organization (MCO) authorizing the rehabilitation or skilled nursing services. It is the nursing facility's responsibility to contact the MCO for (PA) for a client being admitted or any time the client leaves the facility for more than twenty-four hours and is readmitted. The SNF must have an agreement with the MCO in order to receive payment. All billing for rehabilitation or skilled nursing services must be submitted to the MCO following the terms of their agreement.

The SNF must confirm PA with the MCO before admitting the client for rehabilitation or skilled nursing services. The MCO must indicate on the PA the number of rehabilitation or skilled nursing days that are approved. If additional days are needed, the SNF must coordinate this with the MCO. If additional days are not authorized, and the SNF believes that the client continues to meet criteria, the SNF may assist the client in filing an appeal with the MCO. At the time the request for additional days is denied, the SNF must determine if discharge to the community is appropriate. If ongoing services are needed, either in the SNF or in the community, the SNF must contact Home and Community Services (HCS) for an assessment.

Note: A client's managed care plan may change. However, the MCO responsible at the time of admission remains responsible for the client's care, covered under the Apple Health contract, even if the client changes to another MCO after admission.

Note: For a discharge from the facility that is under 24 hours, add a comment to the claim indicating the discharge is under 24 hours.

The SNF must request written confirmation from the MCO that services are approved or denied:

- Before the client is admitted to the SNF.
- If the facility is requesting additional rehabilitation or skilled-nursing services.

The MCO must provide the SNF with written confirmation when:

- A stay is approved or denied.
- The length of a previously authorized stay is being reduced.
- The client does not meet the MCO's rehabilitation or skilled-nursing criteria.

Written confirmation from an MCO or its subcontractor must include:

- Member name
- Date of birth
- Member ID
- ProviderOne ID
- Service description (ex. Skilled Nursing Facility Care)
- Name of admitting facility
- Facility admit date
- Dates approved (ex. MM-DD-YYYY through MM-DD-YYYY)
- Date denied
- Specific reason for denial

What happens if an MCO client's skilled nursing or rehabilitation status is denied or changes to long-term-care?

When a managed care organization (MCO) client's skilled nursing or rehabilitation status is denied or changes to long-term-care (sometimes called custodial care), the skilled nursing facility (SNF)must, for classic and MAGI Apple Health clients, do the following:

- Submit a *Notice of Action – Adult Residential Services* (DSHS 15-031) form. The form must include the date the client's status changed, with the date of hospice election or revocation, if applicable:

  ✓ For classic Apple Health clients: fax to DSHS at 855-635-8305.
  ✓ For MAGI Apple Health clients: fax to the Health Care Authority at 1-866-841-2267.

- Fax the Home and Community Services (HCS) *Intake and Referral* (DSHS 10-570) form to the HCS office in your region to request a nursing facility level of care (NFLOC) assessment through the HCS social service intake process for a client who will receive long-term care services. The fax numbers and region information are on the form. A NFLOC assessment must be in place to receive payment through fee-for-service.

  ✓ For classic Apple Health clients, the date of request for NFLOC is recorded on the *Financial/Social Services Communication* (DSHS 14-443) form which is completed by the nursing facility case manager.

  ✓ For MAGI Apple Health clients, the date of request for NFLOC is recorded on a *NFLOC Determination Modified Gross Income (MAGI) Clients* (DSHS 15-442) form which is completed by the nursing facility case manager.

  Note: When a client elects hospice, nursing facilities must submit the *Notice of Action – Adult Residential Services* (DSHS 15-031) form to DSHS, and the hospice provider must submit the *Hospice Notification* (HCA 13-746) form to HCA. HCA must receive the HCA 13-746 form within five business days of the hospice election date.

If the client needs services in the community, the SNF must request a social service assessment intake from HCS and coordinate with the MCO when discharge planning begins. The SNF must use the *Intake and Referral* (DSHS 10-570) form, to request an assessment. The telephone and FAX numbers for HCS social service intake are located on the form.

The SNF is responsible to report changes when the client's status changes to long-term care (custodial care).

How does the SNF bill if the client has other primary health insurance and is enrolled in an MCO?

Medicaid is the payer of last resort. Providers must follow these steps for billing;

1. Follow the primary health insurance policies (including requesting authorization) for coverage of the nursing facility stay.

2. You may request authorization concurrently with the MCO for a medical necessity determination.

3. If the primary health insurance denies the service, you must request authorization from the agency-contracted managed care organization (MCO) immediately.

