NURSING FACILITIES
Provider Guide

July 1, 2015

About this guide*

This publication takes effect July 1, 2015, and supersedes earlier guides to this program.

> 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.

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
Admission Date	Added a new section called Admission Date.	Policy change
Readmission	Revised the following language in Providing Service to read: It is the hospital discharge planner's responsibility to contact the MCO for prior authorization (PA) …any time the client leaves the facility for more than twenty-four hours and readmits.	Policy clarification
Managed Care	Renamed a section called "Providing Service" as "Managed Care."	Content clarification
Admissions	Moved content to beginning of Managed Care section and revised language about admitting managed care clients under: What should the NF do before admitting a client from a hospital? What should the NF do before admitting an MCO client from another NF?	Policy clarification
Billing	Added required fields 12 and 76 to Completing the UB-04 claim form.	Policy change
NFLOC	Revised the following language under What happens if the client's status changes from rehabilitation to long-term care services? to read: Following local protocols, request a NF level of care (NFLOC) assessment through the HCS social service intake process for a client who will be receiving long-term care. A NFLOC assessment must be in place to receive payment through fee-for-service. The payment start date for clients who meet NF level of care will be based on the date of the request for NFLOC.	Policy clarification

*This publication is a billing instruction.

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.

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Resources Available

Topic	Resource
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	
Questions about payments, denials, claims processing, or agency managed care organizations	Claims Processing Nursing Facilities Unit 1-800-562-3022 ext. 16820 Fax: 1-866-668-1214
Coordination of benefits for clients with private insurance and Medicaid as secondary insurance	Coordination of Benefits 1-800-562-3022 Fax: 360-586-3005
Electronic or paper billing	See the agency Resources Available web page.
Finding agency documents such as provider guides and fee schedules	

Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the agency's Washington Apple Health Glossary 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 people 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 people served to achieve the maximum degree of independence and dignity of which they are capable.

Intermediate/Intellectual Disabilities (ICF/ID) - An ICF/ID facility for DDA is defined as a Title XIX-certified intermediate care facility for people with intellectual disabilities. These facilities:

- Provide IMR services to eligible clients with intellectual disabilities or related conditions who require intensive habilitation training.
- Provide support services which may best be provided in a 24-hour residential care facility.
- Meet the standards and guidelines of the federal nursing facility ICF regulations 42.483 subpart.

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

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 person 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.

Rehabilitation Services - The planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person'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 people receiving adult day or night care, or respite care.

Program Overview

What is the purpose of the Nursing Facilities program?

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

When does the agency pay for services?

The agency pays nursing facilities for costs only when the client is not covered by Medicare, a managed care organization, or third party insurance. Washington Apple Health covers only those services that are ordinary, necessary, related to the care of Washington Apple Health clients, and not expressly unallowable. See RCW 74.46 and WAC 388-96-585 for examples of unallowable costs.

Client Eligibility

How can I verify a patient's eligibility?

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 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 note box below.

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 wish to apply for Washington Apple Health can do so in 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.

Who is enrolled in managed care?

Most Medicaid-eligible clients are enrolled in managed care. Managed care organizations (MCOs) are responsible for payment of medically necessary skilled nursing facility (SNF) or NF stays for rehabilitation or skilled nursing services when the MCO determines that nursing facility care is more appropriate than acute hospital care. These services require prior authorization (PA) by the MCO. NFs must check Apple Health client eligibility and work with hospital staff and MCO staff to ensure authorization for skilled rehabilitation or nursing services for clients transferring from a hospital are authorized. Once admitted to an NF, it is the responsibility of the NF to obtain additional authorization from an MCO for ongoing skilled rehabilitation or nursing services.

Note: If the client is enrolled in managed care, contact the MCO prior to admittance to determine what services have been authorized and for how long.

Who is not enrolled in managed care?

Most people receiving long-term care are Medicare-eligible and are not enrolled in managed care. Clients who meet the following criteria are not enrolled in managed care:

- Clients with Medicare
- Clients with comparable primary insurance coverage
- Clients in the Medically Needy program (MNP)

Who is eligible for NF services?

The implementation of the Affordable Care Act and the expansion of Washington Apple Health means eligibility for NF care has changed. Clients who receive coverage in the following ACES (automated client eligibility system) coverage groups are eligible for payment for NF care assuming all other billing criteria are met. Nursing facilities must always 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. If the payer is an MCO, the NF must obtain prior authorization from the MCO before admission.

Classic Apple Health programs 30 days or longer:

- Long-Term care coverage: K01, K95, L01, L02, L95

Classic Apple Health programs 29 days or less:

- Apple Health non-institutional coverage: A01, A05, D01, D02, D26, G01, G02, G03, G95, R03, S01, S02, S08, S95
- Apple Health spenddown cases – (eligible if spenddown is met) : F99, K99, G99, L99, P99, S99
- Apple Health long-term care (in home /residential) coverage: L21, L22
- Programs transitioning to MAGI-based coverage: F02, F03, F04, F05, F06, F07, F10, P02, and P04.

New MAGI-based programs, regardless of length of stay:

- Apple Health MAGI-based coverage: N01, N02, N03, N05, N10, N11, N13, N23, N31, N33

State-funded NF Program (ALTSA):

- Only with prior authorization from ALTSA program manager: L04, K03

See Appendix A for the Medical Coverage Group Desk Tool.

The NF should verify which MCO the client is enrolled in. In addition, the NF must recognize that the MCO in which the client is currently enrolled is not necessarily the payer. Identifying the payer before admitting the client helps prevent delivering a service for which the NF will not be paid.

Is a completed PASRR screen required for every client prior to admission?

42 CFR 483.100 – 483.138 and WAC 388-97-1920 and 388-97-1940

Yes. Under state and federal law, all people must be screened using the Preadmission Screening and Resident Review (PASRR) screening tool prior to admission. The screening process has two levels, PASRR Level I and PASRR Level II. The entire PASRR process must be completed prior to admission.

The agency may deny payment to the NF if the NF is unable to prove that the required PASRR process was timely completed.

Note: There are some exceptions to the PASRR requirement. These exceptions are listed on the PASRR Level I form.

When are clients not eligible for long-term care under the fee-for-service program?

