Washington State Health Care Authority

Washington Apple Health (Medicaid)

Acute Physical Medicine & Rehabilitation (PM&R) Billing Guide

July 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect **July 1, 2025**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in WAC 182-550-2501 through 182-550-2561.

HCA is committed to providing equal access to our services. If you need accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

[1] This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
How does a hospital become an HCA-approve Acute PM&R provider	Updated DOH WAC references from 246-976-830, -840 to WAC 246-976-800 for Level I and II Trauma Rehab Designation	Previous WACs no longer exist
How do I verify a client's eligibility	Updated the note box from "Apply Now" to "Let's get started"	Updated information about where to click on the Washington Healthplanfinder website when applying for coverage
What are the requirements for PA	Added "When the client has Medicaid primary or Medicaid secondary insurance coverage"	To clarify that primary or secondary Medicaid coverage requires prior authorization
Initial PA	In the note box, changed submit request from "3:00 p.m." to "12:00 p.m."	To assist the agency's review process

Subject	Change	Reason for Change
Extension of PA	In the note box, changed submit request from "3:00 p.m." to "12:00 p.m."	To assist the agency's review process
Requesting Authorization	Added new section for prior authorization requests and limitation extension requests	Ease of submitting PA requests and clarification
How do I update the ProviderOne client ID number and the length-of-stay on an authorization number	Updated the instructions to add additional clarity for updating the ProviderOne client ID number and length-of-stay on an authorization number.	Ease of submitting PA requests

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Table of Contents

Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC** and **WAC 182-550-1050** for a complete list of definitions for Washington Apple Health.

Accredit (or Accreditation) - A term used by nationally recognized health organizations, such as the Commission on Accreditation of Rehabilitation Facilities (CARF), to indicate a facility meets both professional and community standards of medical care.

Acute - An intense medical episode, not longer than three months.

Acute PM&R - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an HCA-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.

Administrative day - One or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate.

Administrative day rate - The Health Care Authority's statewide Medicaid average daily nursing facility rate.

Commission on Accreditation of Rehabilitation Facilities (CARF) – See the CARF International webpage.

Family - People 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 HCA-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 HCA does not consider or pay for as a "hospital covered service." This service or charge may not be billed to the client, except under the conditions identified in WAC 182-502-0160. (WAC 182-550-1050)

Per diem – A hospital-specific daily rate for a service, multiplied by covered allowable days. (WAC 182-550-3000)

Short-term - Two months or less.

Survey – An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with Acute PM&R program requirements.

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About the Program

(WAC 182-550-2501)

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

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. HCA requires prior authorization for Acute PM&R services (see **What are the requirements for PA?**).

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

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

HCA 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 Health Care Authority'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 HCA programs, such as:

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

The Health Care Authority's Acute PM&R program is regulated by:

- RCW 74.09.520, Medical Assistance-Care and services included--Funding limitations
- WAC 182-550-2501, 2521, 2531, 2541, 2551, 2561, and 3381 Acute PM&R
- The Health Care Authority's Core Provider Agreement

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

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

- All of the following 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
  - Skin flap surgery after severe pressure ulcers 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
  - Acute inflammatory demyelinating polyneuropathy (AIDP)

If the client does not meet the clinical criteria set forth in this section, HCA will evaluate the request for services for medical necessity according to the process in WAC 182-501-0165.

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Provider Requirements

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

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

Acute PM&R Program Manager
Clinical Quality and Care Transformation (CQCT)
Medical and Dental Services
PO Box 45506
Olympia, WA 98504-5506

A hospital that applies to become an HCA-approved Acute PM&R facility must provide HCA with documentation that confirms the facility is 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**)
- Accredited by the Commission on Accreditation of Rehabilitation Facilities (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 HCA (see **Conditional approval when waiting for CARF accreditation**)
- Contracted under the Health Care Authority's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the Health Care Authority
- **Operating per the standards set by DOH** (excluding the Certified Rehabilitation Registered Nurse (CRRN) requirement) in either:
  - WAC 246-976-800, Level I Trauma Rehabilitation Designation
  - WAC 246-976-800, Level II Trauma Rehabilitation Designation

> **Note:** Acute PM&R is NOT related to, nor does it qualify any facility for, the DOH Acute Trauma Rehabilitation Designation program.

For a list of CARF-approved providers, go to **CARF International**.

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 HCA if the facility meets both of the following:
  - Provides HCA 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 HCA's conditional approval date. If this requirement is not met, HCA 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 timelines of facility operation under CARF standards must be submitted to HCA at the time of application. Full CARF accreditation must be:
>
> - Obtained within 12 months of HCA's conditional approval
> - Kept current

Final qualification criteria

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

- The facility meets all the applicable requirements in this guide.
- HCA provides written notification that the facility qualifies to be paid for providing Acute PM&R services to eligible medical assistance clients.

> **Note:** HCA-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 HCA ensure quality of care for the client?

To ensure quality of care, the Health Care Authority:

- May conduct reviews (post-pay or on-site) of any HCA-approved Acute PM&R facility
- Requires a provider of Acute PM&R services to 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 one or more of the following:
    - DOH
    - JCAHO
    - CARF
    - The Health Care Authority
    - Other agencies with review authority for HCA programs

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

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Managed Care webpage, under Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Let's get started" button. For patients age 65 and older, or on Medicare, go to Washington Connections – select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes.

Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCO). For these clients, managed care enrollment is displayed on the client's benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating in the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from both the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exception: Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information,

visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage.**

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**: Go to **Washington HealthPlanFinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website:**
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAC) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care

- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Are Primary Care Case Management (PCCM) clients eligible?