4. If the MCO authorization is denied, the SNF may bill fee-for-service when all other billing conditions are met. When billing fee-for-service, the primary health insurance denial and MCO authorization denial letter must be included.

Note: When the stay is covered by the primary health insurance, bill the same patient class code that would be used when submitting as fee-for-service; bill patient class code 55 when the stay is covered by the MCO.

Specialized Nursing Facility Programs

Note: Authorization for a specialized SNF program does not replace all other requirements for admission or payment.

Expanded Community Services

Program overview

Expanded Community Services (ECS) is designed to provide enhanced behavior support services to clients who have either moved into the community after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs. This is also offered on a targeted basis for residents discharging from Western State Hospital (ECS Plus) and for respite behavioral care (ECS Respite).

Contracted SNF providers

The ECS contract requires the SNF to either provide or contract for the Behavior Support Services offered by an ECS team that can meet the scope of the SNF ECS contract.

To request a contract, the SNF should contact the local Home and Community Services (HCS) Resource Support & Development Program Manager.

Authorization

Once contracted, a SNF is eligible to serve clients identified by HCS as ECS eligible. In order to authorize services, the ECS coordinator needs the following information:

- Name of the contracted SNF that will be accepting the qualified client
- Name of qualified client
- Date of birth of qualified client

If approved, the SNF receives an ECS approval letter. The ECS approval letter is the SNF's authorization for payment of this service.

The SNF must contact the ECS coordinator when there has been a change in an ECS client's condition that could affect ECS eligibility or behavioral support needs. The notice must include the following information:

- Name of the contracted SNF that will be discharging the qualified client
- Name of qualified client
- Date of birth of qualified client

Payment

For ECS, the SNF must use patient class code 50 in the *Value Information* section of the institutional claim value code column in the UB-04 claim form in order to receive a specialized payment for an ECS client.

For ECS Plus, the SNF must use patient class code 62 in the *Value Information* section of the institutional claim value code column in the UB-04 claim form in order to receive a specialized payment for an ECS client.

For ECS Respite, the SNF must use patient class code 63 in the *Value Information* section of the institutional claim value code column in the UB-04 claim form in order to receive a specialized payment for an ECS client.

Community Home Project

Program overview

The Community Home Project (CHP) is a specialized authorization to assist clients who reside in an inpatient hospital setting who are transitioning home. CHP provides services in a SNF that are not included in a daily rate and not payable through other means.

Services provided under this program are authorized for a limited duration of up to 90 days.

Authorization

Authorization for CHP is based on an HCS assessment and lack of other available funding or setting to support the service required.

The SNF must coordinate with HCS to request authorization. If approved, the SNF receives a CHP approval letter. The CHP approval letter is the SNF's authorization for payment of this service.

Payment

The SNF must use patient class code 60 in the *Value Information* section of the institutional claim in order to receive a specialized payment for a CHP client.

Bariatric Nursing Home Pilot Program

WAC 182-531-1600

Program overview

The Bariatric Nursing Home Pilot Program is a short-term placement option for clients with bariatric issues who are leaving hospitals and in need of extensive therapy in a SNF.

Services provided under this program are authorized for a limited duration of up to 90 days.

Who qualifies?

The client must be Medicaid-eligible, have a current assessment from HCS, and meet NFLOC. A client eligible for this service must meet the following criteria. The client:

- Has a history of hospitalizations related to bariatric issues.
- Is willing to actively participate in the intensive therapies and expectations of the Bariatric Nursing Home Pilot Program.
- Has a physician order stating that the client needs specialized bariatric Physical Therapy and Occupational Therapy in a SNF, and can tolerate the therapies.
- Has documentation that there is no other placement option at this time for the client.

Authorization

HCS and the SNF coordinate to submit a completed authorization request, which is then reviewed by HCS and HCA. The request must list services and cost calculations, and must include a treatment plan for the client.

If approved, HCS will send the SNF an approval letter. The approval letter is the SNF's authorization for payment of this service.

Payment

The SNF must use revenue code 169 in the *Revenue Code* field of the electronic institutional claim in order to receive a specialized payment for a client.

Ventilator/Tracheotomy program

Program overview

The Ventilator/Tracheotomy (Vent/Trach) program is designed to maintain quality of life for ventilator-dependent clients who reside in a facility with a specialized Vent/Trach unit.

Wrap Around Services for Vent/Trach Clients

SNFs that are currently enrolled in the Vent/Trach program receive a wrap-around payment for the services required by clients in these units. The payer responsible for room and board costs makes this payment.

