Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Acute Physical Medicine & Rehabilitation (Acute PM&R)

Billing Instructions for Inpatient Hospitals

(Chapter 388-550 WAC)

About this publication

This publication supersedes all previous MAA Acute Physical Medicine & Rehabilitation (Acute PM&R) Billing Instructions for Inpatient Hospitals.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
(866) 545-0544

Who do I contact about payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9246
Olympia, WA 98507-9246

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at: http://maa.dshs.wa.gov, Click on Provider Publications/Fee Schedules link.

Who do I contact regarding…

Prior authorization and information updates?

Division of Medical Management
(360) 586-1471

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing?

http://maa.dshs.wa.gov/ecs/

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Definitions

This section defines terms and acronyms used in these billing instructions.

Accredit (or Accreditation) - A term used by a nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care. [WAC 388-550-2511]

Acute - An intense medical episode, not longer than three months. [WAC 388-550-2511]

Acute PM&R - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. [WAC 388-550-2511]

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

Administrative Day Rate - The statewide Medicaid average daily nursing facility rate as determined by the department. [WAC 388-550-2511]

Authorization - MAA 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 MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied. [WAC 388-550-1050]

CARF - The official name for "The Rehabilitation Accreditation Commission" of Tucson, Arizona. CARF is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and accreditations of rehabilitation facilities. [WAC 388-550-2511]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Family - Individuals who are important to and designated by the client and need not be related.

Interdisciplinary Team - A team that coordinates individualized Acute PM&R services at an MAA approved inpatient rehabilitation facility to achieve the following for the client:

- Improved health and welfare; and
- Maximum physical, social, psychological, and vocational potential.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program or medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification Card(s) – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Noncovered Service or Charge - A service or charge that is not covered by the Medical Assistance Administration, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure. [WAC 388-550-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Ratio of Costs-to-Charges (RCC) - The methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services. [WAC 388-550-1050]

Rehabilitation Accreditation Commission, The - See "CARF."

Remittance and Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Review – See Survey.

Revised Code of Washington (RCW) – Washington state law.

Short-term - Two months or less.

Survey – An inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with Acute PM&R program requirements. [WAC 388-550-2511]

Third-Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual & Customary Fee - The fee that the provider typically charges the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is Acute Physical Medicine & Rehabilitation (Acute PM&R)? [Refer to WAC 388-550-2501]

Acute Physical Medicine and Rehabilitation (Acute PM&R) is a 24-hour inpatient comprehensive program of integrated acute medical and rehabilitative services provided during the acute phase of a client's rehabilitation. The Medical Assistance Administration (MAA) requires prior authorization for Acute PM&R services. (See Section D: "*What are the requirements for prior authorization?"*)

An interdisciplinary team coordinates individualized Acute PM&R services at an MAA-approved rehabilitation facility to achieve the following for a client:

- Improved health and welfare; and
- Maximum physical, social, psychological, and educational or vocational potential.

MAA determines and authorizes a length-of-stay based on:

- The client's Acute PM&R needs; and
- Community standards of care for Acute PM&R services.

When MAA's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client achieve maximum potential through other MAA programs such as:

- Home health services;
- Nursing facilities;
- Outpatient physical, occupational, and speech therapies; or
- Neurodevelopmental centers.

MAA's Acute PM&R program is regulated by:

- RCW 74.09.520, Medical Assistance—Care and services included—Funding limitations;
- WAC 388-550-2501, 2511, 2521, 2531, 2541, 2551, 2561, 3381, and 3401 Acute PM&R; and
- MAA's Core Provider Agreement.

How does a client qualify for Acute PM&R services?

[Refer to WAC 388-550-2551]

To qualify for Acute PM&R services, a client must have:

- Extensive or complex:

  - ✓ Medical needs;
  - ✓ Nursing needs; and
  - ✓ Therapy needs.

AND

- A recent or new onset of a condition that causes an impairment in two or more of the following areas:

  - ✓ Mobility and strength;
  - ✓ Self-care/ADLs (Activities of Daily Living);
  - ✓ Communication; or
  - ✓ Cognitive/perceptual functioning.

