

Provider Questions

- 1

- Detox billing for Medicaid without having detox group number. What should a facility do?

- From: Kiyon Smith
- WWRHCC

- The hospital should contact the DASA Regional Administrator. If the county receives funding for detox, the hospital needs to work with the county Alcohol and Drug Coordinator to determine how to get the people to the detox facility in the county. If the county does not have detox funding, the DASA RA would work to get the hospital a detox provider number.

- *Rose Mary Micheli, Title XIX Coordinator*
- *Division of Alcohol and Substance Abuse*
- (360) 725-3750; micherm@dshs.wa.gov
- DASA Homepage: <http://www1.dshs.wa.gov/dasa>

Provider Question - 2

- We have some Dr's that are trying to keep their clients honest by checking med levels & other Lab tests as related to drug dependency issues. Well, that is a non-covered Dx. Unfortunately, I feel that we should do what we can to help the Dr's manage client's care, even if that means a few extra tests. If we are going to help these clients, they have to be held accountable. If we can't order the tests & get paid, then how can we do that?
- From: Jenny Crane
– Mark Reed

Provider Question - 3

- My other area that I may have some questions on is "Restriction" = How can we assist Medicaid/DSHS with these Restricted clients? Now we just see them and bill as usual. Is that all we are supposed to do? Should there be client education involved?
- From: Jenny Crane
– Mark Reed

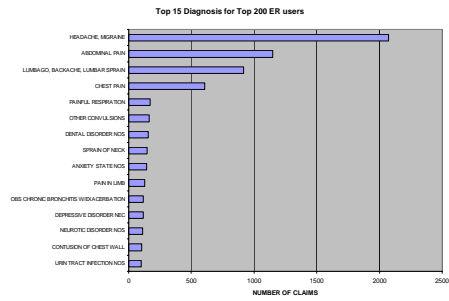
Patient Review and Restriction (PRR) Program

- **State and Federal health and safety program for fee-for-service and managed care clients needing help in the appropriate use of medical services**
- **Potential clients are selected for PRR review:**
 - **Exception report produced by our payment system: high narcotics or multiple ER etc.**
 - **Direct referral from medical providers, social service agencies or other concern parties**
- **PRR restricts client for at least 24 months:**
 - **One primary care provider**
 - **One pharmacy**
 - **One narcotic prescriber**
 - **One hospital for non-emergent services (cannot restrict emergency services)**
- **Authority:**
 - **42CFR 431.54 (e); 456.3; 455.1-16**
 - **WAC 388-501-0135**

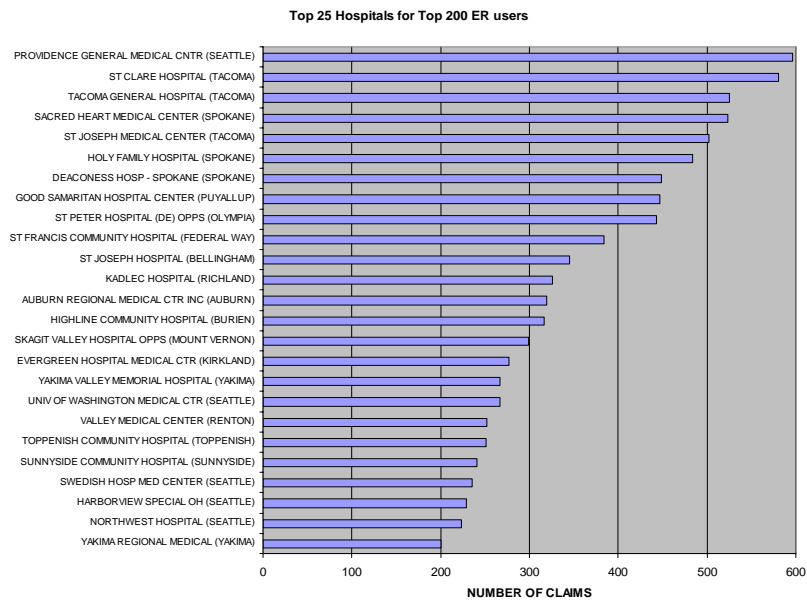
Goals of PRR Program

- **Decrease and control over-utilization and inappropriate use of health care**
- **Minimize medically unnecessary and addictive drug use**
- **Provide patient education and coordination of care**
- **Help providers manage patients with education and resource referrals; facilitate coordination of care**
- **Reduce expenditures on unnecessary and inappropriate services**

