RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 07, 2025
TIME: 8:09 AM

WSR 25-10-099

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency revised these two sections to update outdated terminology (fair hearings to administrative hearings) and removed the outdated options for requesting prior authorization.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-2561, 182-550-2590
Suspended:

Statutory authority for adoption: RCW 35.05.353(1)(c), RCW 41.05.021, RCW 41.05.160

Other authority: None

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 25-06-026 on February 25, 2025 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

	New	____	Amended	2	Repealed	____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	____	Amended	2	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: May 7, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-2561 The agency's prior authorization requirements for acute PM&R services. (1) The medicaid agency requires prior authorization for acute PM&R services. The acute PM&R provider of services must obtain prior authorization:

(a) Before admitting a client to the rehabilitation unit; and

(b) For an extension of stay before the client's current authorized period of stay expires.

(2) For an initial admit:

(a) A client must:

(i) Be eligible under one of the programs listed in WAC 182-550-2521, subject to the restrictions and limitations listed in that section;

(ii) Require acute PM&R services as determined in WAC 182-550-2551;

(iii) Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program; and

(iv) Be willing and capable to participate at least three hours per day, seven days per week, in acute PM&R activities.

(b) The acute PM&R provider of services must:

(i) Submit a request for prior authorization to the agency's clinical consultation team ((~~by fax, electronic mail, or telephone~~)) as published in the agency's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify that:

(A) Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care or independence;

(B) The client's medical condition requires that intensive ((~~twenty-four~~)) 24-hour inpatient comprehensive acute PM&R services be provided in an agency-approved acute PM&R facility; and

(C) The client suffers from severe disabilities including, but not limited to, neurological or cognitive deficits.

(3) For an extension of stay:

(a) A client must meet the conditions listed in subsection (2)(a) of this section and have observable and significant improvement; and

(b) The acute PM&R provider of services must:

(i) Submit a request for the extension of stay to the agency clinical consultation team ((~~by fax, electronic mail, or telephone~~)) as published in the agency's acute PM&R billing instructions; and

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

(4) If the agency denies the request for an extension of stay, the client must be transferred to an appropriate lower level of care as described in WAC 182-550-2501(3).

(5) The agency's clinical consultation team approves or denies authorization for acute PM&R services for initial stays or extensions of stay based on individual circumstances and the medical information received. The agency notifies the client and the acute PM&R provider of a decision.

(a) If the agency approves the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The allowed dates of service;

(iii) An agency-assigned authorization number;

(iv) Applicable limitations to the authorized services; and

(v) The agency's process to request additional services.

(b) If the agency denies the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The reason for the denial;

(iii) Alternative services available for the client; and

(iv) The client's right to request ((~~a fair~~)) an administrative hearing. (See subsection (7) of this section.)

(6) A hospital or other facility intending to transfer a client to an agency-approved acute PM&R hospital or an agency-approved acute PM&R hospital requesting an extension of stay for a client must:

(a) Discuss the agency's authorization decision with the client or the client's legal representative; and

(b) Document in the client's medical record that the agency's decision was discussed with the client or the client's legal representative.

(7) A client who does not agree with a decision regarding acute PM&R services has a right to ((~~a fair~~)) an administrative hearing under chapter 182-526 WAC. After receiving a request for ((~~a fair~~)) an administrative hearing, the agency may request additional information from the client and the facility, or both. After the agency reviews the available information, the result may be:

(a) A reversal of the initial agency decision;

(b) Resolution of the client's issue(s); or

(c) ((~~A fair~~)) An administrative hearing conducted per chapter 182-526 WAC.

(8) The agency may authorize administrative days for a client who:

(a) Does not meet requirements described in subsection (3) of this section; or

(b) Is waiting for a discharge destination or a discharge plan.

(9) The agency does not authorize acute PM&R services for a client who:

(a) Is deconditioned by a medical illness or by surgery; or

(b) Has loss of function primarily as a result of a psychiatric condition; or

(c) Has had a recent surgery and has no complicating neurological deficits. Examples of surgeries that do not qualify a client for inpatient acute PM&R services without extenuating circumstances are:

(i) Single amputation;

(ii) Single extremity surgery; and

(iii) Spine surgery.

AMENDATORY SECTION (Amending WSR 23-21-063, filed 10/12/23, effective 1/1/24)

WAC 182-550-2590 Agency prior authorization requirements for Level 1 and Level 2 LTAC services. (1) The medicaid agency requires prior authorization for Level 1 and Level 2 long term acute care (LTAC) inpatient stays. The prior authorization process includes all the following:

(a) For an initial 30-day stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC 182-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC 182-550-1050.

(ii) The LTAC provider of services must:

(A) Before admitting the client to the LTAC hospital, submit a request for prior authorization to the agency ((~~by fax, electronic mail, or telephone,~~)) as published in the agency's LTAC billing instructions;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Obtain prior authorization from the agency's medical director or designee, when accepting the client from the transferring hospital; and

(D) Meet all the requirements in WAC 182-550-2580.

(b) For any extension of stay, the criteria in (a) of this subsection must be met, and the LTAC provider of services must submit a request for the extension of stay to the agency with sufficient medical justification.

(2) The agency authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received.

(3) A client who does not agree with a decision regarding a length of stay has a right to ((~~a fair~~)) an administrative hearing under chapter 182-526 WAC. After receiving a request for ((~~a fair~~)) an administrative hearing, the agency may request additional information from the client and the facility, or both. After the agency reviews the available information, the result may be:

(a) A reversal of the initial agency decision;

(b) Resolution of the client's issue(s); or

(c) ((~~A fair~~)) An administrative hearing conducted according to chapter 182-526 WAC.

(4) The agency may authorize an administrative day rate payment, as well as payment for medically necessary ancillary services as determined by the agency, pharmacy services, and pharmaceuticals, for a client who meets one or more of the following. The client:

(a) Does not meet the requirements for Level 1 or Level 2 LTAC services;

(b) Is waiting for placement in another hospital or other facility; or

(c) If appropriate, is waiting to be discharged to the client's residence.