Clients covered under an agency-contracted MCO or Medicare are not eligible to receive payment under the long-term care fee-for-service program until rehabilitation or skilled nursing services authorized by the MCO or Medicare has ended.

Some Washington Apple Health clients are eligible for stays of 29 days or fewer, but are not eligible for periods longer than that because they do not meet the eligibility criteria for long-term care programs.

NF services are not covered under the Alien Emergency Medical (AEM) program, unless prior approved for the state-funded NF program by the ALTSA program manager. Contact the program manager at (360) 725- 2450 for more information.

Note: An award letter is issued to all clients who are eligible to receive institutional (Classic Apple Health) Medicaid and meet NF level of care (NFLOC). An institutional benefits award letter does not guarantee payment for clients. Washington Apple Health is the payer of last resort. If there is another payer available, Apple Health will not pay.

Qualified-medical-beneficiary-only (QMB) clients

QMB-only clients 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:

- Agency QMB program approval letter
- ProviderOne for the QMB program (ACES coverage group S03)

QMB-only clients do not pay towards the cost of care, so nursing facilities must not collect participation for these clients.

Managed Care

What should the NF do before admitting an MCO client from a hospital?

Before admitting a client from a hospital, the NF must ask the hospital discharge planner which MCO (if any) authorized the hospitalization. The facility must request authorization from an MCO for any admittance. The payer that was financially responsible for the client when the client was originally admitted to the hospital remains responsible for rehabilitation or skilled nursing services. This applies to any transfer of care from an MCO to another MCO, and to transfers from an MCO to fee-for-service.

What should the NF do before admitting an MCO client from another NF?

Before admitting a client from another NF, the receiving NF must ask the discharge planner at the other NF which MCO authorized the stay in that NF. The payer who authorized the first NF stay is the payer the receiving NF must bill.

Additionally, the NF should contact the MCO for prior authorization before admitting the client.

How does the NF admit a patient who is authorized for rehabilitation or skilled nursing services by an MCO?

It is essential that the NF coordinate with both the hospital discharge planner and the MCO authorizing the rehabilitation or skilled nursing services. It is the hospital discharge planner's responsibility to contact the MCO for prior authorization for a client being admitted or any time the client leaves the facility for more than twenty-four hours and is readmitted. The NF must have an agreement with the MCO in order to receive payment. All billing for rehabilitation or skilled nursing services must be submitted to the MCO following the terms of their agreement.

The NF must confirm PA with the MCO before admitting the client for rehabilitation or skilled nursing services. The MCO must indicate on the PA the number of rehabilitation or skilled nursing days that are approved. If additional days are needed, the NF must coordinate this with the MCO. If additional days are not authorized, and the NF believes that the client continues to meet criteria, the NF may assist the client in filing an appeal with the MCO. At the time the request for additional days is denied, the NF must determine if discharge to the community is appropriate. If ongoing services are needed, either in the NF or in the community, the NF must contact Home and Community Services (HCS) for an assessment.

Note: A client's managed care plan may change at any time. However, the MCO that approved the initial hospitalization or placement remains responsible for the client's care even if the client changes to another managed care plan after admission.

The NF must request written confirmation from the MCO that services are authorized:

- Before the client is admitted to the NF.
- If the facility is requesting additional rehabilitation or skilled-nursing services.

The MCO must provide the NF with confirmation of a change in coverage when:

- The length of a previously authorized stay is being reduced.
- The client does not meet the MCO's rehabilitation or skilled-nursing criteria.

What happens if the client's status changes from rehabilitation to long-term-care services?

When an MCO client's status changes from rehabilitation to long-term-care services (sometimes called custodial care), the NF must:

- For classic Medicaid clients: FAX a Notice of Action – Adult Residential Services form, DSHS 15-031, to DSHS at 855-635-8305. The form must include the date the client's status changed.

- For MAGI-based Medicaid clients:

  1. FAX a Notice of Action – Adult Residential Services form, DSHS 15-031, to the agency at 1-866-841-2267. The form must include the date the client's status changed.

  2. Following local protocols, request a NF level of care (NFLOC) assessment through the Home and Community Services (HCS) social service intake process for a client who will be receiving long-term-care services. A NFLOC assessment must be in place to receive payment through fee-for-service. The payment start date for clients who meet NF level of care will be based on the date of the request for NFLOC.

  3. Submit to the agency a claim with the appropriate Medicaid patient class code and include the MCO's denial of authorization for rehabilitation or skilled-nursing services.

If the client needs services in the community, the NF must request a social service assessment intake from HCS and coordinate with the MCO when discharge planning begins. Social Service Intake phone numbers for HCS are listed on the back side of the *Notice of Action – Adult Residential Services* form, DSHS 15-031 under "Instructions."

The payer responsible for a continuous health event changes when the client is discharged to a home or homelike setting, or the client's status changes to long-term care (custodial care).

Example

If MCO #1 is the payer at time of admittance, and the client changes to MCO #2 during a rehabilitation or skilled-nursing stay, MCO #1 remains responsible until rehabilitative skilled days end, at which time MCO #2 assumes financial responsibility for the client's covered benefits.

Even when room and board for long-term care is a fee-for-service carve out, the MCO remains financially responsible for all the client's other covered benefits.

When must the NF notify the state of an admission or status change?

See the *Notice of Action – Adult Residential Services* form, DSHS 15-031 for instructions on how and when to notify the state of an admission, discharge, or status change. Instructions are printed on the back of the form.

For classic Medicaid clients

After a classic Medicaid client has been admitted to the NF, the NF must complete the *Notice of Action – Adult Residential Services* form, DSHS 15-031, by following the instructions on the back of the form, and fax the form to DSHS at 1-855-635-8305.

A01, A05, D01, D02, D26, G01, G02, G03, G95, G99, K01, K95, L01, L02, L21, L22, L95, L99, L04, L24, R03, S01, S02, S95, S99, S08

For MAGI-based Medicaid clients

After a MAGI-based Medicaid client has been admitted to the NF, the NF must complete a Notice of Action – Adult Residential Services form, DSHS 15-031, by following the instructions on the back of the form, and fax the form to the Health Care Authority Claims Processing—NF Unit at 1-866-841-2267.

