Washington State Health Care Authority

Medicaid Provider Guide

Nursing Facilities
[Chapter 388-96 WAC]

Washington State Health Care Authority

A Billing Instruction

About this publication

This billing instruction is designed to help nursing facility providers and their staff understand the Aging and Disability Services Administration's (ADSA) and Health Care Authority regulations and requirements necessary for reporting accurate and complete claim information. Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

This publication supersedes all previous Agency *Nursing Facility Billing Instructions* published by the Health and Recovery Services Administration, Washington State Health Care Authority.

Effective Date:

The effective date of this publication is: **03/09/2010**.

Effective Date/ Reason for Change	**Section/ Page No.**	**Subject**	**Change**
[date][reason for change, such as WAC]			

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print Agency provider numbered memos and billing instructions, go to the Agency website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to nursing facilities. For more contact information, see the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	**Aging and Disability Services Administration** 1-800-422-3263
What is included in the nursing facility per diem or general rate questions	
Finding out about payments, denials, claims processing, or Agency managed care organizations	**Claims Processing Nursing Home Unit** 1-800-562-3022 ext. 16820
Electronic or paper billing	See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
What is included in the nursing facility per diem or general rate questions	**Aging and Disability Services Administration** 1-800-422-3263

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Glossary at: http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions.

Aging and Disability Services Administration (ADSA) - As a component of the Washington State Department of Social and Health Services, ADSA provides a broad range of social and health services to adult and older persons living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system which enables persons served to achieve the maximum degree of independence and dignity of which they are capable.

Chart – A summary of medical records on the individual patient.

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

Intermediate/Mental Retardation Facility (IMR) - An IMR facility for DDD is defined as a Title XIX-certified intermediate care facility for persons with mental retardation. These facilities:

- Provide IMR services to eligible clients with mental retardation or related conditions who require intensive habilitation training;
- Provide support services which may best be provided in a 24-hour residential care facility; and
- Meet the standards and guidelines of the federal nursing facility IMR program.

Nursing Facility Rates For ADSA Payment - Prospective payment rates as outlined in WAC 388-96-704.

Patient Participation - 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.

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.

QMB Only – An individual who is eligible for the QMB program but is not eligible for 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 persons receiving adult day or night care, or respite care.

Revised Code of Washington (RCW) – Washington State laws.

Nursing Facilities

About the Program

The purpose of the Nursing Facilities program is to pay for medically necessary nursing facility services provided to Medicaid-eligible clients. The nursing facility billing process for The Health Care Authority (the Agency) clients was developed by the Aging and Disability Services Administration (ADSA). Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

Client Eligibility

Who is eligible for nursing facility services?

Clients who qualify for benefits under Chapter 388-513 WAC will be issued an Institutional Benefits Award Letter by a HCS office (or the CSO for short stays in a nursing facility – less than 30 days). This award letter qualifies the client for nursing facility services.

Clients who are eligible as a QMB Only client are eligible for payment of Medicare cost sharing expenses under Medicare Part A, Part B, and Part C (except for Part C premiums and Part D costs). Maximum reimbursement under this program is subject to the limits established in WAC 388-502-0110 and WAC 388-517-0320.

Clients who are eligible under this program do not receive an Institutional Award Letter. A QMB Only client can be verified for eligibility by reviewing the following information:

- Services Card.
- Agency QMB program approval letter.
- WaMedWeb for the QMB program (ACES coverage group S03).

Hospice Clients Who Are Nursing Facility Residents

For information on hospice clients residing in a nursing facility, refer to the current Agency current *Hospice Services Billing Instructions* (see *Important Contacts* to see how to obtain Agency billing instructions).

Please see the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Payment

The Agency pays nursing facilities for costs that are ordinary, necessary, related to the care of medical care recipients, and not expressly unallowable. [RCW 74.46.190 (2)] Refer to RCW 74.46.410 and WAC 388-96-585 for examples of unallowable costs.

Notifying Clients of Their Rights to Make Their Own Healthcare Decisions (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.

Nursing Facility Codes

Patient Class

Enter Value Code 24 with the appropriate Patient Class Code (see table below) in form locator 39-41 on the UB-04 claim form.