Payment

Facilities must use procedure code 94799 in the *Procedure Code* field of the electronic professional claim to receive a specialized payment for a client.

Nursing facilities contracted to provide ventilator and tracheotomy services must bill for consistent dates of service to be paid for their calculated wrap around rate. This means that the facility must bill for the daily rate with a nursing facility claim before billing for the wrap around rate as the vendor claim. If a paid nursing facility claim is not on file for the client for the noted dates of service, the vendor claim will be denied and the facility will be required to rebill for these services. In addition to this policy, the nursing facility will not be paid for these services for the client discharge date – this policy is congruent with the nursing facility claim policy for FFS.

Before submitting the claim, the nursing facility and Durable Medical Equipment (DME) providers are required to record *"Forward to NH Unit only"* in the comments section on Vendor Claims (94799 and E1399). This ensures that the claim will be sent to the appropriate agency staff for processing.

Respiratory Services

The Department of Social and Health Services (DSHS) requires contracted Vent/Trach program facilities to contract with a respiratory provider or provide respiratory therapy services, supplies and equipment.

The payer responsible for room and board costs is also responsible to pay for respiratory services covered under the Vent/Trach program contract (procedure code E1399 with appropriate modifiers).

If respiratory services are provided by the Vent/Trach program facility, the facility is not eligible for payment of procedure code E1399.

Respiratory services covered under the Vent-Trach contract are allowable only for days when a client is eligible for SNF care and is inpatient in a contracted Vent/Trach program facility.

After the nursing facility has billed for FFS claims, the DME vendor can bill for the DME portion of the wrap around rate. These claims must be billed in the form of a vendor claim and must include either the claim modifier for ventilator services or tracheotomy services provided. The vendor cannot bill for a client receiving both services.

If the DME vendor is paid for the services provided for the client under their vendor claim, but the nursing facility FFS claim is recouped, then the DME vendor's claim will also be recouped at the same time. The DME vendor must rebill for the vendor claim after the nursing facility has rebilled the claim and claim has been adjudicated as "paid."

Before submitting the claim, the nursing facility and DME provider must record "*Forward to NH Unit only*" in the comments section on vendor claims (94799 and E1399). This ensures that the claim will be sent to the appropriate agency staff for processing.

For services and supplies provided other than those under procedure code E1399 covered in the Vent/Trach contract, refer to the agency's Respiratory Care Billing Guide for the appropriate billing process.

Non-citizen's long-term care program

Program overview

The Non-Citizen's Long-Term Care (NCLTC) Program is a state-funded program that provides the categorically needy scope of medical coverage for qualified aliens who are not eligible for any other service due to their citizenship or alien status.

Who qualifies?

The client must be an undocumented alien, which means they are not legally present in the United States and will never be eligible for state medical care services or federal Medicaid unless there is documentation that their Immigration and Naturalization Service (INS) status has changed to "legally admitted." Clients must meet the additional eligibility criteria in WAC 182-503-0505(2) and (3)(a), (b), (e), and (f), including:

- Be ineligible for federally-funded or matched programs;
- Be at least 19 years of age;
- Meet NFLOC requirements (WAC 388-106-0355); and
- Be considered a resident of Washington State.

Authorization

Clients may not be enrolled in this program without authorization from DSHS' Aging and Long-term Services Administration (ALTSA) Residential Services Program Manager. Authorization is required prior to the client's admission. Contact Sandy Spiegelberg at (360) 725- 2576 for more information. A SNF authorization in the NCLTC Program is coded as L04.

> **Note:** Providers must have authorization before admitting a client to the NCLTC program. There are limited spaces available in this program.

Payment

Facilities must use patient class code 45 in the *Value Information* section of the electronic institutional claim in order to receive a specialized payment under this program.

Medicare

How is Apple Health (Medicaid) different from Medicare?

Apple Health (Medicaid) and Medicare are very different programs. Medicare is an entitlement program funded entirely at the federal level. It is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease.

The Medicare program provides:

- Medicare Part A, which covers inpatient hospital services
- Medicare Part B, which covers professional, and vendor services
- Medicare Part C, which is a managed care version of Medicare, also called a Medicare Advantage Plan, and offered through private insurance companies
- Medicare Part D, which covers prescription drugs

Apple Health is a needs-based program with eligibility determined by income and covers a wider range of health care services than Medicare (i.e. dental). Some people are eligible for both Medicaid and Medicare. These clients are referred to as "dual-eligible" clients. For more information on Medicare, see the Centers for Medicare and Medicaid Services (CMS) website.

