Washington State Health Care Authority

Washington Apple Health (Medicaid)

Long-Term Acute Care Program Billing Guide

July 1, 2022

Washington State Health Care Authority

Disclaimer

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

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2022**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in WAC 182-550-2565 through WAC 182-550-2596.

The Health Care Authority 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.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

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

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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* This publication is a billing instruction.

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Client eligibility – Clients who are not enrolled in an HCA-contracted managed care plan for physical health services	Clarified who pays if a client received Medicaid-covered services before being automatically enrolled in a BHSO	Program enrollment clarification
Client eligibility – Integrated managed care	Revised paragraph to reflect enrollment in an integrated managed care plan	Clarification
Client eligibility – American Indian/Alaska Native (AI/AN) Clients	Created new subsection and moved this information out of the *Integrated managed care* section	Create a stand-alone section for just AI/AN clients

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Table of Contents

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Resources Available

Note: This section contains important contact information relevant to the Long- Term Acute Care Program. For more contact information, see HCA's Billers, provider, and partners webpage.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage.
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's ProviderOne Resources webpage.
Electronic billing	See HCA's ProviderOne Resources webpage.
Finding HCA documents (e.g., provider guides, fee schedules)	See HCA's ProviderOne Resources webpage.
Private insurance or third-party liability, other than HCA managed care	See HCA's ProviderOne Resources webpage.
Prior authorization, limitation extensions, or exception to rule	For prior authorization or limitation extension, providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's prior authorization webpage for details. Providers may also fax requests to 866-668-1214 along with the following: • A completed, typed *General Information for Authorization* form, HCA 13-835. This request form must be the initial page when you submit your request. • A completed *Fax/Written Request Basic Information* form, HCA 13-756, all documentation listed on this form, most recent hospital admission history, physical, and any other medical justification. • A completed *Long-Term Acute Care Authorization/Update Request* form, HCA 13-890, all documentation listed on this form, and any other medical justification. See Where can I download HCA forms?

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **Chapter 182-500 WAC** for a complete list of definitions for Washington Apple Health. See **WAC 182-550-1050** for additional hospital services definitions.

Acute - An intense medical episode, not longer than three months.

Administrative day - A day of a hospital stay in which an acute inpatient level of care is no longer necessary, and non-inpatient hospital placement is appropriate.

Administrative day rate - The statewide Medicaid average daily nursing facility rate as determined by HCA.

Authorization - HCA's official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number - A nine-digit number assigned by HCA that identifies individual requests for approval of services. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Diagnosis Related Group (DRG) - A classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria.

Level 1 Services - Long term acute care (LTAC) services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one (or both) of the following:

- Ventilator weaning care; or
- Care for a client who has:
    - Chronic open wounds that require on site wound care specialty services and daily assessments and/or interventions; and
    - At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

Level 2 services - Long term acute care (LTAC) services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

- Ventilator care for a client who is ventilator dependent and is not weanable, and has complex medical needs; or
- Care for a client who:
    - Has a tracheostomy;
    - Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and
    - Has at least one comorbid condition (such as quadriplegia.)

Long-term Acute Care (LTAC) - Inpatient intensive long term care services provided in HCA-approved LTAC hospitals to eligible medical assistance clients who require Level 1 or Level 2 services.

LTAC fixed per diem rate - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

Survey - An inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements.

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About the Program

What is the Long-Term Acute Care (LTAC) Program?

- The Long-Term Acute Care (LTAC) Program is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in an HCA -approved LTAC facility during the acute phase of a client's care. These facilities specialize in treating patients that require intensive hospitalization for extended periods of time. Patients transferred to these hospitals are typically in the intensive care unit of the traditional hospital that initiated their medical care. Under federal guidelines, only a few hospitals have been designated as specialists in treating patients requiring intensive medical care for extended periods. Medicare calls these hospitals "long-term acute care hospitals" (LTAC).
- HCA requires prior authorization for all LTAC stays. HCA determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in **PA Requirements for Level 1 and Level 2 LTAC Services**.
- A multidisciplinary team coordinates individualized LTAC services at an HCA -approved LTAC facility to achieve improved health and welfare for a client.
- When HCA-authorized stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

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Client Eligibility

Note: HCA requires prior authorization for all long-term acute care services. See Prior Authorization for instructions on requesting prior authorization. HCA will verify the client's eligibility prior to authorizing services.

Most Apple Health clients are enrolled in an HCA-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 HCA'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.