MAGI-based ACES coverage groups are: N01, N02, N03, N05, N10, N11, N13, N23, N31, and N33

Clients must continue to meet NF level of care (NFLOC) in order to receive payment.

Note: Clients who are eligible for MAGI-based ACES coverage groups do not contribute towards the cost of care—NFs do not need to collect participation for these clients.

When will DSHS/ALTSA issue an institutional benefits award letter?

For classic Apple Health clients not enrolled in managed care, DSHS/ALTSA issues an institutional benefits award letter to clients who have been approved for long-term care services if:

- ALTSA has approved payment for a short stay (fewer than 30 days in the facility).
- ALTSA has approved an institutional program.

Note: These approval letters are required for classic Medicaid clients only —they are not required for MAGI-based clients.

For a classic Medicaid client who is not enrolled in managed care, there is no change in how to bill for a short stay or long-term care services coverage. Continue to follow existing processes for Medicare crossover claims or Medicaid fee-for-service claims on these clients.

When will DSHS not issue an institutional benefits award letter?

If the client is eligible to receive health care coverage in a MAGI program, regardless of setting, the client will **not** contribute to the cost of care and **no** institutional benefits award letter will be sent. However, for claims to pay, the NF must request a NFLOC assessment for a MAGI client when:

- It is determined the client will likely no longer meet rehab or skilled criteria, or
- The client is not enrolled in managed care.

MAGI-based clients are identified in the ProviderOne client benefit inquiry screen with the following codes: N01, N02, N03, N04, N05, N10, N11, N13, and N23.

Note: Receipt of an award letter **does not guarantee payment** of the service if the client is enrolled in managed care, or has primary coverage under Medicare or other insurance.

Billing

How does the NF complete the CMS-1500 claim form?

The agency's online Webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- DDE Professional claim
- DDE Professional with Primary Insurance
- DDE Medicare Crossover Claim

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

How should the NF bill if the client has other insurance?

Bill the other insurance before billing Medicaid—Medicaid is the payer of last resort. When billing Medicaid, state on the claim form that the NF has already billed the other insurance.

Third-party liability is discussed on the agency's Coordination of Benefits Information for Medicaid Contracted Providers web page. Navigate to that page and select "Download a file on Cost Avoidance" for more information.

How does the NF bill when a client is admitted and dies on the same day?

If a client is 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 does the NF bill for a client who is discharged in a current month?

When discharging a client from the NF, use the appropriate patient status code and enter the total number of units not including the discharge day.

Will the NF 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).

How does the NF bill for MAGI-based clients if no institutional benefits award letter is issued?

For MAGI-based clients enrolled in managed care, the NF must bill the MCO. When the client does not meet rehabilitation or skilled nursing criteria with the Apple Health managed care organization, the NF must request a NF level of care (NFLOC) assessment through the HCS intake process and bill HCA for the stay. NFLOC for MAGI clients must be verified prior to payment from Health Care Authority (HCA). The NF should bill ProviderOne with the appropriate patient class code and attach a copy of the MCO's letter stating that skilled nursing and rehabilitation have ended.

Bill FFS for all other clients through ProviderOne with the appropriate patient class code.

How does the NF bill for clients who are eligible for Medicare and Medicaid or who are QMB-only?

Bill Medicare first. If the NF bills Medicaid for a class 24, 29 or 56 before the Medicare payment, the NF will automatically receive a $0.00 reimbursement from Medicaid. If money is owed to the NF on a class 24 claim after Medicare makes payment, the NF must submit an adjustment form with the appropriate Medicare backup.

- If Medicare pays the claim, the NF must bill the agency within 6 months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, the NF must meet the agency's initial 365-day requirement for initial claim.

Note: Patient class codes 29 and 56 are not entitled to secondary Medicaid payment.

Example:

The NF bills the agency for Class Code 24 days and Medicare pays $150 per day. If the Medicaid rate is $165 per day, the NF may submit a claim adjustment for $15 per day unless another insurer is liable for the difference. The NF may not collect additional fee-for-service or Part C coinsurance costs from the client.

Note: Clients who are eligible under QMB only do not receive an institutional award letter.

For more details concerning Medicare crossover claims, see the agency's ProviderOne Billing and Resource Guide.

Medicare Advantage Plans (Part C)

The agency reimburses nursing facilities for Medicare Part C cost sharing expenses up to the maximum reimbursement limits established under WAC 182-502-0110 and WAC 182-517-0320.

In order to receive payment from the agency, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the agency. If the NF bills Medicaid for a class 29 or 24 prior to Managed Medicare payment, the NF will automatically receive a $0.00 reimbursement from Medicaid.

> **Note:** Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C). The Managed Medicare – Medicare Advantage Plan is the primary payer and should be billed first.

After the Medicare Advantage plan processes the claim, if money is owed, an adjustment form must be submitted with the appropriate Managed Medicare – Medicare Advantage (Part C) EOB to DSHS. Bill the agency on the same claim form used to bill the Medicare Advantage plan. Make sure the services and billed amounts match what the NF billed to the Medicare Advantage plan. Attach the Medicare Advantage EOB.

The agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

If Medicare denies a service that requires prior authorization (PA), the agency waives the PA requirement, but still requires some form of agency authorization based on medical necessity.

Billing for Managed Medicare – Medicare Advantage (Part C) Plans

In order to receive payment from the agency, follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the agency.

If there is a capitated copayment due on a claim:

Capitated copayments do not require the biller to submit an explanation of benefits (EOB); with the claim. Indicate "Managed Medicare capitated copayment" on billing forms as follows:

- UB-04 in box 80
- Direct data entry (DDE) submission

If there is coinsurance, a deductible, or a noncapitated copayment due on a claim:

If no balance is due for services provided, the claim will be paid at zero.

If a balance is due for services provided:

- Bill all services, paid or denied, to the agency on one claim form, and attach an EOB.
- Indicate "Managed Medicare" on billing forms as follows:
  - ✓ UB-04 in box 80; or
  - ✓ Direct data entry (DDE) submission
- The agency will compare the allowed amount for DSHS and Managed Medicare – Medicare Advantage and select the lesser of the two. Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage

Billing 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 readmission only if the client left the facility for at least a full 24-hour period. NFs are required to notify DSHS of social or therapeutic leave in excess of 18 days per year through a Notice of Action (DSHS form 15-031).