AND

- A new or recent onset of one of the following conditions:

  - ✓ Brain injury caused by trauma or disease;
  - ✓ Spinal cord injury resulting in:
    - ➢ Quadriplegia; or
    - ➢ Paraplegia;
  - ✓ Extensive burns;
  - ✓ Bilateral limb loss;
  - ✓ Stroke or aneurysm with resulting hemiplegia or severe cognitive deficits, including speech and swallowing deficits;
  - ✓ Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits; or
  - ✓ Severe pressure ulcers after skin flap surgery for a client who:
    - ➢ Requires close observation by a surgeon; and
    - ➢ Is ready to mobilize or be upright in a chair.

Provider Requirements

How does a hospital become an MAA-approved Acute PM&R provider? [Refer to WAC 388-550-2531]

MAA accepts applications from in-state and border hospitals only. To apply to become an MAA-approved Acute PM&R facility, MAA requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Division of Medical Management
Medical Assistance Administration
PO Box 45506
Olympia, WA 98504-5506

A hospital that applies to become an MAA-approved Acute PM&R facility must provide MAA with documentation that confirms the facility meets all of the following:

- A Medicare-certified hospital;
- Accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- Licensed by the Department of Health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010);
- CARF accredited as a comprehensive integrated inpatient rehabilitation program or as a pediatric family-centered rehabilitation program, unless the facility has obtained a 12-month conditional approval from MAA (see "Conditional Approval when waiting for CARF Accreditation" on page B.2);
- Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirements by MAA; and
- **Operating per the standards set by DOH** [excluding the Certified Rehabilitation Registered Nurse (CRRN) requirement] in either:

  - ✓ WAC 246-976-830, Level I Trauma Rehabilitation Designation; or
  - ✓ WAC 246-976-840, Level II Trauma Rehabilitation Designation.

☞ **Note:** Acute PM&R is NOT related to, nor does it qualify any facility for, the Department of Health's (DOH) Acute Trauma Rehabilitation Designation program.

Conditional Approval when waiting for CARF Accreditation

A hospital not yet accredited by CARF (the Rehabilitation Accreditation Commission):

- May apply for or be awarded a 12-month conditional written approval by MAA if the facility:

  ✓ Provides MAA with documentation that shows it has started the process of obtaining full CARF accreditation; and
  ✓ Is actively operating under CARF standards.

- Is required to obtain full CARF accreditation within 12 months of MAA's conditional approval date. If this requirement is not met, MAA sends a letter of notification to revoke the conditional written approval.

☞ **Note:** If a hospital is working with a CARF consultant, a letter of active intent showing time lines of facility operation under CARF standards must be submitted to MAA at the time of application. Full CARF accreditation must be:

- Obtained within 12 months of MAA's conditional approval; and
- Kept current.

Final Qualification Criteria

A hospital qualifies as an MAA-approved Acute PM&R facility when:

- The facility meets all the applicable requirements in this section;
- MAA's clinical staff has conducted a facility site visit; and
- MAA provides written notification that the facility qualifies to be reimbursed for providing Acute PM&R services to eligible medical assistance clients.

☞ **Note:** MAA-approved Acute PM&R facilities must meet the general requirements in Chapter 388-502 WAC, Administration of Medical Programs-Providers.

Notifying Clients of Their Right to Make Their Own Health Care Decisions (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:

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

Quality of Care [WAC 388-550-2541]

- To ensure quality of care, MAA may conduct reviews (e.g., post-pay or on-site) of any MAA-approved Acute PM&R facility.

- A provider of Acute PM&R services must act on any report of substandard care or violation of the facility's medical staff bylaws and CARF standards. The provider must have and follow written procedures that:

  ✓ Provide a resolution to either a complaint or grievance or both; and
  ✓ Comply with applicable CARF standards for adults or pediatrics as appropriate.

- A complaint or grievance regarding substandard conditions or care may be investigated by and one or more of the following:

  - The Department of Health (DOH);
  - The Joint Commission on Accreditation of Hospital Organizations (JCAHO);
  - CARF;
  - MAA; or
  - Other agencies with review authority for MAA programs.

[Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

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Client Eligibility

Who is eligible? [Refer to WAC 388-550-2521 (1)]

Clients presenting a current Medical Identification (ID) card with the following program identifiers **are eligible** for Acute PM&R services:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
CNP **Emergency Medical Only**	Categorically Needy Program - Emergency Medical Only
General Assistance **No Out-of-State Care**	ADATSA, ADATSA Medical Only
GA-U No Out-of-State Care	General Assistance-Unemployable Any Acute PM&R services performed out-of-state, except for border areas, are not covered.
LCP-MNP	Limited Casualty Program-Medically Needy Program
LCP-MNP **Emergency Medical Only**	Limited Casualty Program-Medically Needy Program – Emergency Medical Only
***MIP-EMER Hospital Only** **No Out-of-State Care**	Medically Indigent Program

***Emergency hospital-based and emergency transportation services.** These clients may receive Acute PM&R services only when:

- ✓ The client is transferred directly from an acute hospital stay and MAA has approved Acute PM&R services;
- ✓ The client's Acute PM&R needs are directly related to the emergency medical condition that qualifies the client for MIP.

Are clients enrolled in managed care eligible?

[Refer to WAC 388-550-2521 (2)]

Acute PM&R services are covered under the MAA managed care program (Healthy Options). Clients enrolled in a managed care plan will have an HMO indicator in the HMO column on their Medical ID card. If a client is enrolled in an MAA Healthy Options managed care plan at the time of acute care admission, that plan pays for and coordinates Acute PM&R services as appropriate. The plan's 1-800 telephone number is located on the client's Medical ID card. MAA does not process or reimburse claims for clients enrolled in managed care (Healthy Options) for services provided under the Healthy Options contract.

To prevent claim denials, please check the client's Medical ID card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the plan. Be sure you are contracted with the client's managed care plan.

Are clients enrolled in Primary Care Case Management (PCCM) eligible?

Yes! For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID card for the PCCM. (See the *Billing* section for further information.)

Note: To prevent billing denials, please check the client's Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

Prior Authorization

Is prior authorization required for Acute PM&R services?
[WAC 388-550-2501]

YES!

What are the requirements for prior authorization?
[Refer to WAC 388-550-2561]

The acute PM&R provider must obtain prior authorization:

- Before admitting a client to the rehabilitation unit; and
- For an extension of stay, before the client's current authorized period of stay expires.

Initial Prior Authorization

For an initial admit:

- A client must:
  - ✓ Be eligible for Acute PM&R services (see *Client Eligibility* section);
  - ✓ Require Acute PM&R services (see "How does a client qualify for Acute PM&R services?" on page A.2);
  - ✓ Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program; and
  - ✓ Be willing and capable to participate at least three (3) hours per day, seven (7) days per week, in acute PM&R activities.

- The Acute PM&R provider must:
  - ✓ Submit a request for prior authorization to MAA (see the *Important Contacts* section); and
  - ✓ Include sufficient medical information to justify that:
    - ➢ Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care and/or independence;
    - ➢ The client's medical condition requires that intensive 24-hour inpatient comprehensive Acute PM&R services be provided in an MAA-approved Acute PM&R facility; and
    - ➢ The client suffers from severe disabilities including, but not limited to, neurological and/or cognitive deficits.

Extension of Prior Authorization

For an extension of stay:

- A client must:

  ✓ Be eligible for Acute PM&R services (see *Client Eligibility* section);
  ✓ Require Acute PM&R services;
  ✓ Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program;
  ✓ Be willing and capable to participate at least three (3) hours per day, seven (7) days per week, in Acute PM&R activities; and
  ✓ Have observable and significant improvement.

- The Acute PM&R provider must:

  ✓ Submit a request for the extension of stay to MAA (see the *Important Contacts* section); and

  ✓ Include sufficient medical information to justify the extension and include documentation that the client's condition has observably and significantly improved.

If MAA denies the request for extension of stay, the client must be transferred to an appropriate lower level of care (see "*What is Acute Physical Medicine & Rehabilitation (Acute PM&R)?"* on page A.1).

☞ **Note:** To request authorization (either initial or an extension), fax your completed Acute Medicine and Rehab Admit/Extension form to MAA (see the Appendix for a blank form).

What happens after prior authorization is requested?

A facility intending to transfer a client to an MAA-approved acute PM&R facility, and/or an acute PM&R facility requesting an extension of stay for a client must:

- Discuss MAA's authorization decision with the client and/or the client's legal representative; and
- Document in the client's medical record that MAA's decision was discussed with the client and/or the client's legal representative.

When does MAA authorize administrative day(s)?