How do I verify a client's eligibility?

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 HCA will not pay for.

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 HCA'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 HCA'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.
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 the Washington Healthplanfinder's website or call the Customer Support Center.

Are clients enrolled in managed care plans eligible for LTAC services?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's contracted MCOs. For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

- Clients are eligible for LTAC services through their managed care plan when the client is enrolled in the plan at the time of acute care admission.
- The plan pays for, coordinates, and authorizes LTAC services when appropriate.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from both the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the HCA-contracted MCO, if appropriate. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-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 fee-for-service (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. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health managed care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

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**."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Primary care case management (PCCM)

The Client Benefit Inquiry screen in ProviderOne will display the PCCM provider when a client who has chosen to obtain care with a PCCM provider. HCA requires prior authorization for LTAC Services. Prior authorization is obtained through the LTAC program manager not the PCCM provider.

> **Note**: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see HCA **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

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Provider Requirements

What is required to become an LTAC hospital?

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

Submit a letter of request to:

LTAC Program Manager

Healthcare Services

The Health Care Authority

P.O. Box 45506

Olympia WA 98504 5506

and

Include in the letter documentation that confirms the hospital is all of the following:

- Medicare certified for LTAC
- Accredited by the joint commission on accreditation of healthcare organizations (JCAHO)
- For an in state hospital, licensed as an acute care hospital by the Department of Health (DOH) under WAC 246 310 010 and Chapter 246 320 WAC
- For an out of state hospital licensed as an acute care hospital by the state where the hospital is located
- Enrolled with HCA as a Medicaid participating provider

The hospital qualifies as an HCA approved LTAC hospital when all of the following are met:

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

HCA may, at its sole discretion, approve a hospital located in Idaho or Oregon that is not in a designated bordering city as an LTAC hospital if both of the following are met:

- The hospital meets the requirements of this section
- The hospital provider signs a contract with HCA agreeing to the LTAC criteria for services in accordance with WAC 182 550 2595

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

Postpay or on-site reviews

To ensure quality of care, HCA may conduct postpay or on-site reviews of any HCA-approved LTAC hospital. See WAC 182-550-2585, "Audits and the audit appeal process for contractors/providers," for additional information about audits conducted by HCA staff.

To ensure a client's right to receive necessary quality of care, a provider of LTAC services is responsible to act on reports of substandard care or violations to the hospital's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or a grievance or both. A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- The Department of Health (DOH)
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- HCA
- Other agencies with review authority for medical assistance programs

Notifying clients of their rights (advance directives)

(42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to all of the following:

- Accept or refuse medical treatment
- Make decisions concerning their own medical care
- Formulate an advance directive, such as a living will or durable power of attorney for health care

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Prior Authorization

Does HCA require prior authorization (PA) for LTAC services?

Yes.

> **Note**: Please see HCA's ProviderOne Billing and Resource Guide for more information on requesting authorization.

PA requirements for Level 1 and Level 2 LTAC services

The prior authorization process includes all of the following:

- **For an initial thirty-day stay**:
  - The client must meet the following:
    - Be eligible under one of the programs listed in WAC 182 550 2575; or
    - Be eligible under the alternative benefits plan (APB) as defined in WAC 182-500-0010

and

    - Require Level 1 or Level 2 LTAC services as defined in WAC 182-550-1050
- **Before admitting the client to the LTAC hospital the LTAC provider of services must**:
  - Submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's prior authorization webpage for details). Providers may also fax requests to 866-668-1214.
  - HCA may request additional information as follows:
    - A completed Long-Term Acute Care Authorization/Update Request form, HCA 13-890
    - LTAC intake form
    - The most recent hospital admission history and physical exam notes or results
    - Any other medical justification.

For information about downloading HCA forms, see Where can I download HCA forms?

> **Note**: Contact HCA to request prior authorization (see Resources Available).

To request an extension for LTAC days, please use the following instructions:

Go to **Document submission cover sheets**:

- Scroll down and click on number 7. PA (Prior Authorization) Pend Forms.
- When the form appears on the screen, insert the Authorization Reference number (ProviderOne authorization number) in the space provided and press enter to generate the barcode on the form.

> **TIP**: The ProviderOne authorization number for this type of request can be found using the ProviderOne authorization inquiry feature. The ProviderOne authorization number is listed above the client's ID number on the PA Utilization screen.