Billing for hospice clients

If the client in an NF is on hospice status, bill the hospice agency according to the instructions on the agency's Hospice Services Medicaid Provider Guide.

Changing a previously paid claim

If the NF needs 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.

Where on the UB-04 claim form do I enter patient participation?

"Patient participation" refers to 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.

Enter the client patient participation amount into boxes 39-41 using value code 31; do not enter it into box 57. These funds must be contributed toward the patient's cost of care.

The NF cannot collect participation from an agency client when billing for patient class codes 24, 29, 55, or MAGI-based clients.

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 NF.

Where on the UB-04 claim form do I enter the spenddown amount?

"Spenddown" means the process by which a person uses incurred medical expenses to offset income, resources, or both to meet the financial standards established by the agency. See WAC 182-519-0110.

Enter the client spenddown amount into boxes 39-41 using value code 66; do not enter it into box 57.

Completing the UB-04 claim form

Providers may access online webinars demonstrating how to submit institutional fee-for-service claims using direct data entry and how to upload a HIPAA batch file.

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.

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

Box	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.
10	Patient Birthdate	Enter the client's birthdate (MMDDYYYY).
11	Patient Sex	Enter the client's sex (M or F).
12	Admission Date	Enter the client's admission date (MMDDYYYY).
14	Priority (Type) of Visit	The priority (type) of admission. Enter: a. 1 for Emergency b. 2 for Urgent c. 3 for Elective 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

Box	Name	Entry
		e. 5 for Transfer from a Skilled nursing facility f. 7 for Emergency Room 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 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= patient 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 NF daily rate.
45	Service Date	Same as box 6.
46	Units of Service	Enter the number of days. Do not include the date of discharge.
47	Total Charges	Equals the amount in box 44 multiplied by the amount in box 46.
48	Non-Covered Charges	Any charges not covered by the agency.
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

Box	Name	Entry
		include participation amount here. 54A: Any prior payments from payer listed in box 50A. 54B: Any prior payments from payer listed in box 50B. 54C: Any prior payments from payer listed in box 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 boxes 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.
76*	Attending Provider	The attending provider's national provider identifier (NPI)

∗ The attending provider's NPI must be known in ProviderOne.

Patient class code

Enter Value Code 24 with the appropriate patient class code (see table below) in box 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 (Managed Care MCO)
56: QMB Cost Sharing
60: Community Home Project
62: Department Of Corrections
63: Traumatic Brain Injury
64: Bariatric

Patient status codes

Enter the appropriate patient status code from the table below in box 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

Admission date

If the client is being admitted to an NF from an inpatient setting, the NF must use the date of admission to the hospital as the admission date for its NF claim.

If the client is being admitted to an NF from a home or community setting, the NF must use the date of admission to the NF as the admission date for its NF claim.

Revenue code

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

Medical Coverage Group Desk Tool

Program Category	ACES	DESCRIPTION	Scope	NF-short stay if on Apple Health MCO (admission under 30 days)	NF short stay (admission under 30 days) if not on Apple Health MCO	Institutional (30 days or more) on Apple Health MCO	Institutional (30 days or more) not on Apple Health MCO "long term care services"
SSI and SSI Related (non-institutional) Classic SSI and SSI related also called Aged/Blind/Disabled category Disability is determined by SSA or by NGMA referral to DDDS	**S01**	SSI Recipients	CN	No AL issued for NF short stay if on AH MCO	Short stay NF AL issued if NFLOC	No FFS-NF coverage if on AH MCO skilled nursing or rehabilitation. DSHS considers a Medicaid redetermination under institutional ABD program and issues A/L once determined eligible. A/L is not guarantee of payment if AH MCO is responsible for rehabilitation or skilled nursing.	NF coverage 30 days or more. DSHS does a redetermination under institutional ABD Medicaid and issues A/L once institutional eligibility is determined. The program is changed and award letter is issued even if AH MCO has authorized and is responsible for skilled nursing or rehabilitation payment. This is the same process DSHS financial workers do for Medicare admissions and Medicare admissions once in NF 30 days or more.
	S02	ABD Categorically Needy	CN				
	S03	QMBMedicare Savings Program (MSP) Medicare premium and Medicare co-payments	MSP	Pays Medicare co-insurance days as a claim **if active QMB only.** No application required for NF if co-insurance days only and no other service is needed. No award letter issued. Medicare co-insurance days only. Medicare clients are not enrolled in WA MCO. Application required for non-Medicare co-insurance days. No AL issued. Consult Provider Billing Instructions.			
	S04	QDWI Medicare Savings Program	MSP	Has no NF coverage if stand-alone program. Individuals on other medical programs may have NF coverage as part of the scope of care.			
	S05	SLMB Medicare Savings Program. Medicare	MSP				

		Premium only					
	S06	QI-1 (ESLMB) Medicare Savings Program	MSP				
	S07	Undocumented Alien. Emergency Related Service Only	ERSO	No NF coverage Hospital, cancer or End stage renal only.			
	S95	Medically Needy no Spenddown	MN	No award letter issued for NF short stay	Short stay NF award letter issued if NFLOC	Medically Needy not enrolled in AH MCO. No FFS-NF coverage	No NF coverage 30 days or more. DSHS does a redetermination under institutional ABD Medicaid
	S99	Medically Needy with Spend down (SD)	MN		Short stay NF award letter issued if NFLOC AND meets SD	Medically Needy not enrolled in WA MCO. No FFS-NF coverage	No NF coverage 30 days or more. DSHS does a redetermination under institutional ABD Medicaid
SSI Related (non-institutional) Classic Living in an alternate living facility - AFH, AL or DDA group home.	**G03**	Non Institutional Medical in ALF CN Income under the SIL plus under state rate x 31 days + 38.84	CN		Short stay NF award letter issued if NFLOC	No FFS-NF coverage if on AH MCO rehabilitation.	No NF coverage 30 days or more. DSHS does a redetermination under institutional ABD Medicaid
	G95	Medically Needy Non Institutional in ALF no spenddown	MN			Medically Needy not enrolled in AH MCO. No FFS-NF coverage	
	G99	Medically Needy Non Institutional in ALF with Spenddown	MN		Short stay NF award letter issued if NFLOC AND meets spend down	Medically Needy not enrolled in AH MCO. No FFS-NF coverage	
SSI Related (non-institutional)	**S08**	Healthcare for Workers with Disability CN Premium based program.	CN		Short stay NF award letter issued if NFLOC	No FFS-NF coverage if on AH MCO rehabilitation.	No FFS NF coverage under this program 30