Note: When Medicare is the primary payer and denies a service not included in the NH per diem but covered by the agency with a prior authorization requirement the agency waives the "prior" requirement in this circumstance. Refer to the appropriate billing guide for the service and submit a request for authorization. Attach the Explanation of Benefits (EOB) to the request for services denied by Medicare.

Does the agency pay for Medicare Advantage Plans (Part C) cost-sharing expenses?

Yes. The agency reimburses nursing facilities for Medicare Part C cost sharing expenses up to the maximum reimbursement limits established under WAC 182-502-0110 and Chapter 182-517 WAC.

The skilled nursing facility (SNF) must first bill the client's Managed Medicare – Medicare Advantage (Part C) Plan. If money is owed after the Managed Medicare – Medicare Advantage (Part C) plan has been billed and payment received, the SNF must submit a claim to the agency for additional payment with patient class code 24, following the instructions in the Billing with commercial insurance or Medicare as primary fact sheet.

The agency must receive claims for additional payment within six months of the Managed Medicare - Medicare Advantage (Part C) plan payment date.

Does the agency pay Medicare cost-sharing expenses for Qualified-Medical-Beneficiary (QMB) clients?

Yes. The agency reimburses nursing facilities for Medicare cost-sharing expenses under Medicare Part A, Part B, and Part C (except for Part C premiums). For QMB clients, the agency reimburses up to the maximum reimbursement limits established in WAC 182-502-0110 and WAC 182-517-0320.

The agency issues a QMB program approval letter to the client. Clients who are covered by QMB only do not receive an institutional award letter. QMB-only clients do not pay towards the cost of care for Medicare-only days, and nursing facilities must not collect participation from these clients for Medicare-only days. For more information, see the Client Eligibility section for more information on eligibility and coverage groups.

For clients who are also eligible for long-term care, Home and Community Services issues an institutional award letter.

How does the SNF bill for clients who are eligible for Medicare and Medicaid or who are QMB-only?

Bill Medicare first.

- Patient class codes 29 and 56 are not entitled to secondary Medicaid payment. Claims submitted with patient class codes 29 and 56 will receive a $0.00 reimbursement from Medicaid.
- If money is owed to the skilled nursing facility (SNF) after Medicare makes a payment, the SNF can submit a claim to the agency for additional payment with patient class code 24 and follow the instructions in the "Billing with commercial insurance or Medicare as primary" fact sheet.
- If Medicare pays the claim, the SNF must bill the agency within 6 months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, the SNF must meet the agency's 365-day requirement for an initial claim.

For more details concerning Medicare crossover claims, see the agency's ProviderOne Billing and Resource Guide.

Billing

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 is the admission date?

The admission date is the date the person physically admitted or readmitted to the SNF.

How does the SNF bill if the client has other primary health insurance?

Bill the other primary health insurance before billing Medicaid; Medicaid is the payer of last resort. After other primary health insurance is billed, refer to the Billers and providers Fact sheet for instructions on "Billing with commercial insurance or Medicare as primary."

Third-party liability (TPL) for nursing facilities is discussed in Coordination of Benefits Resource Guide for Skilled Nursing Facilities located on the agency's Provider billing guides and fee schedules webpage.

For affected billing changes, see How does the SNF bill if the client has other primary health insurance and is enrolled in an MCO?

How does the SNF bill for a discharged client?

The SNF must bill for the date of discharge using the appropriate patient status code and enter the total number of units, not including the discharge day. The agency does not pay the skilled nursing facility (SNF) for the date of discharge unless the client is admitted and dies on the same day. When a client is discharged from the SNF in the same month as they are admitted, use the appropriate patient status code and enter the total number of units, not including the discharge day.

How does the SNF bill for date of death?

The SNF must bill for the date of discharge using the appropriate patient status code. When a client dies, use patient status code 20 and enter the total number of units, not including the death/discharge day. The agency does not pay the nursing facilities for the date of discharge unless the client is admitted and dies on the same day. Use patient status 20 and enter the total number of units including the death/discharge day.

How do SNF providers enrolled in Medicaid bill for dual eligible clients?

SNFs enrolled in the state's Medicaid program must submit claims with patient class code 24 for dual eligible Medicare/Medicaid clients during Medicare days.

How do SNF providers not enrolled in Medicaid bill for QMB cost-sharing expenses?

All SNFs not enrolled in the state's Medicaid program must submit claims with patient class code 56 for Qualified Medicare Beneficiaries (QMB) cost-sharing expenses. The SNF must notify DSHS/ALTSA contracts and complete appropriate documentation in order to submit these claims.

