Washington State Health Care Authority

Medicaid Provider Guide

Nursing Facilities
[Chapter 388-96 WAC]

May 15, 2013

Washington State Health Care Authority

A Billing Instruction

About this guide

This guide is designed to help nursing facility providers and their staff to understand the Aging and Long-Term Support Administration (ALTSA) 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, by the Health Care Authority (agency), supersedes all previous *Nursing Facility Medicaid Provider Guide* published by the Department of Social and Health Services.

Note: The underlined words and phrases are links in this guide. Some are internal, taking you to a different place within the document, and some are external to the guide, leading you to information on other websites.

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-30	May 15, 2013	Definitions & Abbreviations	Replace ADSA with Aging and Long-Term Support Administration (ALTSA).
		About the program	Replace ADSA with Aging and Long-Term Support Administration (ALTSA).
		Healthy Options	Add information about submitting claims for Healthy Options clients.
		QMB only	Add information about client eligibility verification and reimbursement.
		Patient class	Add class codes 54, 55, 56, 62, 63, and 64.
		Where on the form do I enter patient participation (Form locator 39.-41.)?	Add class code 55 as an exception to funds that must contribute toward patient cost of care.
		Completing the UB-04 Claim Form	Add form locator number 55 to the instruction table.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

Table of Contents

Resources Available

Note: This section contains important contact information relevant to nursing facilities. For more contact information, see the agency *Resources Available*.

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	**Aging and Long-Term Support 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*.
Finding agency documents (e.g., Medicaid provider guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than agency managed care	

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in this guide. Please refer to the Medical Assistance Glossary at: http://www.hca.wa.gov/medicaid/billing/pages/medical_assistance_glossary.aspx for a more complete list of definitions.

Aging and Long-Term Support Administration (ALTSA) - As a component of the Washington State Department of Social and Health Services, ALTSA 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 ALTSA 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.

Rehabilitative Services - The planned interventions and procedures which constitute a continuing and comprehensive effort to restore an individual to the individual's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

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

Nursing Facilities

About the program

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

How can I verify a patient's eligibility?

Clients who qualify for benefits under Chapter 182-513 WAC will be issued an Institutional Benefits Award Letter by a Home and Community Services (HCS) office for short stays in a nursing facility – (a short stay is less than 30 days). This award letter qualifies the client for nursing facility services.

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Hospice clients who are nursing facility residents

Please see the agency's *Hospice Services Medicaid Provider Guide* for information on hospice clients residing in a nursing facility.

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 74.46.431] Refer to RCW 74.46 and WAC 388-96-585 for examples of unallowable costs.

Qualified Medical Beneficiary Only (QMB) clients

Clients who are eligible as a "QMB Only client" are eligible for 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 182-502-0110 and WAC 182-517-0320.

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.
- ProviderOne for the QMB program (ACES coverage group S03).

Healthy Options (HO)

Rehabilitation Services for HO Clients

HO clients may reside in adult residential service facilities, which include assisted living facilities, group homes, adult family homes, and nursing facilities. HO clients are covered for rehabilitation services, which must be provided in eligible nursing facilities. An eligible nursing facility is an agency participating provider licensed to provide inpatient rehabilitation services.

When a client has been approved by an HO plan to receive rehabilitation services, the eligible nursing facility must submit a Notice of Action – Adult Residential Services form, DSHS 15-031, to the Department of Social and Health Services (DSHS) with the date of the client's:

- Admission to the eligible nursing facility, if the client resides in an assisted living facility or a group home; or
- Change of status including the end of rehabilitation days, or hospice election, revocation; or
- Discharges from a facility; or
- Transition to rehabilitation status, if the client resides in a nursing facility that is an agency participating provider that can provide rehabilitation services.

In order for a nursing facility to receive payment for providing rehabilitation services to HO clients, a nursing facility must:

- Submit a request and receive prior authorization from the HO plan to provide such services; or

- Be an agency participating provider that can provide such services; **and**

- Submit claims for rehabilitation days using payment class code 55. (date of service (DOS) covered by the HO plan.)

Long Term Care

When an HO client's status days change from "rehabilitation" to "long term care" (also known as custodial care) the client is dis-enrolled from HO. The nursing facility must:

- Submit a Notice of Action – Adult Residential Services form, DSHS 15-031, to DSHS with the date the client's status changed;

- Submit a claim with class code 20 and include documentation from the client's primary care physician that rehabilitation status has ended. The agency will notify the HO plan to dis-enroll the client from the plan.

- Request a social service assessment intake from Home and Community Services (HCS) on the date the rehabilitation status ends. (Social Service Intake phone numbers for HCS are listed on DSHS 15-031 form)

For more information on Healthy Options and long-term care, see the DSHS EAZ manual.

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 code

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
54: Specialized Behavior Support – Level 1
55: Rehabilitation with Managed Medicaid (HO)
56: Specialized Behavior Support – Level 3
60: Community Home Project
62: Department Of Corrections
63: Traumatic Brain Injury
64: Bariatric

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's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Third-party liability

Information about third-party liability is available online at Coordination of Benefits Information for Medicaid Contracted Providers. Select Download a file on cost avoidance.

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 (keep this in mind when entering total number of units).

If Medicare has charged a coinsurance for the date of discharge, 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 readmittance 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 for which the agency has already paid, refer to the ProviderOne Billing and Resource Guide, Key Step 6 in the "Submit Fee-for-Service Claims to Medical Assistance" section. (Examples of claim changes are a change in patient participation, split months, discharge in error)

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 class codes 24, 29 and 55. For a definition of "Patient Participation," please refer to the Definitions and Abbreviations in this guide.

You cannot collect participation from an agency client when billing for class code 29, 55 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. These clients are not required to contribute toward 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 agency's Medical Assistance Glossary.

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, you must bill the agency within 6 months of the date Medicare processes the claim.

- If Medicare denies payment of the claim, the agency requires you 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*.

Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual are 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, resubmit denied claim; 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 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 Charges**	Any charges not covered by the agency.

Form Locator No.	Name	Entry
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.
55	**Estimated Amount Due**	Expected Medicaid payment
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.
69.	**Admitting Diagnosis Code**	The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.