MAA may authorize administrative day(s) for a client who:

- Does not meet the "extension" authorization requirements described in this section;
- Stays in the facility longer than the "community standard length-of-stay"; or
- Is waiting for a discharge destination or a discharge plan.

When does MAA <u>not</u> authorize Acute PM&R services?

MAA does not authorize acute PM&R services for a client who:

- Is deconditioned by a medical illness or by surgery; or
- Has loss of function primarily as a result of a psychiatric condition(s); or
- Has had a recent surgery and has no complicating neurological deficits.

  Examples of surgeries that do not qualify a client for Acute PM&R services without extenuating circumstances are:

  ✓ Single amputation;
  ✓ Single extremity surgery; and
  ✓ Spine surgery.

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Reimbursement

What is included in Acute PM&R room and board?
(WAC 388-550-3381 (2)]

Acute PM&R **room and board** includes, but is not limited to:

- Facility use;
- Medical social services;
- Bed and standard room furnishings; and
- Dietary and nursing services.

How does MAA determine reimbursement?
[Refer to WAC 388-550-3381 (1)]

MAA's payment methodology for Acute PM&R services provided by Acute PM&R facilities is described below:

- MAA pays a rehabilitation facility according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500, Payment method-RCC.

- MAA's payment obligation consists of the allowed charges multiplied by the RCC **minus** the sum of:

  ✓ Client liability (whether or not collected by the contracted provider) and

  ✓ Other coverage from third parties, collected or collectible (if timely claimed by the contracted provider), including, but not limited to:

    - Insurers and indemnitors;
    - Other federal or state medical care programs;
    - Payments actually made to the provider on behalf of the client, whether before or after the services are provided by individuals or organizations (other than insurers or Federal/State programs) not legally liable for the client's financial obligations; **and**
    - Any other contractual or legal entitlement of the client, including, but not limited to: workers' compensation, crime victims' compensation, individual or group insurance, court-ordered dependent support arrangements, and the tort liability of any third party.

MAA may authorize administrative day(s) for a client who:

- Does not meet "extension" authorization requirements (see *Prior Authorization* section);
- Stays in the facility longer than the "community standards length-of-stay"; or
- Is waiting for a discharge destination or a discharge plan. **[WAC 388-550-2561 (8)]**

☞ **Note:** For third-party liability cases, MAA's payment obligation is the lesser of either the RCC payment amount or the provider's allowed charges, minus the sum of client liability and other third-parties as listed above.

How does MAA reimburse for administrative day(s)?
[WAC 388-550-3381 (3)]

When MAA authorizes administrative day(s) for a client, MAA reimburses the facility:

- The administrative day rate; and
- For pharmaceuticals prescribed for the client's use during the administrative portion of the client's stay.

How does DSHS reimburse for ambulance transportation services provided to clients receiving Acute PM&R services?
[Refer to WAC 388-550-3381(4)]

The department reimburses for transportation services provided to a client receiving Acute PM&R services in a rehabilitation facility according to Chapter 388-546 WAC.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ☞ **Note:** If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the time limit for billing is 365 days from the date the plan recouped the payment from the provider.

  Medicare Crossover Claims: If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim. If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

✓ MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

- DSHS certification of a client for a retroactive[2] period; or
- The provider proves to MAA's satisfaction that there are other extenuating circumstances.

✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **<u>Resubmitted Claims</u>**

✓ Providers may resubmit, modify, or adjust any timely initial claim, <u>except</u> prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period(s) listed above. When rebilling, send a copy of the original Remittance and Status Report along with the claim. Be sure to cross out any lines that have already been paid.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, **must not bill a client or a client's estate** when:

✓ The provider fails to meet these listed requirements; and
✓ MAA does not pay the claim.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

What fee should I bill MAA?

Bill MAA your *usual and customary fee* (the fee you bill the general public). MAA's payment will be either your usual and customary fee or MAA's maximum allowable rate, whichever is less.

What revenue codes should I use when billing MAA for services provided in an MAA-approved Acute PM&R facility?

Bill MAA using any applicable revenue code with the following exceptions:

- For acute PM&R room and board services, bill only revenue code 128.

- For administrative days, bill only revenue codes 169 (Room and Board - Other) and 025x (Pharmacy).

MAA only reimburses for covered revenue codes. Refer to MAA's Inpatient Hospital Billing Instructions for a complete list.