How does the SNF bill for social leave?

The agency pays for the first 18 days of social leave in a year. Report the client as still a client for these days. Do not discharge and readmit the client. After 18 days of social leave have been used, report discharge and readmission only if the client left the facility for at least a full 24-hour period. SNFs are required to notify DSHS of social or therapeutic leave in excess of 18 days per year through a *Notice of Action* (DSHS 15-031) form.

Does the SNF bill the agency for clients in hospice status?

No. If the client in an SNF is on hospice status, it is the hospice provider's responsibility to bill the agency using the agency's Hospice Services Billing Guide. The SNF should work with the hospice provider for appropriate billing.

Note: For classic Medicaid clients who elect or revoke hospice, the nursing facility must notify DSHS/ALTSA using *Notice of Action* DSHS 15-031 form. The hospice provider must notify the agency using *HCA Medicaid Hospice Notification* (HCA 13-746) form; this form is required from the hospice provider in order to authorize Medicaid payment.

How does the SNF change a previously paid claim?

If the SNF needs to make changes to claims for dates of service for which the agency has already paid, refer to the ProviderOne Billing and Resource Guide section on adjusting claims.

Where on the institutional claim do I enter patient participation?

"Patient participation" refers to the amount a client is responsible to pay each month toward the total cost of long term care services they receive. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

The patient participation amount must be submitted on each claim using the *Value Information* section, value code 31, even if the participation amount is zero. These funds must be contributed toward the patient's cost of care.

The SNF cannot collect participation from an agency client when billing for patient class codes 24, 29, 55, 56 or MAGI-based clients.

The agency cannot reduce a Medicaid client's participation using unpaid Part C copayment or coinsurance charges if the Medicare payment exceeds the maximum reimbursement that is allowed under Medicaid.

The agency does not calculate participation for QMB-only clients. These clients are not required to contribute toward the cost of care while in the SNF.

Where on the institutional claim do I enter the spenddown amount?

Spenddown means the process by which a person uses incurred medical expenses to offset income, resources, or both to meet the financial standards established by the agency. See WAC 182-519-0110.

Enter the client spenddown amount into the *Value Information* section using value code 66.

How do I submit claims?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, 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) webpage.

The following instructions are specific to nursing facilities.

- **Type of Facility**: enter 2-Skilled Nursing.

- **Statement dates**: Enter the beginning and ending dates of service for the period covered by the bill. Bill only dates of service for which the client is eligible.

- **Medicare Crossover Claims**: refer to Fact Sheets under Billing with commercial insurance as Medicare as primary.

- **Patient status codes**; enter the appropriate patient status code; the following are some frequently used patient status codes:

  01 Discharged to home or self-care
  02 Discharged/transferred to a Short Term General Hospital for Inpatient Care
  03 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
  04 Discharged/transferred to an Intermediate Care Facility (ICF)
  05 Discharged/transferred to a Designated Cancer Center or Children's Hospital
  06 Discharged/transferred to home
  07 Left against medical advice or Discontinued Care
  20 Expired
  30 Still patient
  50 Hospice – home
  51 Hospice - medical facility
  61 Discharged/transferred to Hospital-based Medicare Approved Swing Bed
  70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

- **Value Information (Value Code/Value Amount)**:

  Value Code 24: SNF claims must be submitted with Value Code 24. Enter this code in the *Value Code* field with the Patient Class immediately following in the *Value Amount* field. See Patient class codes. (e.g., 20.00= patient class code 20).

  Value Code 31: SNF claims must be submitted with Value Code 31. Enter this code in the *Value Code* field with the Patient Participation amount for the entire month immediately following in the *Value Amount* field.

  Value Code 66: Enter this code in the *Value Code* field with the entire Patient Spenddown Amount immediately following in the *Value Amount* field.

- **Attending/Servicing Provider**: Enter attending provider's national provider identifier (NPI) and taxonomy.

- **Other Insurance Information**: Enter primary health insurance other than Apple Health. See Billing with commercial insurance or Medicare as primary fact sheet

  ✓ Third-party liability (TPL) for nursing facilities is discussed in Coordination of Benefits Resource Guide for Skilled Nursing Facilities located on the agency's Provider billing guides and fee schedules webpage.

  ✓ For affected billing changes, see How does the SNF bill if the client has other primary health insurance and is enrolled in an MCO?

- **Revenue Code:** Enter revenue code 0190.