Top Diagnosis for Top PRR ER Users in FY 2005



Top Hospitals for Top 200 PRR ER Users in FY 2005



PRR Referrals

- PRR Referral Line
 - (360) 725-1780
- PRR Website
 - <http://maa.dshs.wa.gov/PRR>

Billing for Medicaid Swing Bed Days



Department of Social and Health Services
Aging and Disability Services
Lyle Baker: bakerld@dshs.wa.gov (360) 725-2513
Health and Recovery Services Administration
Carolyn Adams: adamscr@dshs.wa.gov (360) 725-1854
Larry Linn: linnl@dshs.wa.gov (360) 725-1856
Nicole Nguyen: nguyen@dshs.wa.gov (360) 725-1079
Mary Fry: frymf@dshs.wa.gov (360) 725-1065
Cynthia Smith smithch@dshs.wa.gov (360)725-1839

Information in this slide show is only applicable when Medicaid is/or has become the primary payor

What are the client related requirements for a qualified facility to bill for a Medicaid Swing Bed Day?

The client :

- **must be Medicaid Eligible**
- **must be assessed and found to be “Functionally and Financially Eligible” for Institutional Long Term Care (LTC)**
- **must have Medicaid Award Letter authorizing institutional benefits in effect for the dates of service billed.**
- **must not be receiving inpatient acute care on the dates of service that swing bed days are billed (exception, swing bed day of discharge)**

How is the Medicaid Swing Bed Daily Rate Determined?

- The Medicaid swing bed daily rate is the approximate statewide average nursing facility daily rate for the previous state fiscal year.
- This statewide swing bed daily rate is calculated yearly and is in effect July 1st through June 30th.
- The rate is paid based on dates of service.
- This rate includes payment for services and supplies ordinarily provided in long term care facilities.

How Does a Medicaid Client Become Placed in a Swing Bed for LTC?

- Clients can only be placed in Swing Beds for long term acute care after they are determined to be “functionally eligible” for long term acute care services as a result of a Comprehensive Assessment done by the Regional Home and Community Services Office

What Conditions Qualify a Medicaid Client for LTC in a Swing Bed?

- Assessments are the main tool used to determine eligibility for a Medicaid client for long term care benefits.
- Assessments focus on the client's ability to perform Activities of Daily Living (ADL) rather than on specific medical conditions.

How Long Can a Medicaid Client Stay in a Swing Bed for LTC?

- A Medicaid client can stay in a long term care swing bed as long as the financial and functional eligibility continues.
- Home and Community Services Division of Aging and Disability Services Administration conducts reviews and reauthorizes clients receiving long term care services administered by ADSA.

What are appropriate Discharge Procedures for Medicaid LTC Clients

- The local Home and Community Service Office will help in determining the appropriate discharge time and discharge destination.

What Gets Reimbursed by Medicaid for Swing Bed LTC?

- Through Aging and Disability Services Administration the daily Swing Bed Rate covers all the necessary and ordinary costs related to a client's daily needs.
- Through Health and Recovery Services Administration, any pharmacy needs are billed through the point of sale. Any medical needs are provided only upon the occurrence of an incident such as a broken limb or need for the emergency services.

What services are reimbursed by Medicaid for swing bed-long term acute care clients?

- Medicaid reimburses for all covered and medically necessary service provided to client's as one or more of the following:
 - Swing bed long term care daily rate
 - Co-existing point of sale claim
 - Co-existing outpatient hospital claim or
 - Claim for services and supplies not included in the swing bed daily rate(See following slides for more detail on each of these bullets)

Swing bed long term care daily rate

- This rate is reimbursed by Aging and Disability Service Administration and includes all of the necessary and ordinary costs related to a client's daily needs.
- The following are **examples** of necessary and ordinary services and supplies:
 - ✓ Therapies
 - ✓ Over the counter medications
 - ✓ Basic mobility aids
- Provider number must begin with "42"
- Billing form UB-92/837i

Co-existing point of sale claim

- These claims are paid by Health and Recovery Services Administration
- Provider number must begin with “ ? “
- Type of bill is Point of Sale (POS)