How do I bill MAA for administrative day(s)?

[WAC 388-550-3381 (3)]

Bill the administrative day portion of the client's stay:

- On a separate claim form from the Acute PM&R portion of the stay;
- Using the client's date of admission to the Acute PM&R facility for rehabilitation services in form locator 17;
- Using the authorization number assigned by MAA; and
- Using the facility's Acute PM&R provider number.

How do I update the PIC and verify the length-of-stay on an authorization number?

Fax your completed "Acute Rehab Update Form" (see *Important Contacts* section) to MAA. A blank copy of the form is located in the Appendix in this document.

When can I bill the client?

Please refer to MAA's General Information Booklet for information on billing the client or to WAC 388-502-0160.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator 83 on the UB-92 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator 83 when you bill MAA, the claim will be denied.

How do I bill for clients eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance and the services are covered by Medicare, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Payment for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical Identification card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

Note:

- **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- **A Medicare Remittance Notice or EOMB must be attached to each claim.**

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical Identification card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB; and
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  ✓ Patient's name and date of birth;
  ✓ Dates of service(s);
  ✓ Name and title of person performing the service, if other than the billing practitioner;
  ✓ Chief complaint or reason for each visit;
  ✓ Pertinent medical history;
  ✓ Pertinent findings on examination;
  ✓ Medications, equipment, and/or supplies prescribed or provided;
  ✓ Description of treatment (when applicable);
  ✓ Recommendations for additional treatments, procedures, or consultations;
  ✓ X-rays, tests, and results;
  ✓ Plan of treatment and/or care, and outcome;
  ✓ Specific claims and payments received for services;
  ✓ Authorization letters from MAA; and
  ✓ Documentation of discussions related to MAA's authorization decisions.

  ☞ **Note:** Acute PM&R providers must also keep authorization letters from MAA and documentation of discussions related to MAA's authorization decisions.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

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How to Complete the UB-92 Claim Form

General Instructions

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital
Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's medical ID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
08 = Discharged/transferred to home under care of a Home IV provider
20 = Expired
30 = Still patient

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter one or more of the following codes, if applicable.

J0 = Baby on mom's PIC
01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
06 = Crime Victims
X1 = Trauma Condition Code

39-41. Value Codes and Amounts

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

Medicare Crossover claims only

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the hospital rehabilitation provider number issued to you by DPS. For billing administrative days, use your main hospital number, not your rehabilitation number. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

Medicare Crossover claims only

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

57. **Due From Patient - Spenddown**

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter V57.89.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis**

80. **Principal Procedure Code** - Enter V57.89.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

APPROVED OMB NO. 0938-0279

REHAB CENTER
123 Main Street
Anytown, WA 99999

2 | 3 PATIENT CONTROL NO: 1234567 | 4 TYPE OF BILL

5 FED TAX NO. | 6 STATEMENT COVERS PERIOD FROM: 040103 THROUGH: 041503 | 7 DOW D | 8 N-O D | 9 O-I D | 10 I-N D. | 11

12 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 1111 Market Street, Anytown, WA 99999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D-HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
MMDDYYYY	F		040103	14	2	4	12	01									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37 A B C

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a					
b					
c					
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
128	Room and Board	700.00		14	9,800 00		
251	Pharmacy			56	750 00		
270	Medical Supplies			4	300 00	50 00	
430	Occutapional Therapy			50	2,000 00		
911	Psych Svcs - Rehab			20	750 00		
001	Total Charges				13,600 00	50 00	

SAMPLE A
UB-92 Claim Form

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	32XXXXX				13,550 00	

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
57XXXXXXX			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
V57.89	907.0								V57.89		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	
C		D		E		

82 ATTENDING PHYS. ID: 9999999 Dr. John Johnson
83 OTHER PHYS. ID: A
OTHER PHYS. ID: B

84 REMARKS

85 PROVIDER REPRESENTATIVE: X | 86 DATE

UB-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

REHAB CENTER
123 Main Street
Anytown, WA 99999

2

3 PATIENT CONTROL NO. 1234567

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 040103 THROUGH 041503

7 COV'D. 8 NON-COV'D. 9 COND. 10 L-R-D 11

12 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 111 Market Street Anytown, WA 99999

