

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  
**Mental Health Division**  
**Olympia, Washington**

**To:** All Providers  
MHD Designees

**Memorandum No: 01-08**  
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**From:** Richard Kellogg, Director  
Mental Health Division (MHD)

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**Subject:** Medicare or commercial insurance coverage and the 30 day limit on retroactive certification/authorization.

**The purpose of this memorandum is to clarify that hospitals will be allowed to request retrospective certification/authorization of an inpatient stay beyond 30 days after discharge—if the delay in seeking certification/authorization resulted from attempts to pursue Medicare or other third party coverage.**

**Why is this clarification necessary?**

Currently, the *Community Psychiatric Inpatient Instructions and Requirements* state on page 11 in the last paragraph:

Retrospective authorization may *only* occur if the consumer becomes eligible for medical assistance after admission or in the rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission.

Furthermore on page 12 in the last item they note:

- ✓ For retrospective certification requests *after the discharge*, the hospital must submit a request for authorization as well as provide all the required clinical information to the MHD designee within 30 days of discharge. The MHD designee must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

In the section regarding Commercial (Private) Insurance on page 13, however, the current instructions and requirements state:

The MHD designee may provide authorization retrospectively in cases where a delay has occurred in the commercial insurer's notification to the hospital that the benefit is exhausted.

**Analysis:**

A strict 30 day time limit for hospitals to request a retroactive authorization for admission does not allow time for completion of Medicare and other third party transactions for MHD designee service enrollees. Routine billing cycles typically take 60 to 90 days. Non-routine billing adjustments related to all third party payer transactions may also impact the Medicaid portion of the bill months after a MHD designee's service enrollee is discharged.

Medicare or commercial insurance inpatient psychiatric benefits, present at admission, may not actually be available or exhaust prior to discharge. Hospitals may not know this until they submit a bill and receive a denial from Medicare or the insurance company.

**MHD Clarification:**

As noted in the billing instructions: "The MHD designee may provide authorization retrospectively in cases where a delay has occurred in the commercial insurer's notification to the hospital that the benefit is exhausted." The process and outcome of third party coordination of benefits (COB) for Medicaid eligible and/or commercially insured consumers is frequently beyond the control of hospitals. Therefore, with regard to dual eligible or Third Party Liability (TPL) impacted eligible consumers, hospitals will be allowed to seek retrospective certification of an inpatient stay beyond 30 days after discharge if the delay in seeking authorization resulted from attempts to pursue Medicare or other third party coverage. Prior Authorization must be sought whenever possible. Hospitals continue to risk denial of authorization if medical necessity isn't present.