- **Service Units:** Enter the number of days. Do not include the date of discharge unless a client is admitted and dies on the same day.

- **Total Line Charges:** Enter the SNF usual and customary daily rate.

Patient class code

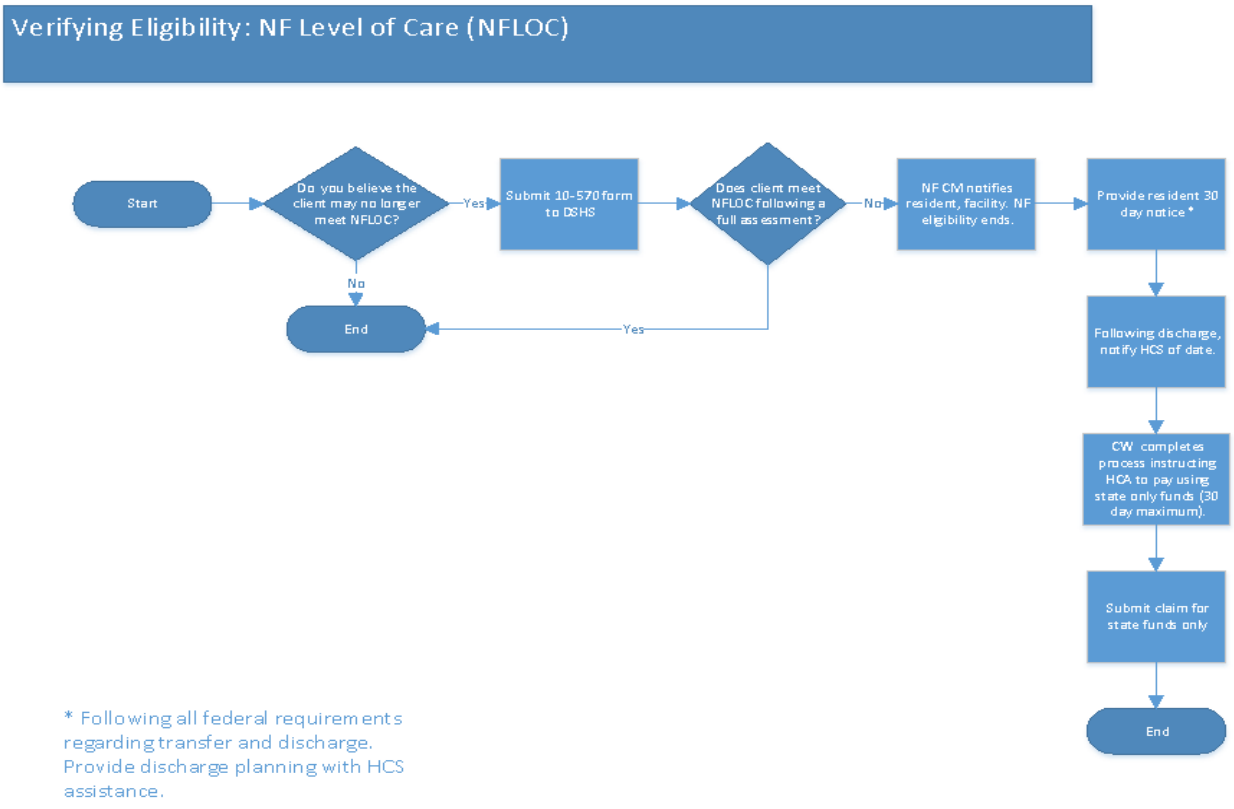
Enter Value Code 24 with the appropriate patient class code below and submit as shown in How do I bill claims electronically?