- Print the Pend form and use it as the cover sheet and attach the additional information behind it.
- Fax pages to HCA using the fax number on the bottom of the Pend Form.

> **Note**: The Pend for MUST be the first page of the fax.

- Use the LTAC Request, form HCA 13-890. See **Where can I download HCA forms**?
- Include sufficient medical information to justify the requested extension of stay.

HCA authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received.

A client who does not agree with a decision regarding a length of stay has a right to a fair hearing under **Chapter 182-526 WAC**. After receiving a request for a fair hearing, HCA may request additional information from the client and the facility, or both. After HCA reviews the available information, the result may be any of the following:

- A reversal of the initial HCA decision
- Resolution of the client's issue(s)
- A fair hearing conducted per Chapter 182-526 WAC

HCA may authorize an administrative day rate payment, as well as payment for pharmacy services and pharmaceuticals, for a client who meets one or more of the following:

- Does not meet the requirements for Level 1 or Level 2 LTAC services
- Is waiting for placement in another hospital or other facility
- If appropriate, is waiting to be discharged to the client's residence

Payment

What does the LTAC fixed per diem rate include?

In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the services and equipment in the table below. Use revenue code 100 in the appropriate field of the institutional claim when billing for the services included in the fixed per diem rate. The amount billed must be the usual and customary charges for the services included in the per diem rate. HCA pays for these services at HCA's LTAC fixed per diem rate.

Note: Bill the usual and customary charges for all charges incurred for services included in the fixed per diem rate under revenue code 100.

Do not bill separately for any of the revenue codes listed below as these charges should be included in your charges for revenue code 100. **Exception: Revenue code 250**.

Code	Description
100	**Your usual and customary charges for the following services are included and should be billed under revenue code 100. HCA pays for these services at HCA's LTAC fixed per diem rate**.
128	Room and Board – Rehabilitation
200	Room and Board – Intensive Care
250	Pharmacy - Up to and including $200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
270	Medical/Surgical Supplies and Devices
300	Laboratory – General
301	Laboratory – Chemistry
302	Laboratory – Immunology
305	Laboratory – Hematology
306	Laboratory – Bacteriology and Microbiology

Code	Description
307	Laboratory – Urology
309	Laboratory – Other Laboratory Services
410	Respiratory Services
420	Physical Therapy
430	Occupational Therapy
440	Speech-Language Therapy

Who pays for continuous care events when a client enrolls in an HCA-contracted managed care organization?

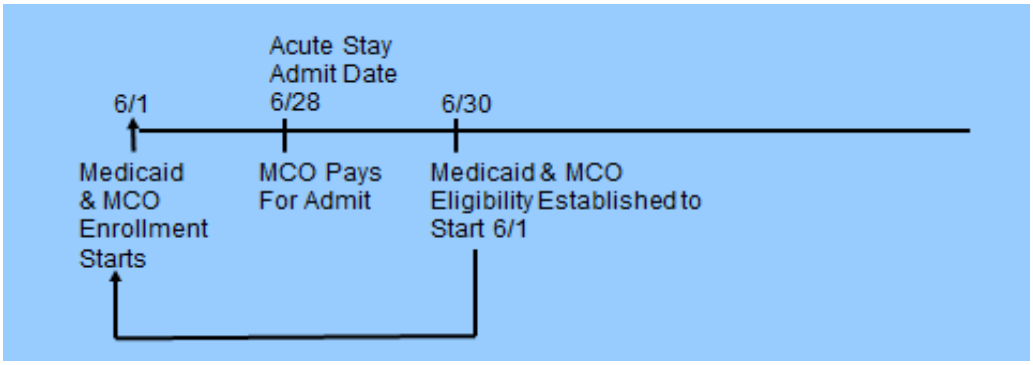
When a patient transfers from acute care to a rehabilitation setting (e.g., an acute physical medicine and rehabilitation (acute PM&R) facility, a long-term acute care (LTAC) facility, or a skilled nursing facility (SNF)), HCA considers each stay a separate event. Whether HCA of the managed care organization (MCO) pays depends on the date of admission compared to the date of Medicaid eligibility and the date of enrollment with the MCO.

HCA does not pay:

- For an admission to an acute PM&R facility, LTAC facility, or SNF, if the admission started on or after the effective date of enrollment in an MCO.
- For a covered service that is the responsibility of HCA-contracted MCO.

