

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services that require 24-hour institutional care to meet the workers needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the workers accepted industrial injury or illness.

Prior authorization is required by an L&I ONC or the self-insured employer.

Services must be:

- Proper and necessary and
- Required due to an industrial injury or occupational disease and
- Requested by the attending physician and
- Authorized by an L&I ONC or self-insured employer before care begins.

Facilities

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for 24-hour institutional care including:

- Skilled Nursing Facilities (SNF)
- Nursing Homes (NH)
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital
- Critical Access Hospitals (CAHs) licensed by DOH using swing beds to provide long term care
- Adult Family Homes/Boarding Homes including
 - Assisted Living Facilities
 - Adult Residential Care
 - Enhanced Adult Residential Care
- Hospice care providers

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

NONCOVERED SERVICES

Services in adult day care centers are **not covered** by L&I or by self insurers.

AUTHORIZATION REQUIREMENTS

Initial Admission

Residential care services require **prior authorization**. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator. Call the Provider Hotline at 1-800-848-0811 for authorization.

For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing Facilities. Nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker within 10 working days of admission. The form is available from CMS at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

L&I has a form available that can be substituted for the MDS form. The Resource Utilization Group (RUG) Residential Care Services for injured workers form F245-052-000 is available at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1623>

Adult Family Homes, Boarding Homes and Assisted Living Facilities.

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN) within 10 days of admission. The tool will determine the appropriate L&I payment grouping. Failure to complete the assessment tool may result in delayed or reduced payment. An assessment must be completed at least once per year after the initial assessment.

The tool is available at

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345>

Critical Access Hospitals using swing beds to provide long term care.

Critical Access Hospitals must

- Obtain a long term care provider number from L&I before care can be authorized. Call the L&I provider hotline at 1-800-848-0811 for more information.
- Utilize L&I form F245-052-000 Resource Utilization Group (RUG) Residential Care Services for Injured Workers available at

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1623>

When Care Needs Change

State Fund

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for re-authorization of the workers care.

Self-Insured

Find contact information for self-insured claims at

<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ImportEmpLists/Default.asp>

BILLING INFORMATION

Billing Requirements

Providers beginning treatment on an L&I claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section.

The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125, Billing procedures.

All Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627>

Pharmaceuticals and Durable Medical Equipment

State Fund

Residential facilities cannot bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed separately.



Inappropriate use of CPT[®] and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

L&I REVIEW OF RESIDENTIAL SERVICES

State Fund

L&I, its designee or the self-insured employer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but are not limited to, on-site review of the worker and review of medical records.

All services rendered to workers are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

FEES

Negotiated payment arrangements; Insurers with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By report

NOTE: Insurers with existing negotiated arrangements made prior to January 1, 2005 may continue their current arrangements and continue to use code 8902H until the worker's need for services no longer exists or the worker is transferred to a new facility.

Hospice Care

Hospice claims are paid on a By report basis. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following HCPCS codes:

Code	Abbreviated Description	Maximum Fee
Q5003	Hospice Care Prov in Nrsng Lng-Trm Care Facility	By report
Q5004	Hospice Care Prov in Skill Nursing Facility	By report
Q5005	Hospice Care Prov in Inpatient Hospital	By report
Q5006	Hospice Care Prov in Inpatient Hospice Facility	By report
Q5007	Hospice Care Prov in Lng Trm Care Facility	By report
Q5008	Hospice Care Prov in Inpatient Psychiatric Facility	By report
Q5009	Hospice Care Prov in Place NOS	By report

Boarding Homes and Adult Family Homes

For dates of service January 1, 2009 or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The payment rates below are daily payment rates.

Code	Description	Assessment Score	Maximum Fee
8893H	L&I RF Low	0 - 20	\$164.90
8894H	L&I RF Medium	21 - 36	\$200.23
8895H	L&I RF High	37 - 57	\$235.57

These three levels of care will be applied to all non nursing home facility types. Do not bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

Adult Family Homes with dates of service before January 1, 2009:

Continue to use the following billing code.

Code	Description	Maximum Fee
8891H	L&I Adult & Family Home	\$235.57

Adult Family Homes with continuing residents that predate the January 1, 2009 establishment of the new residential services fee schedule will continue to use billing code 8891H through June 30, 2010.

Nursing Home, Transitional Care Unit and Critical Access Hospital Swing Bed Fees - State Fund

The insurer uses a modified version of the skilled nursing facility prospective payment system for developing the residential facility payment system.

The fee schedule for Nursing Home beds, Transitional Care Unit beds and Critical Access Hospital Swing Beds is a series of daily facility payment rates including room rates, therapies and nursing components depending on the needs of the worker. Medications are not included in the L&I rate.

Fee Schedule – NH, TCU and CAH Swing Beds Effective **July 1, 2009**

Code	Description	Included Medicare RUG Groups	Maximum Fee
		REHAB GROUPS	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	\$650.86
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	\$487.96
8882H	Rehab-High	RMX, RHX, RHL, RHC, RHB, RHA	\$460.15
8883H	Rehab-Medium	RML, RMC, RMB, RMA	\$423.91
8884H	Rehab-Low	RLX, RLB, RLA	\$330.89
		NURSING SERVICES GROUPS	
8885H	Extensive Services	SE3, SE2, SE1	\$412.20
8886H	Special Care	SSC, SSB, SSA	\$307.04
8887H	Clinically Complex	CC2, CC1, CB2, CB1, CA2, CA1	\$305.37
8888H	Impaired Cognition	IB2, IB1, IA2, IA1	\$225.26
8889H	Behavior Only	BB2, BB1, BA2, BA1	\$223.59
		REDUCED PHYSICAL FUNCTION GROUPS	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	\$235.57