Co-existing outpatient hospital claim

- These claims are paid by Health and Recovery Services Administration
- Outpatient claims are only allowed in combination with claims for swing bed daily rate payments when the service is not included in the swing bed daily rate and there is a separately identifiable medical event requiring acute care ie: emergency room visit
- Type of bill is 131
- Provider number must begin with “ 3 “
- Billing form UB-92/837i

Claim for services and supplies not included in the swing bed daily rate

- These claims are paid by Health and Recovery Services Administration
- These services and supplies are not readily available in a long term care facility, examples of such services might be:
 - ✓Eye glasses
 - ✓Hearing aides
 - ✓Dentures
- Type of bill varies, not 131
- Provider number varies, does not begin with “ 3 “ or “42”
- Billing form varies: HCFA-1500, ADA but not UB-92 or 837i

How to Bill

- For **LTC services in a swing bed** please bill the “Swing Bed Daily Rate” using the Provider Number beginning with “**42**”
- For **inpatient acute care in a swing bed** please bill using the appropriate Hospital Provider Number that begins with a “**3**”. Will not be reimbursed for same dates of services as LTC services in a swing bed.
- For **other covered acute care** provided by the hospital while the client is in LTC status in a swing bed, bill using the appropriate Hospital Provider Number that begins with a “**3**”.
- For **prescription pharmaceuticals**, bill through the “**point of sale**” system.

Valid Outpatient Claim

(Sample Claim)

Revenue Code	Description	Proc Code
0250	Pharmacy	
0270	Med Surg Supply	
0320	Radiology	72040
0320	Radiology	73030
0450	Emergency Room	99283

****UB-92/837i, Bill Type 131**

Invalid Outpatient Claim

(Sample Claim)

Revenue Code	Description	Proc Code
0420	Physical Therapy	****Add proc
0270	Occupational Therapy	****Add proc

These services are considered to be included in the swing bed long term acute care daily rate and are therefor not separately billable.

Billing Instructions

- Hospital Billing Instructions (BI) and Washington Administrative Code (WAC) updates are in process presently.
- Please provide HRSA with input in the next couple of months on what information you feel is needed to make these BI and WAC documents useful to you.
- Send input to Larry Linn at linnld@dshs.wa.gov .

What to do when a Medicaid Swing Bed Billing is Denied?

- Review Remittance Advise
- Review this presentation and/or
- Contact MACSC - Medical Assistance Customer Service Center at 1-800-562-3022

Services	Swing Bed Daily Rate (#42.) Claim type	Oupatient Hospital Claim (#3.....) Claim type 131	Point of Sale (#) Claim type ?	Med Vendor Claim (#) Claim type ?
Swingbed daily rate	Ok	No	No	No
Eye Glasses	No	No	No	Yes

Updates

- New WAC effective 8/1/07
 - 388-550-4500
- CCI
- Medicare Ready
- Modifiers
- BI s
- Fee Schedules
- Dental Policy changes
- Inpatient payment

VRI

- **Pediatrics Rate Increase** - Funding is provided 48 percent rate increase for pediatric services for fee-for-service providers, roughly equivalent to a 90 percent of the Uniform Medical Plan rate in January 2008. This increase is
- **Adult Office Visits** - Effective January 2008, funding is provided to raise Medicaid reimbursement for adult office services by 12 percent for fee-for-service providers, to improve access to a medical home.

Targeted Dental Rate Increases - Funding is provided for targeted dental rate increases in four areas in order to provide improved access:

- 1) children's orthodontics and crowns
- 2) providers who participate in the Access to Baby and Child Dentistry program
- 3) dental prosthesis for adults, and 4) reimbursement for primary care physicians to provide dental disease preventative services such as oral health screenings, risk assessment, and fluoride varnish.

Adult and Children's Endodontics - Funding is provided to expand dental services and access for adults and children, specifically in the area of endodontic, or root canal therapy. Services are restored for adults and a rate increase is provided for children's endodontics in order to obtain access to specialty dental providers.

Private Duty Nursing Increase - 10 percent rate increase for Private Duty Nursing services, which provide nursing care to approximately 200 children with disabilities through the Medically-Intensive Home Care Program and to 75 clients over age 18 who would otherwise be institutionalized in skilled nursing facilities or receive care in hospitals.