Patient Class Code ProviderOne (P1) Payment	**Description** A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories for billing for an identified service authorized and provided.	**Billing Requirements**
20: SNF	Daily Medicaid NH Rate. Set every semiannual period but can be more frequent.	Apple Health clients; default class when no other class is appropriate
23: IMR-Title XIX Eligible	Intermediate/Intellectual Disability Services – Note Medicaid Title XIX Eligible (1997). This patient class is restricted and only used by a very few homes; Rocky Bay and facilities within the Camelot Society and Providence Health & Services-Oregon. While there are others that have used the rate in the past, these are the only ones currently billing.	Any Intermediate Care Facility - Intellectually Disabled (ICF-ID) will bill this patient class code for all Medicaid residents.
24: Dual Medicare/Medicaid	All SNFs enrolled in the state's Medicaid program are required to bill Medicaid with patient class code 24 for dual eligible Medicare/Medicaid clients. Up to the first 100 days, patient class code pays difference if Medicaid rate is greater than Medicare rate.	Submit claim if money is owed to the SNF after Medicare makes a payment.
26: Swing Bed	Medicaid Hospital Swing Bed Rate. Set every July 1 using prior year July 1 patient class code 20 rate weighted by prior July 1 billed days (minus SNA component). Hospital facilities that have swing beds to service Medicaid nursing facility clients.	Hospitals that are approved through the Department of Health and have submitted a Core Provider Agreement through the Health Care Authority can bill this patient class code for Medicaid nursing facility clients occupying their swing beds.
29: Full Medicare	Patient class code 29 is not entitled to secondary Medicaid payment. Zero P1 remittance advice (the payment will always pay at zero) is produced to document claim used for Medicare bad debt cost reporting.	SNFs can bill for this patient class code in order to receive claim verification and Remittance Advice generation for Medicare claims.
45: Non-Citizen's Long-Term Care (NCLTC) Program	Medicaid NH patient class code daily 20 rate for NH approved to serve non-citizen clients. The Non-Citizen's Long-Term Care (NCLTC) Program is a state-only funded program that provides the categorically needy scope of medical coverage for qualified aliens who are not eligible for any other service due to their citizenship or noncitizen status.	SNFs that admit a preapproved non-citizen client will bill for this patient class code for state covered services for undocumented residents. Preapproval from DSHS' Aging and Long-term Services Administration (ALTSA) is required.

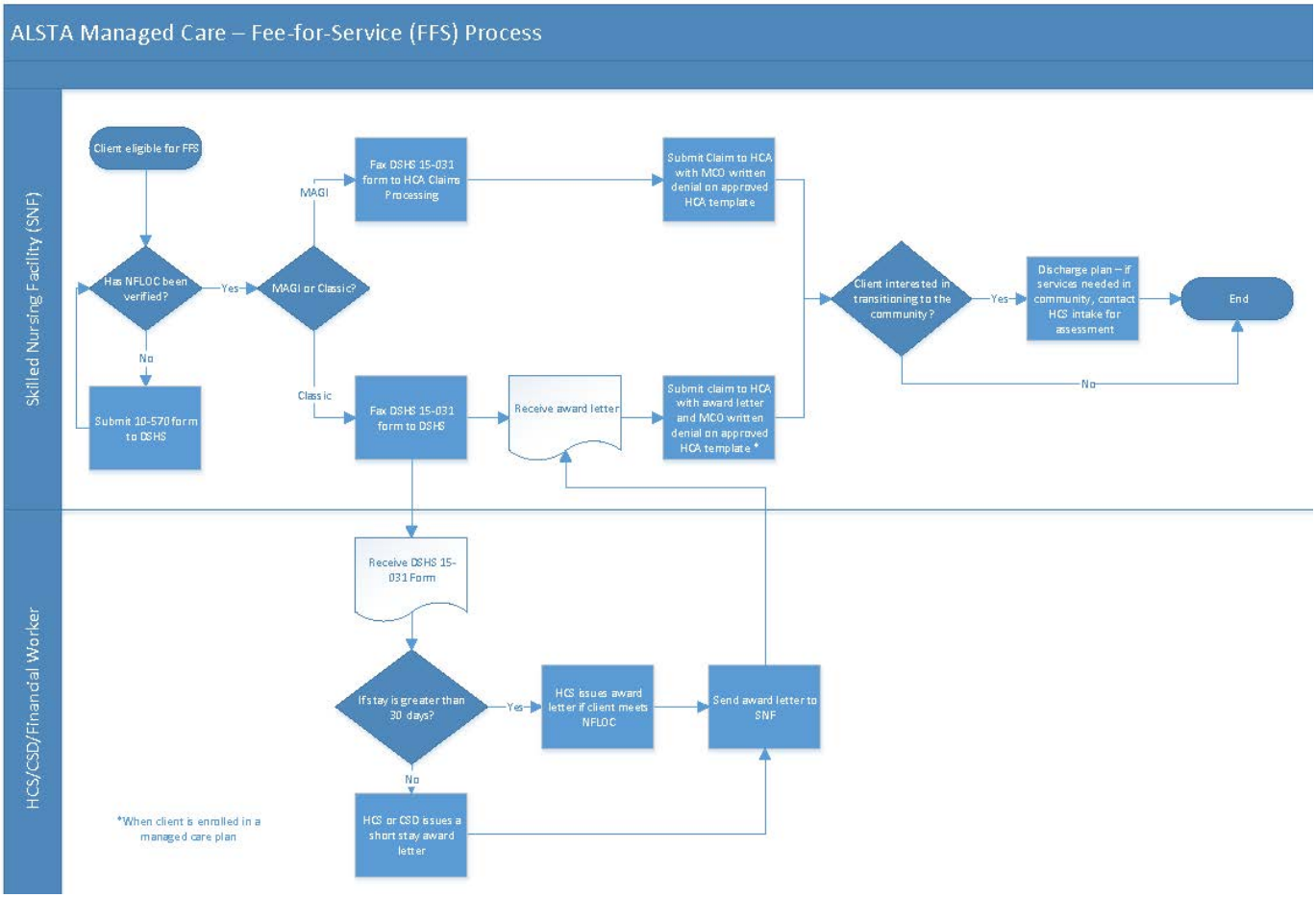
Patient Class Code ProviderOne (P1) Payment	**Description** A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories for billing for an identified service authorized and provided.	**Billing Requirements**
50: ECS (Behavioral support)	Medicaid NH patient class code daily 20 rate plus $80. Expanded Community Services (ECS) is designed to provide enhanced behavior support services to clients who have either moved into the NH after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs. Medicaid NF needs to get contract approval.	SNFs that have been awarded a contract allowing ECS services can bill for this patient class code. Residents must be preapproved for this program through the HCS Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.
54: Department of Corrections	Medicaid NH patient class code daily 20 rate plus $45. The SNF must have a Medicaid contract and be approved for DOC client placement.	SNFs have been preapproved by ALTSA to admit these clients and provide services.
55: Rehabilitation with Managed Medicaid (Managed Care MCO)	SNF will bill patient class code 55 when the Medicaid stay is covered by the managed care organization (MCO).	SNFs will bill for this class code when the MCO covers the cost of the care for the client. This patient class code will pay out at $0.00 for all appropriately billed claims.
56: QMB Cost Sharing (Non-Medicaid contracted)	Qualified Medicare Beneficiaries (QMB) Cost Sharing. SNF providers not enrolled to bill through Medicaid bill patient class code 56 instead of 24. Patient class code 56 is not entitled to secondary Medicaid payment. Like patient class code 24, this code only pays the difference if the Medicaid rate is greater than the Medicare rate. The average swing bed rate is used as a proxy for the comparison.	
60: Community Home Project	Medicaid NH Rate patient class code 20 daily rate plus additional costs for therapy and rehabilitation supplies and services. The Community Home Project (CHP) is a specialized authorization to assist clients who reside in an inpatient hospital setting who are transitioning home. CHP provides services in a SNF that are not included in a daily rate and not payable through other means. Services provided under this program are authorized for a limited duration of up to 90 days. The client needs to be approved for this type of care by HCS/HCA before payment will be authorized.	SNFs that have been awarded a contract by ALTSA allowing CHP services can bill for this patient class code. Residents must be preapproved for this program through ALTSA and HCA, and the facility must receive an approval letter from both ALTSA/HCS and HCA.