14 BIRTHDATE MMDDYYYY | 15 SEX F | 16 MS | 17 DATE 040103 | 18 HR 14 | 19 TYPE 2 | 20 SRC 4 | 21 D HR 12 | 22 STAT 01 | 23 MEDICAL RECORD NO | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 | 37 A B C

	39 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT
a	A1 840 00		7,000 00
b			
c			
d			05/01/03

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
128	Room and Board	700.00		14	9,800 00		
251	Pharmacy			56	750 00		
270	Medical Supplies			4	300 00	50 00	
430	Occupational Therapy			50	2,000 00		
911	Psych Services - Rehab			20	750.00		
001	Total Charges				13,600 00	50 00	

SAMPLE B

Medicare Part A Crossover Claim Form

50 PAYER	51 PROVIDER NO.	52 REL. BEN.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	32XXXXX				84000	
Medicare	5XXXXX			7,000 00		

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 INSD. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. V57.89 | OTHER DIAG. CODES 68 CODE 907.0 | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 | 74 | 75 ADV. DIAG. CD. V57.89 | 76 E-CODE | 77

78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID: Dr. John Johnson

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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Acute Medicine and Rehab Admit/Extension

Rehab Coordinator Name: _____

☐ Admit or ☐ Update

Auth#:5 7 0 __ __ __ __ __ __

Phone No. _____

Fax No. _____

Resident MD _____

MD Phone# _____

Client Information:

Name: _____ PIC #: _____

Home: _____ Birthdate: _____

Address: _____ SSN: _____

Zip: _____

Rehab Facility Information

Facility Name: _____ Attending Physiatrist: _____

Date of proposed Admit: _____ Estimated LOS: _____

Date of Admit to Acute Care: _____

Rehab Dx & Pertinent Past Medical Hx: _____

Prior acute inpatient rehab for this condition? ☐ No ☐ Yes

If yes, where _____ When? _____

Client is currently at:

☐ home ☐ SNF ☐ Hospital Name: _____

Client's living situation prior to hospitalization? _____

Was client independent prior to acute admit? ☐ Yes ☐ No

If not, describe functional level: _____

Current Deficits: _____

Current functional status:

Ambulation ☐ no ☐ indep ☐ w/chair ☐ cga ☐ mina ☐ moda 1-2 ☐ maxa 1-2

Amb distance & Assistive Devices? _____

Braces Used? _____

Balance Problems? _____

Transfers ☐ independent ☐ cga ☐ mina ☐ moda 1-2 ☐ maxa 1-2

UE dsg ☐ independent ☐ cga ☐ mina ☐ moda 1-2 ☐ maxa 1-2

LE dsg ☐ independent ☐ cga ☐ mina ☐ moda 1-2 ☐ maxa 1-2

Eating ☐ independent ☐ cga ☐ mina ☐ moda 1-2 ☐ maxa 1-2

PO ☐ yes ☐ no ☐ peg tube Trach? ☐ yes ☐ no

Diet type _____

Orientation _____

Cog deficits? explain _____

Does client have carry over? ☐ Yes ☐ No

Follows commands ☐ 1 step %___ ☐ 2 step %___ ☐ multiple

Other Speech needs _____

Continence: ☐ Incont bowel ☐ incont bladder ☐ incont both ☐ foley

Intermittent cath ☐ dep indep ☐ mina ☐ moda

Goals of therapy: _____

Number of hours of therapy tolerated? _____

***Discharge plan:**

☐ home alone ☐ home with family ☐ AFH ☐ SNF

Who will be caregiver at D/C & relationship to patient? _____

Attn: MAA Rehab Program Manager Fax: (360) 586-1471

To: Rehab Program Manager

LOCATION: Medical Assistance Administration, DSHS, Olympia, Wash.

FAX#: 360 - 586 - 1471

ACUTE REHAB UPDATE FORM

Date:_____

PATIENT NAME_____

REHAB AUTHORIZATION # 5 7 0 __ __ __ __ __ __

PATIENT PIC #_____

DATES OF SERVICE :

DATE OF ADMIT _____

DATE OF DISCHARGE _____

From_____

Location:_____

Phone #:_____

Fax#:_____

Your acute rehab authorization will be updated to reflect the information you are forwarding. You will not receive a telephone call back unless there is a problem/conflict with the update.