Patient Class Code
20: SNF
23: IMR-Title XIX Eligible
24: Dual Medicare/Medicaid
26: Swing Bed
27: IMR-non eligible for Title XIX
29: Full Medicare
40: Exceptional Therapy Care
45: Alien Emergency Medical (AEM) Program, Non-Medicaid Eligible
50: Behavioral support
60: Community Home Project

Revenue Code

Bill nursing facility claims using revenue code **0190** (Subacute Care General Classification) in form locator 42 on the UB-04 claim form.

Patient Status Codes

Enter the appropriate Patient Status Code from the table below in form locator 22 on the UB-04 claim form.

CMS Patient Status Code	Description
01	Home
02	To hospital
03	To skilled nursing facility
04	To ICF (Intermediate Care Facility)
05	Discharged/Transferred to a designated cancer center or children's hospital
20	Expired (also use when a patient is admitted and dies on the same day)
30	Still a patient
50	Hospice/Home
51	Hospice/Medical facility
70	To another type of institution

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients; and
- Record keeping requirements.

Third-Party Liability

Information about third-party liability is available online at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Nursing_Facilities.html

Click on the "Skilled Nursing Facilities Cost Avoidance" link under "Resource Links" on the right hand side of the page. This link connects to the "Coordination of Benefits" page, select "download a PDF on Cost Avoidance" under "Other useful information."

How Do I Bill When a Client Is Admitted and Dies on the *Same Day*?

If a client is newly admitted and dies on the ***same day***, use Patient Status 20 when billing this claim. This **does not include** when a client is admitted and discharged on the same day.

How Do I Bill for a Client Who Is Discharged in a Current Month?

When discharging a client from your facility, use the appropriate Patient Status Code and enter the total number of units not including the discharge day.

Will I Be Paid for the Date of Discharge If a Client Is Discharged to a Hospital?

The Agency does not pay nursing facilities for the date of discharge (keep this in mind when entering total number of units).

Will I Be Paid for the Date of Discharge?

No. The Agency does not pay nursing facilities for the date of discharge for Medicaid clients (keep this in mind when entering total number of units).

If Medicare has charged a coinsurance for the date of discharge, you may bill the Agency for coinsurance charges for QMB Only Medicare clients.

How Do I 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 readmit only if the client left the facility for at least a full 24-hour period.

How Do I Change a Previously Paid Claim?

If you need to make changes to claims for dates of service that the Agency has already paid (e.g., because of the change in patient participation, split months, discharge in error), refer to the ProviderOne Billing and Resource Guide. You may find detailed instructions under Key Step 6 in the "Submit Fee-for-Service Claims to Medical Assistance" section. You may access these instructions on the Agency website at:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Where on the Form Do I Enter Patient Participation (Form Locator 39.-41.)?

Enter the client Patient Participation amount into form locators 39-41 using value code 31, Do not enter it into form locator 57. These funds must be contributed toward the patient's cost of care, except when billing for patient classes Code 24 and 29. For a definition of "Patient Participation," please refer to the Definitions and Abbreviations Section in these billing instructions.

You may not collect participation from a Agency client when billing for Class Code 29 and Class Code 24 Medicare days.

The Agency cannot reduce a Medicaid client's participation liability 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, and these clients are not required to contribute towards the cost of care while in the nursing facility.

Where on the Form Do I Enter the Spenddown Amount (Form Locator 39.-41.)?

Enter the client spenddown amount into form locators 39-41 using value code 66. Do not enter it into form locator 57. For a definition of "spenddown" please refer to the Definitions and Abbreviations Section in these billing instructions.

How Do I Bill for Clients Who Are Eligible for Medicare and Medicaid or Clients Who Are QMB Only?

Bill Medicare first. If you bill Medicaid for a class 29 or 24 prior to the Medicare payment, you will automatically receive a $0.00 reimbursement from Medicaid. If money is owed to you on a class 24 claim after Medicare makes payment, you must submit an adjustment form with the appropriate Medicare backup.

- If Medicare pays the claim, the provider must bill the Agency within six months of the date Medicare processes the claim.