Classic HWD - Healthcare for Workers w/ Disability		Substantial Gainful Activity (SGA) not a factor in Disability determination.					days or more
HCB Waiver or Hospice Classic (SSI or SSI related institutional Waiver or Hospice)	**L21**	Categorically Needy DDA/HCS Waiver or Hospice in NF on SSI	CN			No FFS-NF coverage if on AH MCO rehabilitation. No FFS-NF coverage	No FFS NF coverage under this program 30 days or more
	L22	Categorically Needy DDA/HCS Waiver or Hospice – Gross income under the SIL for DDA Waiver/Hospice Income under MNIL + State Average NF rate for HCS Waiver	CN			No FFS-NF coverage if on AH MCO rehabilitation. No FFS-NF coverage	No FFS NF coverage under this program 30 days or more
	L24	Undocumented Alien/Non-Citizen LTC - residential placement or in home placement. Must be preapproved by ADS-HCS (Sandy Robertson) State funded CN care. (45 slots)	SFCN	NF coverage must be pre-approved by ALTSA. Program is state funded and limited. NF AL issued if client pre-approved on this program by RoberSK@dshs.wa.gov. Not enrolled into AH MCO. Program is limited to 45 slots.			
Institutional Classic SSI or SSI related Residing in a medical institution 30 days or more	**L01**	SSI recipient in a Medical Institution	CN	No award letter issued for NF short stay	Program not used for short stay, If on one of these programs, If client is on this program it means the client is in an institution 30 days or more and not eligible for MAGI	No FFS-NF coverage if on AH MCO rehabilitation. NF A/L is issued showing institutional eligibility. Does not guarantee payment if on MCO rehabilitation days	Institutional Medicaid. Must be NFLOC. Award letter issued for institutionalization 30 days or more. May have client responsibility payment toward the cost of care
	L02	SSI related CN in a Medical Institution Income under the SIL	CN				

	L04	Undocumented Alien/Non-Citizen LTC must be pre- approved by ADS-HCS program (Sandy Robertson) State funded CN scope of care (45 slots)	SFCN	NF coverage must be pre-approved by ALTSA RoberSK@dshs.wa.gov Program is state funded and limited. Same instructions as L24		NF coverage must be pre-approved by ALTSA. Program is state funded and limited. SF-not enrolled into MCO	
	L95	SSI related Medically Needy no Spenddown Income over the SIL. Income under the state rate.	MN	Medically Needy not enrolled in AH MCO		Medically Needy not enrolled in MCO. Institutional Medicaid. Must be NFLOC. Award letter issued for institutionalization 30 days or more. May have participation toward the cost of care	
	L99	SSI related Medically Needy with Spenddown Income over the SIL & the state rate, but under the private rate. Locks payment to state NF rate		Medically Needy, not enrolled in AH MCO		Medically Needy not enrolled in MCO. Institutional Medicaid. Must be NFLOC and meet SD for FFS NF payment. AL issued for institutionalization 30 days or more. Locks clients into the state rate even if spenddown not met	
INSTITUTIONAL Family/Children TANF related income/resource rules MAGI methodology eligibility done by DDA LTC specialty unit not the HBE	**K01**	Categorically Needy Family in Medical Institution	CN	No award letter issued for NF short stay if on AH MCO		AH MCO responsible for authorized skilled nursing or rehabilitation. Many K01 cases are in hospitals or child psychiatric facilities (CLIP)	Institutional Medicaid. Must be NFLOC. Award letter issued for institutionalization 30 days or more. No participation. MAGI methodology for eligibility but not considered a MAGI program
	K03	Undocumented Alien Family in Hospital Emergency Related Services Only	ERSO			No NF coverage. Hospital, cancer or end stage renal only	
	K95	Family LTC Medically Needy no Spenddown in	MN			Medically Needy not enrolled in AH MCO. Institutional Medicaid. Must be NFLOC.	

		Medical institution – up to age 21				Award letter issued for institutionalization 30 days or more. Rules based on MAGI methodology for eligibility, but not considered a MAGI program. No participation.
	K99	Family LTC Medically Needy with Spenddown In Medical institution – up to age 21	MN			Medically Needy not enrolled in WA MCO. Institutional Medicaid with spenddown. Must be NFLOC. Award letter issued for institutionalization 30 days or more. Rules based on MAGI methodology, but not considered a MAGI program.
Pregnancy and Family Planning	**P02**	Pregnant 185 FPL & Postpartum Extension	CN		NF award letter issued if NFLOC x	No NF coverage 30 days or more.
	P04	Undocumented Alien Pregnant Woman	CN			
	P05	Family Planning Service Only	FP	No NF coverage		
	P06	Take Charge family Planning only	FP	No NF coverage		
	P99	Medically Needy Pregnant Women & Postpartum Extension	MN	No award letter issued for NF short stay if on AH MCO	NF award letter issued if NFLOC	Medically Needy not enrolled in managed care. Institutional Medicaid. Must be NFLOC. Award letter issued for institutionalization 30 days or more. May have participation toward the cost of care
Refugee	**R01**	Refugee cash and Medical (ENDS 09/30/13)	CN			No FFS NF coverage 30 days or more. DSHS will do a redetermination for consideration of another medical program
	R02	Transitional 4 Month Extension	CN			
	R03	Refugee Categorically Needy	CN			
DCFS/JRA Medical Foster Care **Classic**	**D01**	SSI Recipient FC/AS/JRA Categorically Needy	CN			
	D02	FC/AS/JRA Categorically Needy	CN			
	D26	Title IV-E federal foster care – under 26	CN			

