



Acute Physical Medicine & Rehabilitation Provider Guide

July 1, 2014

Washington State
Health Care Authority

About this guide*

This publication takes effect July 1, 2014, 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
No change at this time		

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

* This publication is a billing instruction.

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Resources Available web page
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., provider guides, provider notices, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Prior Authorization (admission or extension), Limitation Extension, or Exception to Rule	
Information on Length of Stay	Mail to: Length of Stay PO Box 45503 Olympia, WA 98504-5503

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Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the [Washington Apple Health Glossary](#) for a more complete list of definitions.

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 182-550-2511](#))

Acute - An intense medical episode, not longer than three months.
(WAC 182-550-2511)

Acute PM&R - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at a agency-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 182-550-2511)

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 agency.
(WAC 182-550-2511)

Authorization Number - A nine-digit number assigned by the agency 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, pending, or denied.
(WAC [182-550-1050](#))

Benefit Package - A grouping of benefits or services applicable to a client or group of clients.

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 182-550-2511)

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 agency-approved inpatient rehabilitation facility to achieve the following for the client:

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

Noncovered Service or Charge - A service or charge that is not covered by the Health and Recovery Services Administration, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure. (WAC 182-550-1050)

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 182-550-1050](#))

Rehabilitation Accreditation Commission, The - See "CARF."

Review – See Survey.

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 182-550-2511](#))

About the Program

(WAC [182-550-2501](#))

What is Acute Physical Medicine & Rehabilitation (Acute PM&R)?

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 agency requires prior authorization for Acute PM&R services (see [What are the requirements for prior authorization?](#)).

An interdisciplinary team coordinates individualized Acute PM&R services at an agency-contracted rehabilitation facility for a client's:

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

The agency determines and authorizes a length-of-stay based on:

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

When the agency'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 agency programs such as:

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

The agency's Acute PM&R program is regulated by:

- [RCW 74.09.520](#), Medical Assistance-Care and services included-Funding limitations.
- WAC [182-550-2501](#), 2511, 2521, 2531, 2541, 2551, 2561, and 3381 Acute PM&R.
- The Core Provider Agreement.

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

(WAC [182-550-2551](#))

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

- Extensive **or** complex:
 - ✓ Medical needs
 - ✓ Nursing needs
 - ✓ 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
 - ✓ 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
 - 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
 - ✓ Severe pressure ulcers after skin flap surgery for a client who meets both of the following:
 - Requires close observation by a surgeon
 - Is ready to mobilize or be upright in a chair

Provider Requirements

How does a hospital become an agency-approved Acute PM&R provider?

(WAC [182-550-2531](#))

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

Acute PM&R Program Manager
Health Care Authority
PO Box 45506
Olympia, WA 98504-5506

A hospital that applies to become an agency-approved Acute PM&R facility must provide the agency 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](#))
- Is accredited by the Rehabilitation Accreditation Commission (CARF) 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 the agency (see [Conditional approval when waiting for CARF accreditation](#))
- Contracted under the agency's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the agency

- **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
 - ✓ 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:

- May apply for or be awarded a 12-month conditional written approval by the agency if the facility meets both of the following:
 - ✓ Provides the agency with documentation that shows it has started the process of obtaining full CARF accreditation.
 - ✓ Is actively operating under CARF standards.
- Is required to obtain full CARF accreditation within 12 months of the agency's conditional approval date. If this requirement is not met, the agency 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 the agency at the time of application. Full CARF accreditation must be:

- Obtained within 12 months of the agency's conditional approval.
- Kept current.

Final qualification criteria

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

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

Note: Agency-approved Acute PM&R facilities must meet the general requirements in Chapter [182-502](#) WAC, Administration of Medical Programs-Providers.

Is notifying clients of their right to make their own health care decisions (Advance Directives) required?

([42 CFR, 489 Subpart I](#))

All Medicare and 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.
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How does the agency ensure quality of care for the client?

(WAC [182-550-2541](#))

- To ensure quality of care, the agency may conduct reviews (e.g., post-pay or on-site) of any agency-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 meet both of the following:
 - ✓ Provide a resolution to either a complaint or grievance or both
 - ✓ 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
 - ✓ The agency
 - ✓ Other agencies with review authority for agency programs

Note: Being selected for an audit does **not** mean that the business has been predetermined to have faulty business practices.

Client Eligibility

(WAC [182-550-2521](#) (1))

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 are not Washington Apple Health clients may submit an application for health care coverage in one of 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.