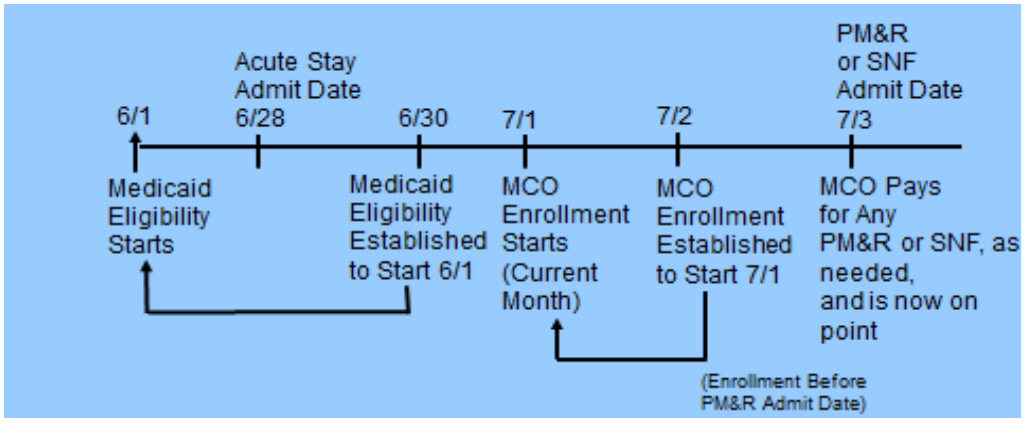
Scenario 1:

If the effective date for the client's Medicaid eligibility and MCO enrollment is *before* an acute care admission date, the MCO is responsible.



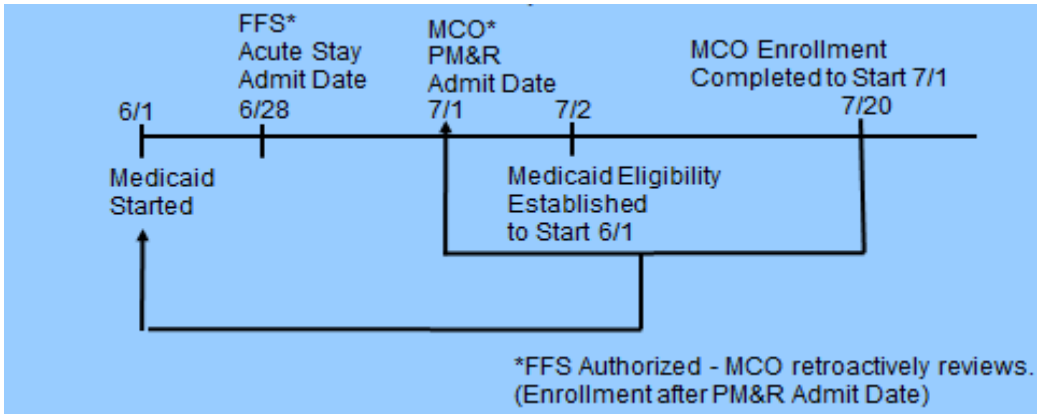
Scenario 2:

If the MCO enrollment effective date is *after* the acute care admission date, HCA fee-for-service (FFS) program is responsible for the acute care admission. The MCO is responsible for any subsequent admissions for PM&R, LTAC, or SNF services occurring after the MCO enrollment effective date.



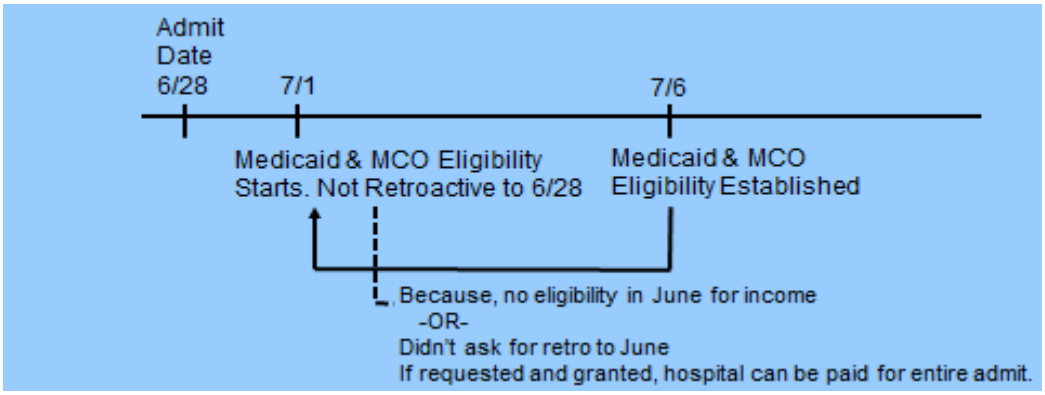
Scenario 3:

If the MCO enrollment is effective the month following the acute care admission date, but Medicaid eligibility is established back to the first of the month in which the admission occurred, HCA FFS program is responsible for the acute care stay and any other admissions (PM&R, LTAC, SNF) that begin *before* the MCO enrollment effective date. The MCO pays for any PM&R, LTAC, or SNF admissions that begin after the MCO enrollment effective date.



Scenario 4:

If the effective dates for the client's Medicaid eligibility and MCO enrollments are after the acute care, PM&R, LTAC, or SNF admission date and no retroactive eligibility is granted back to the date of admission, HCA FFS program is responsible for the admission until discharge. However, HCA will prorate and pay only for those dates the client is eligible for Medicaid.



What is not included in the LTAC fixed per diem rate?

The following specific services and equipment are excluded from the LTAC fixed per diem rate and may be billed by providers in accordance with applicable HCA fee or rate schedules:

> **Note**: Bill your total usual and customary charges for revenue code 250 in the appropriate form locator field. Enter the first $200 per day in locator 48 as noncovered.

Revenue Code	Description
250	Pharmacy - After the first $200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
255	Drugs/Incidental Radiology
260	IV Therapy
320	Radiology
340	Nuclear Medicine
350	Computered Tomographic (CT) Scan

Revenue Code	Description
360	Operating Room Services
370	Anesthesia
390	Blood and Blood Component, Processing and Storage
391	Blood and Blood Component, Administration
402	Other Imaging Services – Ultrasound
460	Pulmonary Function
480	Cardiology
710	Recovery Room
730	EKG/ECG
750	Gastro-Intestinal Services
801	Inpatient Hemodialysis
921	Peripheral Vascular Lab

Note: HCA uses the appropriate payment method described in HCA's other billing instructions to pay providers other than LTAC facilities for services and equipment that are covered by HCA but not included in the LTAC fixed per diem rate. The provider must bill HCA directly and HCA pays the provider directly. See WAC 182-550-2596.

How does HCA determine payment for LTAC services?

HCA pays the LTAC facility the LTAC fixed per diem rate in effect at the time the LTAC services are provided, minus the sum of both of the following:

- Client liability, whether or not collected by the provider
- Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:
  - Insurers and indemnitors
  - Other federal or state medical care programs
  - Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations

- Any other contractual or legal entitlement of the client, including, but not limited to:
  - Crime victims' compensation
  - Workers' compensation
  - Individual or group insurance
  - Court-ordered dependent support arrangements
  - The tort liability of any third party

Note: HCA may make an annual vendor rate increase to the LTAC fixed per diem rate. HCA may rebase the LTAC fixed per diem rate periodically.

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

Does HCA pay for ambulance transportation?

Transportation services to transport a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC hospital, or related to transporting a client to another facility after discharge from the LTAC hospital:

- Are not covered or paid through the LTAC fixed per diem rate
- Are not payable directly to the LTAC hospital
- Are subject to the provisions in **Chapter 182-546 WAC**
- Must be billed directly to one of the following:
  - HCA by the transportation company to be paid if the client required ambulance transportation
  - HCA's contracted transportation broker, subject to the PA requirements and provisions described in Chapter 182-546 WAC, if the client meets one of the following:
    - Required non-emergency transportation
    - Did not have a medical condition that required transportation in a prone or supine position

Note: HCA evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions under the provisions of WAC 182-546.

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

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see **Paperless Billing at HCA**. For providers approved to bill paper claims, scroll down to "*Paper Claim Billing Resource*."

What are the general billing requirements?

Providers must follow HCA **ProviderOne Billing and Resource Guide**. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

Exception: If billing Medicare Prat B crossover claims, bill the amount submitted to Medicare.

Does HCA allow interim billing?

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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners 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 claim instructions relate to the long-term acute care program and are the only appropriate code(s) for this billing instruction:

Name	Code Entry	To Be Used For
Place of Service	12	Client's residence
Place of Service	13	Assisted living facility
Place of Service	32	Nursing facility
Place of Service	31	Skilled nursing facility
Place of Service	99	Other