Family/children Related. TANF rules. Most programs will be converted over to MAGI based medical programs starting 11/22/2013.	**F01**	TANF cash and Medicaid (ENDS 09/30/13)	CN			
	F02	Transitional Medicaid	CN			
	F04	TANF Related	CN			
	F05	Newborn	CN			
	F06	Categorically Needy Medical Children (Effective 1/1/09, this may be CN Medicaid children or CN State funded children)	CN			
	F07	Children's Health Insurance Program – Title 21	CN			
	F09	Undocumented Alien-Emergency Related Service Only **NO NF coverage**	ERSO		NO NF coverage for this program	
	F10	Interim Categorically Needy (2 months max only)	CN		NF award letter issued if NFLOC	No NF coverage institutional 30 days or more. DSHS will re-determine eligibility considering an institutional program
	F99	Medically Needy no Spenddown	MN	Medically Needy, not enrolled in AH MCO	NF award letter issued if NFLOC And SD met	

	ACES	Program Description	SCOPE	MAGI are enrolled into AH MCO. AH MCO is responsible for skilled nursing and rehabilitation days. No award letter issued on these clients
MAGI – Done by the Health Benefit Exchange. Not DSHS	**N01**	MAGI Parent/Caretaker Medicaid; adult	CN	Medical coverage is done by the Health Benefit Exchange. No DSHS financial worker is assigned to these cases. Active cases are managed by Health Care Authority (HCA). AH MCO authorized skilled nursing and rehabilitation paid through AH MCO plan. NF FFS pays as a claim – no NF A/L needed to pay a claim once AH MCO authorized days have ended. N track will cover NF even if in long term care services over 30 days. DSHS 15-031 notices are FAXED to the HCA NF claims processing unit on all MAGI cases to report status changes. NF should request a social service intake from HCS if services in the community are needed at NF discharge.
	N02	12 month Transitional MAGI Parent/Caretaker Medicaid; adult	CN	
	N03	MAGI Pregnancy	CN	
	N05	MAGI adult Medicaid; income =<133% (Medicaid Expansion)	ABP	
	N10	MAGI Newborn Medical birth to one year	CN	
	N11	MAGI Children's Medicaid/age under 19,	CN	
	N13	MAGI Children's Health Insurance Program (CHIP) Children under 19; premium payment program	CN	
	N21	MAGI Parents/Caretaker; Emergency only; AEM	ERSO	**No NF coverage** Hospital, cancer or end stage renal only
	N23	MAGI Pregnancy; not lawfully present	CN	Medical coverage is done by the Health Benefit Exchange. No DSHS financial worker is assigned to these cases. Active cases are managed by Health Care Authority (HCA). AH MCO authorized skilled nursing and rehabilitation paid through AH MCO plan. NF FFS pays as a claim – no NF A/L needed to pay a claim once AH MCO authorized days have ended. N track will cover NF even if in long term care services over 30 days. DSHS 15-031 notices are FAXED to the HCA NF claims processing unit on all MAGI cases to report status changes. NF should request a social service intake from HCS if services in the community are needed at NF discharge.
	N25	MAGI adult Medicaid; non-citizen- income =<133% (Medicaid Expansion) AEM	ERSO	**No NF coverage** Hospital, cancer or end stage renal only
	N31	MAGI Children's medical; under 19; non-citizen	SFCN	Medical coverage is done by the Health Benefit Exchange. No DSHS financial worker is assigned to these cases. Active cases are managed by Health Care Authority (HCA). AH MCO authorized skilled nursing and rehabilitation paid through AH MCO plan. NF FFS pays as a claim – no NF A/L needed to pay a claim once AH MCO authorized days have ended. N track will cover NF even if in long term care services over 30 days.
	N33	MAGI Children's Health Insurance Program (CHIP): under 19; premium payment program, non-citizen	SFCN	

				DSHS 15-031 notices are FAXED to the HCA NF claims processing unit on all MAGI cases to report status changes. NF should request a social service intake from HCS if services in the community are needed at NF discharge.			
Category	**ACES**	**Program Description**	**Scope**	**NF-short stay if on WA MCO (admission under 30 days)**	**NF short stay (admission under 30 days) if not on WA MCO**	**Institutional (30 days or more) on WA MCO rehabilitation**	**Institutional (30 days or more) not on WA MCO "long term care services"**
Medical Care Services (MCS) and ABD Cash with CN Medical **Note**: ABD cash and medical delinked 12/31/13 for all clients under age 65 MCS not enrolled in AH MCO	**G01 (A01/ A05)**	G01 is used for cash or MCS or both until 1/1/2014. Effective 1/1/2014, G01 will be used for MCS only. This program will convert to A01/A05 9/2014. Award letter issued if NFLOC	SFR	State funded medical. Not enrolled in WA MCO. NF award letter issued by DSHS if NFLOC. Only considered for people not eligible for a federally funded Medicaid program. Program is limited to legally admitted non-citizens in their 5 year bar for Medicaid or people with Primary residence under color of law (PROCUL) status			
	G02	G02 ABD cash and medical for clients age 65 or older. This medical program will be converted to S02 effective 9/2014. G02 will end 9/2014	CN	No award letter issued for NF short stay if on AH MCO unless DSHS is notified by the DSHS	NF award letter issued if NFLOC and AH MCO authorized skilled nursing or rehabilitation days have ended.		

				15-31 that AH MCO authorized skilled nursing or rehabilitation days has ended.			
	G02	**G02 ABD cash** (If case is coded RC – recipient of cash only, no medical is attached) Clients will be converted to other existing medical coverage groups and N05.	n/a	Note: You will still see the G02 coverage group showing for ABD cash recipients only. Not eligible for any service unless another medical coverage group is active. They are only receiving ABD cash and no medical under this AU. **No NF coverage for cash only program**			
Breast and Cervical Cancer program	**S30**	Breast and Cervical Cancer (Health Department approval)	CN	No award letter issued for NF short stay if on AH MCO	NF award letter issued if NFLOC and not on WA MCO. Short stay only		No NF coverage
Take Charge	**P06**	Family Planning (Take Charge)	FP	No NF coverage			