- If Medicare denies payment of the claim, the Agency requires the provider to meet the Agency's initial 365-day requirement for initial claim.

For more details concerning Medicare crossover claims, refer to the Agency *ProviderOne Billing and Resource Guide* at:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

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.

The following instructions are specific to nursing facilities. Bill only dates of service for which the client is eligible.

Form Locator No.	Name	Entry
1.	**Provider Name, Address & Telephone Number**	Enter the provider name, address, and telephone number as filed with the Agency.
4.	**Type of Bill**	Enter: a. 0211 for claims; b. 0217 for adjustments; and c. 0218 for voids.
6.	**Statement Covers Period**	Enter the beginning and ending dates of service for the period covered by this bill.
8.a.	**Patient ID Number**	Enter the client's ProviderOne Client ID if different from the subscriber/insured's ID.
8.b.	**Patient Name**	Enter the client's last name, first name, and middle initial as shown on the client's Services Card.
9.	**Patient Address**	Enter the client's address.

Form Locator No.	Name	Entry
10.	**Patient Birthdate**	Enter the client's birthdate (MMDDYYYY).
11.	**Patient Sex**	Enter the client's sex (M or F).
14.	**Priority (Type) of Visit**	The priority (type) of admission. Enter: a. 1 for Emergency; b. 2 for Urgent; c. 3 for Elective; and d. 5 for Trauma
15.	**Admission Source**	The source of admission. Enter: a. 1 for Physician Referral; b. 2 for Clinic Referral; c. 3 for HMO Referral; d. 4 for Transfer from a Hospital; e. 5 for Transfer from a Skilled Nursing Facility; f. 7 for Emergency Room; and g. A for Transfer from a Critical Access Hospital
17.	**Discharge Status/Patient Status**	Enter a valid Patient Status code to represent the disposition of the patient's status.
39.-41.	**Value Codes and Amounts**	The following Value Codes are required to process your nursing facility claims: **Value Code 24 –** Enter this code in the code field with the Patient Class immediately following in the amount field. See page C.1 for valid Patient Class codes. (e.g., 20.00=class code 20) **Value Code 31** – Enter this code in the code field with the Patient Participation amount for the entire month immediately following in the amount field. **Value Code 66** – Enter this code in the code field with the entire Patient Spenddown Amount immediately following in the amount field.
42.	**Revenue Code**	Enter revenue code 0190.
43.	**Revenue Descriptions (Procedure Descriptions)**	(Required for Paper Only) The description of the related revenue code. Abbreviations may be used.
44.	**HCPCS/Rates**	Enter nursing facility daily rate.
45.	**Service Date**	Same as form locator 6.
46.	**Units of Service**	Enter the number of days. Do not include the date of discharge.
47.	**Total Charges**	Equals the amount in form locator 44 multiplied by the amount in form locator 46.
48.	**Non-Covered**	Any charges not covered by the Agency.

Form Locator No.	Name	Entry
	Charges	
50.	**Payer Identification: A/B/C**	All health insurance benefits available. **50A**: Enter Primary Payer. **50B**: Enter the name of the Secondary Payer (e.g., Medicaid, Medicare, Aetna, etc.), if applicable. **50C**: Enter the name of the Tertiary Payer, if applicable.
54.	**Prior Payments: A/B/C**	The amount due or received from all insurances. **Do not include participation amount here.** **54A**: Any prior payments from payer listed in form locator 50A. **54B**: Any prior payments from payer listed in form locator 50B. **54C**: Any prior payments from payer listed in form locator 50C.
58.	**Insured's Name: A/B/C**	The insured's name if other insurance benefits are available and coverage is under another name.
60.	**Insured's Unique ID: A/B/C**	Enter the unique number assigned by the health plan to the insured (following A/B/C for form locators 50-55). For the line represented by Medicaid, enter the ProviderOne Client ID exactly as displayed in ProviderOne. This information consists of the client's: a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available). b. Six-digit birthdate, consisting of *numerals only* (MMDDYY). c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker. d. An alpha or numeric character (tiebreaker).
69.	**Admitting Diagnosis Code**	The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.