Patient Class Code ProviderOne (P1) Payment	**Description** A nursing facility uses a class code to bill for specific services within the ProviderOne payment system. Class codes are unique categories for billing for an identified service authorized and provided.	**Billing Requirements**
62: ECS Plus (Behavioral Support Plus)	Medicaid NF Rate flat rate of $425. ECS Plus means: A level of behavior support services that includes dedicated staffing and availability of daily behavior support, consultation and training in a skilled nursing environment. Requires HCS contract approval.	SNFs that have been awarded a contract from ALTSA allowing ECS services can bill for this patient class code. Residents must be preapproved for this program through the ALTSA/HCS Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.
63: ECS Respite (Behavioral Support Respite)	Medicaid NF Rate flat rate respite bed of $425. The length of stay in the ECS Respite bed will be 20 days or less for any particular episode of service for any particular ECS residential client unless an exception is provided by the HCS Field Services Administrator or his/her designee. ECS Respite means a short-term medically based SNF placement as an intervention for ECS or SBS residential clients experiencing an escalation in behavioral challenges that does not fit the definition for mental health voluntary or involuntary detention but that jeopardizes the ECS client's residential placement as determined by HCS.	SNFs that have been awarded a contract from ALTSA allowing ECS services can bill for this patient class code. Residents must be preapproved for this program through the ALTSA/HCS Case Manager and the facility must receive an approval letter from the Office of Rates Management for billing.

Verifying eligibility flow chart



Managed care billing flow chart



Managed care enrollee process flow chart