Abbreviation	Definition
AH MCO	Washington Apple Health Managed Care. (Formally called Healthy Options) Managed Care Program under Washington Apple Health (WAH) for people not on Medicare, Tribal exclusion or credible coverage insurance. All people on WAH are enrolled into Washington Apple Health Managed Care
AL	Award Letter
ABP	Alternative Benefit Plan
CN	Categorically Needy
ERSO	Emergency Related Services Only (AEM)
FFS	Fee- for- service. Client is on FFS Washington Apple Health rather than on WA MCO coverage
FFS-NF	Fee- for- service nursing facility coverage. People not on WA MCO or under approved rehabilitation or skilled nursing status
FP	Family planning service
HO	Managed Care program under WAH for people not on Medicare, Tribal exclusion or credible coverage insurance. All people on WAH are enrolled into HO unless they meet an exclusion
MAGI	Modified Adjusted Gross Income
MCS	Medical Care Services (state funded medical)
MN	Medically Needy
MSP	Medicare Savings Program
NF	Nursing Facility
SD	Spenddown
SF	State-funded

SFCN	State-funded with state funded CN scope of care
SFR	State-funded residential – HCS program for clients on the G01 program needing residential placement
WAH	Washington Apple Health. This term is used for all medical coverage including MAGI, Classic Medicaid, MCS, Institutional and HCB Waiver medical.

MAGI-based medical programs are under the N track. N track with the exception of N21 and N25 cover NF. All N track programs are done by the Health Benefit Exchange. These medical programs are NOT maintained by DSHS. Most MAGI-based clients are enrolled into an AH MCO plan the first of the month following the Medicaid opening. The AH MCO is responsible for pre-approved NF rehabilitation and skilled nursing services. NF fee- for- service is billed when WA MCO skilled nursing or rehabilitation days have ended.

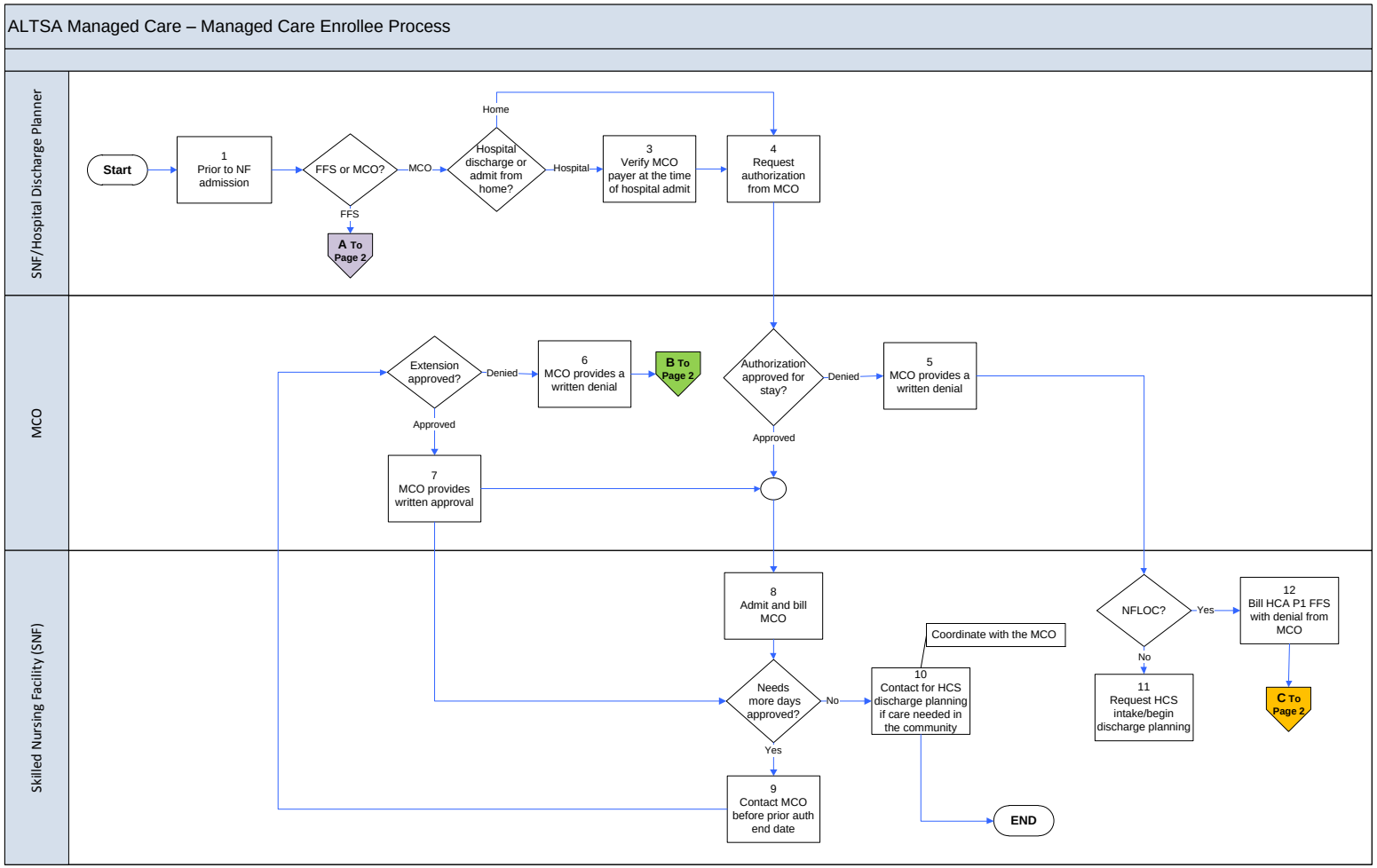
- Classic Medicaid programs are for the Aged, Blind and Disabled. Institutional Medicaid programs are considered a Classic Medicaid program. Foster care medical is also considered Classic Medicaid