Are clients enrolled in managed care eligible?

(WAC [182-550-2521](#) (2))

Yes! When verifying eligibility using ProviderOne, if the client is enrolled in an agency managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen.

If a client is enrolled in a managed care plan at the time of acute care admission, that plan pays for and coordinates Acute PM&R services as appropriate. Clients can contact their managed care plan by calling the telephone number provided to them.

The agency does not process or pay claims for clients enrolled in Healthy Options for services provided under the Healthy Options contract.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Are Primary Care Case Management (PCCM) clients covered?

Yes! For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Prior Authorization

Is prior authorization (PA) required for acute PM&R services?

(WAC [182-550-2501](#))

Yes! The agency requires PA for Acute PM&R services.

What are the requirements for PA?

(WAC [182-550-2561](#))

The acute PM&R provider must obtain prior authorization:

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

Initial PA

For an initial admission:

- A client must:
 - ✓ Be eligible for Acute PM&R services (see [Client Eligibility](#)).
 - ✓ Require Acute PM&R services (see [How does a client qualify for 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.

- The Acute PM&R provider must:
 - ✓ Submit a request for prior authorization to the agency (see [Resources Available](#)).
 - ✓ Include sufficient medical information to justify that all of the following apply:
 - 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 agency-approved Acute PM&R facility.
 - 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 meet all of the following:
 - ✓ Be eligible for Acute PM&R services (see [Client Eligibility](#))
 - ✓ 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
 - ✓ Have observable and significant improvement
- The Acute PM&R provider must do both of the following:
 - ✓ Submit a request for the extension of stay to the agency (see [Resources Available](#))
 - ✓ Include sufficient medical information to justify the extension and include documentation that the client's condition has observably and significantly improved

If the agency 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 \(Acute PM&R?\)](#)).

Note: To request authorization (either initial or an extension), fax the completed Acute Physical Medicine and Rehab Admit/Update form, [13-838](#), to the agency at: 360-725-1966.

Note: See the agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

What happens after prior authorization is requested?

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

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

When does the agency authorize administrative day(s)?

The agency may authorize administrative day(s) for a client who meets one of the following:

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

When does the agency not authorize Acute PM&R services?

The agency does not authorize acute PM&R services for a client who meets one of the following:

- Is deconditioned by a medical illness or by surgery
- Has loss of function primarily as a result of a psychiatric condition(s)
- 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
- ✓ Spine surgery

Payment

(WAC [182-550-3381](#) (2))

What Is Included in Acute PM&R room and board?

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

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

How does the agency determine payment?

(WAC [182-550-3381](#) (1))

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

- The agency pays a rehabilitation facility according to the individual hospital's current ratio of costs-to-charges as described in WAC [182-550-4500](#), Payment method-RCC.
- The agency's payment obligation consists of the allowed charges multiplied by the RCC **minus** the sum of all of the following:
 - ✓ Client liability (whether or not collected by the contracted provider)
 - ✓ 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.

- 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.

The agency may authorize administrative day(s) for a client who meet one of the following:

- Does not meet "extension" authorization requirements (see [Prior Authorization](#))
- Stays in the facility longer than the **community standards length-of-stay**
- Is waiting for a discharge destination or a discharge plan. (WAC [182-550-2561](#) (8))

Note: For third-party liability cases, the agency'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 the agency pay for administrative day(s)?

(WAC [182-550-3381](#) (3))

When the agency authorizes administrative day(s) for a client, the agency pays the facility both of the following:

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

How does the agency pay for ambulance transportation services provided to clients receiving Acute PM&R Services? (WAC [182-550-3381](#)(4))

The agency pays for transportation services provided to a client receiving Acute PM&R services in a rehabilitation facility according to Chapter [182-546](#) WAC.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

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

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

- For acute PM&R room and board services, bill only revenue code 0128.
- For administrative days, bill only revenue codes 0169 (Room and Board - Other) and 025x (Pharmacy).

The agency pays for covered revenue codes only. See the agency's [Inpatient Hospital Services Provider Guide](#) for a complete list.

How do I bill the agency for noncovered days?

Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	\$xx.xx	
0xx4		\$xx.xx

How do I bill the agency for administrative day(s)?

(WAC [182-550-3381](#) (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 the agency.
- Using the facility's Acute PM&R NPI.

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

Fax your completed Acute Physical Medicine and Rehabilitation (PM&R) Update form, [13-839](#), to the agency.

Completing the UB-04 claim form

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](#).