Integrated Managed Care Inpatient FAQs

2/11/2020

The Health Care Authority (HCA) has updated our frequently asked questions from providers about authorization and payment for inpatient services.

Involuntary Inpatient Treatment

1: **The Behavioral Health – Administrative Service Organization (BH-ASO) authorizes involuntary treatment for a non-Medicaid client. Before discharge, the client is back-dated as Medicaid eligible. Who is responsible for payment?**

Medicaid is responsible from the date of eligibility. If the client's MCO enrollment is back-dated to prior to the date of admission, the MCO pays for treatment. If the client's back-dated enrollment begins after the date of admission, HCA will pay. Contact HCA for guidance in these situations at HCAMCPrograms@hca.wa.gov.

2: If the client becomes Medicaid eligible after the BH-ASO pays for services, does the provider have to bill the MCO?

If it is a crisis related service, the provider does not need to rebill. Instead, a reconciliation is performed twice a year between the MCO and BH-ASO.

If a non-crisis related service, the ASO would need to recoup payment, then the provider would need to bill the MCO. MCOs would honor the ASO's authorization for services, assuming that normal rules for medical necessity under Medicaid applied to that authorization. The provider will resubmit the authorization request as a retro authorization request to the MCO. The provider will identify the request as a retro enrollment request as well as provide information on the previous ASO approval if available.

3: **A client with private insurance is admitted to a facility through the Involuntary Treatment Act (ITA). The commercial insurance company is not credentialed at the facility OR won't authorize the treatment. If a client with private insurance is detained on an ITA, who authorizes the treatment?**

Providers generally do not authorize services, they request authorization of payment from the liable payor. ITA services generally can be considered emergency medical conditions and many medical plans are obligated to cover costs of emergency services when properly billed as such.

State medical assistance programs are the payer of last resort. If a third party payer is present, BH-ASOs should follow coordination of benefits rules and pay allowable amounts not covered by the primary.

In some circumstances if the expected primary payer's payment does not materialize (certain payers may have more restrictive standards of medical necessity than BH-ASOs)—the BH-ASO can be billed, however, the hospital should make appropriate efforts to collect from the primary insurer.

4: When a client moves across regional lines for residential treatment, they might have their residential address changed and lose enrollment with their MCO. Who does the provider bill in this instance?

The provider should contact the MCO the member is assigned to and work with the MCO on how to resolve this. The MCO Contact List is posted on HCA's website at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources.

5: Do providers bill the BH-ASO or the MCO for ITA investigations?

Providers should bill the BH-ASO for ITA Investigations and other due process related costs (i.e. court costs).

Substance Use Disorder (SUD) Inpatient Treatment

1: Who should request the authorization for SUD inpatient treatment from the MCO? Does the SUD outpatient (OP) provider complete a SUD IP referral form and send it to an MCO? Does the SUD IP provider admit the client and then get the authorization from the MCO?

The MCOs can accept the information from either provider, they do not have a preference between inpatient or outpatient providers. However, the MCOs need the most current clinical information which may require the providers to work together to determine who has the most recent information.

2: If SUD outpatient or inpatient providers are having problems with proper forms or requests for authorizations, who do they contact?

Providers should route the issues to the Behavioral Health Utilization Manager of each MCO for assistance. The contact list is updated when the MCOs request changes. In addition, MCOs have distributed authorization guidance relating to different services. The MCO Contact List and Prior Authorization Grid are posted on HCA's website at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources.

3: **When an inmate needs direct placement to an inpatient/Residential SUD treatment upon release from jail, how should a provider coordinate the jail transition when requesting pre-authorization from the MCOs?**

In coordinating jail transitions, follow the steps below:

1. Identify which MCO had the inmate enrolled prior to incarceration. They will be reinstated with that MCO upon release if still available in your region. If not, please reach out to HCA at hcamcprograms@hca.wa.gov.
2. Contact that MCO to inform them you need the prior authorization for inpatient treatment upon release from jail. The MCOs should be prepared for these calls. The MCOs will need clinical documentation to process the authorization- same as any request for this service.
3. If the individual had an MCO that is no longer in the region, the provider can coordinate with HCA to determine which MCO will be responsible for the inmate upon release. Then they will work with that MCO to get the prior authorization.
4. If for some reason the client's enrollment is switched to a different MCO on release, that MCO will accept the authorization provided by the MCO during the discharge planning.

If suspended, the client will not show coverage with a health plan in ProviderOne because their coverage is suspended while incarcerated. They will be reinstated with the health plan (or a new health plan if that plan is no longer in the region) upon release from jail. This is not a new process. It will take 24 hours to process this enrollment on HCA's end, so the provider won't see it in the system until the following day.

Out-of-State Clients and Secure Detox Facilities

A Nevada Medicaid Enrollee is detained to a Washington Secure Detox facility. Who is responsible for covering the individual's placement?

First, determine whether or not the patient is truly a resident of Nevada. If the individual has chosen to reside in Washington, enrollment in WA Medicaid likely should be pursued.

According to 42 CFR 435.403(h)(1):

> … "the State of residence is the State where the individual is living and—
>
>> (i) Intends to reside, including without a fixed address;…"

Medicaid programs generally must pay for services furnished out of State when the conditions of 42 CFR 431.52 are met:

(1) Medical services are needed because of a medical emergency;

(2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

If payment by an out of state MCO is unavailable, the BH-ASO is obligated to pay the costs of individuals residing/present in their region who would otherwise experience financial hardship.

Voluntary Inpatient Treatment for Non-Medicaid Clients

Who do providers need to contact for authorization if a non-Medicaid client requests voluntary inpatient services at their facility but they live in a different region?

The BH-ASO in the client's region of residence is responsible for authorization and payment for the non-Medicaid client. Providers need to contact the BH-ASO and request authorization for treatment services. This includes treatment provided at E&T facilities and community hospitals. For non-Medicaid clients at or below the 220% Federal Poverty Level, prior authorization is required. See the Mental Health Billing Guide for more details: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing

Crisis Triage or Stabilization Authorizations

Who do providers contact for authorization for crisis triage or crisis stabilization in a residential setting? What do they do when the client needs to step down to a lower level of care?

For Medicaid clients, servicing providers need to coordinate authorizations and payments with the MCO. The process requires notification with concurrent review, including when stepping down to a lower level of care. The MCO Prior Authorization Grid is posted on HCA's website at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources.

If the client is not yet active or assigned to an MCO, the provider can initially work with the BH-ASO for crisis services.

If the client is a non-Medicaid client, the provider needs to work with the BH-ASO.

Single Bed Certifications

1. **A Medicaid client is detained on a single bed certification; what process is used for authorizing the services?**

For patients detained on single bed certifications, the admitting facility should notify the MCO within 24 hours or business day (regardless if ITA or voluntary), followed by concurrent review. This is the same across all MCOs. The MCOs are required to pay if the stay is the result of an ITA, but MCOs want to do concurrent review to monitor progress.

2. **For Single Bed Certifications, who is responsible for sending in the request for a single bed certification?**

Per WAC 182-538D-0526 (https://www.hca.wa.gov/assets/103E-18-14-027.pdf):

- For adults, the BHO-ASO or the designee (i.e. DCR) must submit the request for a single bed certification to the Health Care Authority, via fax to the State Hospital.
- For children, the admitting facility submits the request.
- For extensions for either adults or children, the admitting facility submits the request.