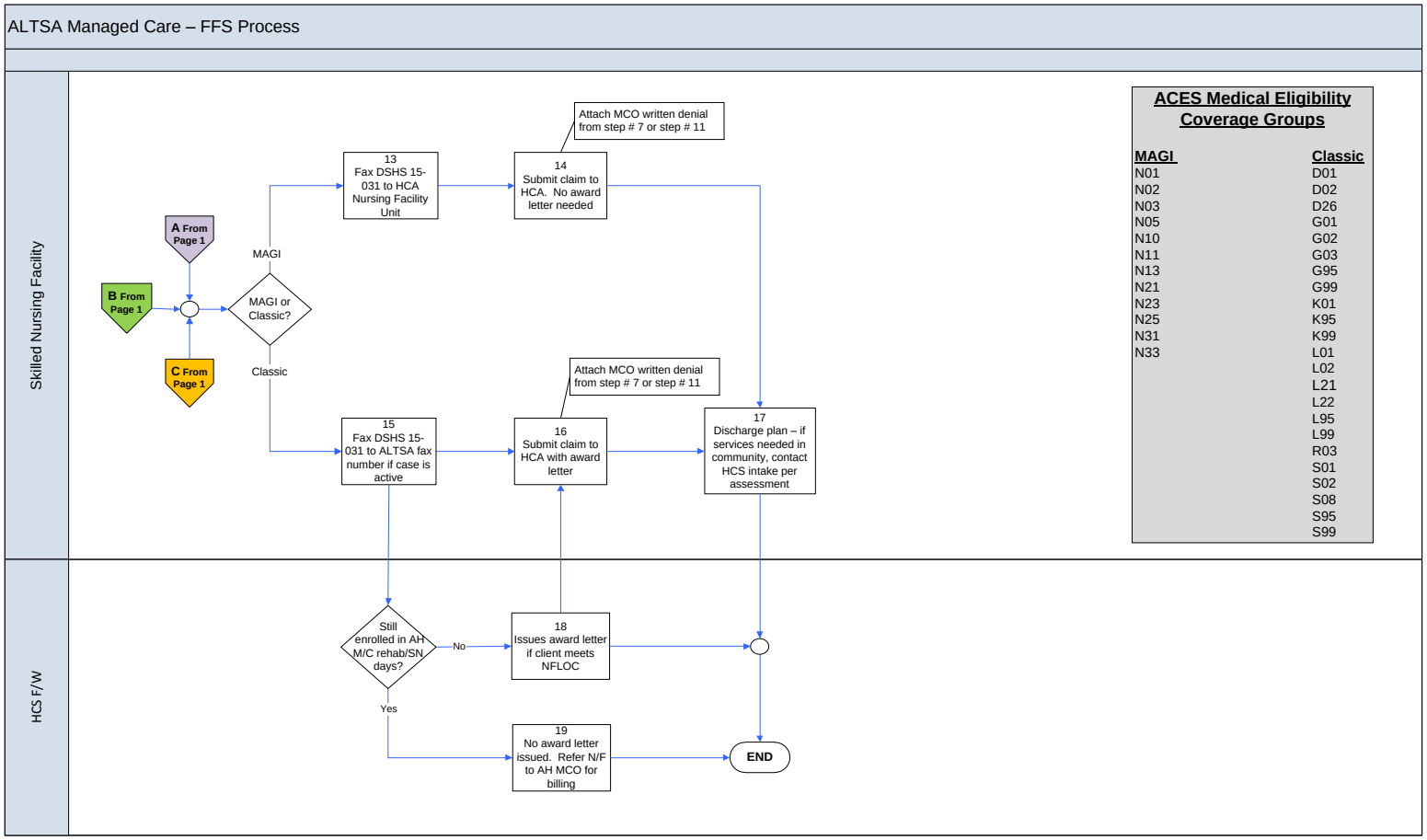
- Institutional Medicaid programs are under the L track and K track. The L track programs include those that are residing in a medical institution 30 days or more, Home and Community Based Waiver programs and Hospice. (Definition of institutional 182-513-1320). All institutional Medicaid programs have 2 parts to eligibility, initial and post eligibility treatment of income (PETI). The PETI calculation determines how much clients may need to pay toward their cost of care. All clients on an institutional program are subject to participation depending on their income and deductions.

- For NON- MAGI-based clients that are on a non-institutional Classic Medicaid program, there is a requirement to do a redetermination under institutional Medicaid rules once a client is considered “institutionalized” or residing in an institution 30 days or more. When this redetermination is completed, the system will issue a new award letter showing the maximum participation a client must pay. This award letter DOES NOT MEAN a client enrolled under Washington Apple Health Managed Care is under FFS NF. It means the client has been determined eligible for an institutional Medicaid program. For ALL Medicaid programs, if there is a primary coverage such as Medicare, insurance, LTC insurance or WA MCO coverage that is responsible for payment first because the client is in rehabilitation status, that entity is responsible for payment, not FFS-NF. Medicaid FFS is the payer of last resort.

Description of MAGI groups paid as a NF fee for service claim after WA MCO Rehabilitation days has ended	Scope	RAC	ACES
MAGI parent/caretaker Medicaid; adult	CN	1197	N01
12 month transitional MAGI parent/caretaker adult	CN	1198	N02
MAGI Pregnancy	CN	1199 and 1200	N03
MAGI adult Medicaid; income =<133% (Medicaid Expansion)	ABP	1201	N05
MAGI Newborn Medical birth to one year	CN	1202	N10
MAGI Children's Medicaid/age under 19,	CN	1203, 1204 and 1205	N11
MAGI Children's Health Insurance Program (CHIP) Children under 19; premium payment program	CN	1206 and 1207	N13
Non-citizen pregnant Covered under CHIPRA	CN	1209	N23

Managed care billing flow chart




ALTSA Managed Care – FFS Process
Skilled Nursing Facility
HCS F/W
A From Page 1
B From Page 1
C From Page 1
MAGI or Classic?
MAGI
Classic
13 Fax DSHS 15-031 to HCA Nursing Facility Unit
14 Submit claim to HCA. No award letter needed
Attach MCO written denial from step # 7 or step # 11
15 Fax DSHS 15-031 to ALTSA fax number if case is active
16 Submit claim to HCA with award letter
Attach MCO written denial from step # 7 or step # 11
17 Discharge plan – if services needed in community, contact HCS intake per assessment
Still enrolled in AH M/C rehab/SN days?
No
Yes
18 Issues award letter if client meets NFLOC
19 No award letter issued. Refer N/F to AH MCO for billing
END
ACES Medical Eligibility Coverage Groups
MAGI
N01
N02
N03
N05
N10
N11
N13
N21
N23
N25
N31
N33
Classic
D01
D02
D26
G01
G02
G03
G95
G99
K01
K95
K99
L01
L02
L21
L22
L95
L99
R03
S01
S02
S08
S95
S99