Yes. Providers must follow HCA's **ProviderOne Billing and Resource Guide**. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill HCA for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record-keeping requirements.

> **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 HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

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Prior Authorization

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

Yes. HCA requires PA for Acute PM&R services.

What are the requirements for PA?

> **Note:** Authorization of services does not guarantee payment. Providers must meet administrative requirements (client eligibility, claim timeliness, third-party insurance, etc.) before HCA pays for services.

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
- When the client has Medicaid primary or Medicaid secondary insurance coverage

> **Note:** HCA does not routinely approve retroactive requests for authorization.

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 participating in 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 legible, signed request for prior authorization (PA) to the Health Care Authority. You must use the current version of the *Acute Physical Medicine and Rehab Admit/Extension Request* (HCA 13-838) form. See **Where can I download HCA forms?** Older versions submitted will not be accepted. You must use a correct Acute PM&R billing provider NPI on the

request form. Failure to use the correct NPI will result in a delay of processing and payment.

Note: Requests submitted after 12:00 p.m. on weekdays will be considered the following workday. HCA is closed on weekends and all major holidays as identified in WAC 357-31-005.

- 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 or independence, or both.
  - The client's medical condition requires intensive 24-hour inpatient comprehensive Acute PM&R services in an HCA-approved Acute PM&R facility.
  - The client suffers from severe disabilities including, but not limited to, neurological or cognitive deficits, or both.

Extension of PA

For an extension of stay:

- A client must continue to meet all criteria for initial admission, as well as have observable, documented evidence of significant improvement.
- The Acute PM&R provider must do both of the following:
  - Submit a legible, signed request for prior authorization (PA) to HCA. Providers must use the current version of the Acute Physical Medicine and Rehab Admit/Extension Request (HCA 13-838) form. See **Where can I download HCA forms?** Older versions submitted will not be accepted. You must use a correct Acute PM&R billing provider NPI on the request form. Failure to use the correct NPI will result in a delay of processing and payment.

    Note: Requests submitted after 12:00 p.m. on weekdays will be considered the following workday. HCA is closed on weekends and all major holidays as identified in **WAC 357-31-005.**

  - Include documented medical evidence to justify the extension; include all pertinent medical records that substantiate the client's condition has observably and significantly improved.

If HCA 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 (PM&R)?**).

Requesting Authorization

To request an initial authorization:

- Complete the *Acute Physical Medicine and Rehab Admit/Update* form (HCA 13-838). See **Where can I download HCA forms**?
- Submit a request online through direct data entry into ProviderOne. See HCA's **Prior Authorization webpage** for details.
    - Include a completed HCA 13-838 form; and
    - Medical documentation providing justification to support the request

A back-up option for authorization requests can be submitted by fax to 1-866-668-1214.

To request an authorization extension

- Complete the *Acute Physical Medicine and Rehab Admit/Update* form (HCA 13-838). See **Where can I download HCA forms**?
- Use the **ProviderOne PA Pend Forms Submission** Barcode Sheet
    - Enter the 9-digit reference number from the authorization letter into the Authorization Reference # field
    - Click on the Print Cover Sheet button
    - Choose Yes when asked whether or not you want to allow the document to print

Fax the barcode sheet as the FIRST page (no coversheet), then the supporting documents (HCA 13-838 and medical justification) to 1-866-668-1214

The documents will then be added to the authorization

What happens after prior authorization is requested?

A facility intending to transfer a client to an HCA-approved Acute PM&R facility or an Acute PM&R facility requesting an extension of stay for a client must do both of the following:

- Discuss HCA's authorization decision with the client or the client's legal representative, or both
- Document in the client's medical record that HCA's decision was discussed with the client or the client's legal representative, or both

When does HCA authorize administrative days?

HCA may authorize administrative days for a client who meets one of the following:

- Does not meet the "extension" authorization requirements described in this guide
- Stays in the facility longer than the community standard length-of-stay

- Is waiting for a discharge destination or a discharge plan

When does HCA not authorize Acute PM&R services?

HCA 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 because 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 include but are not limited to:

- Single amputation
- Single extremity surgery
- Spine surgery

Payment

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

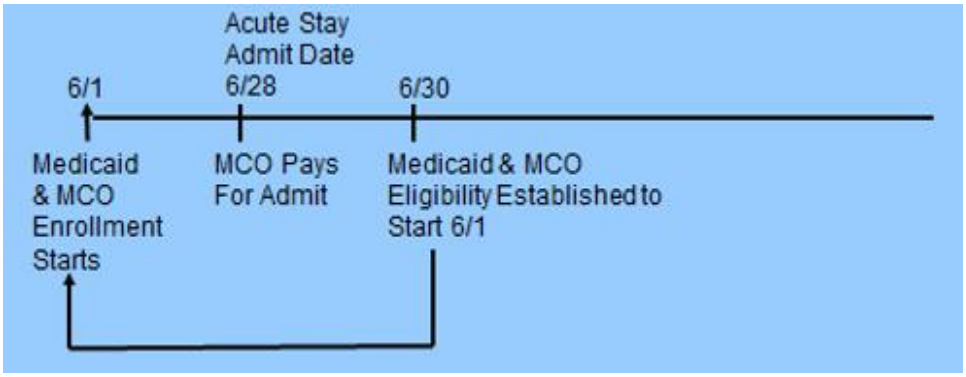
Who pays for care when a client enrolls in an HCA-contracted managed care organization (MCO) during an admission?

In situations when a patient receives care from an acute medical care facility and is then transferred to a rehabilitation setting (e.g., an acute physical medicine and rehabilitation (acute PM&R) facility, a long-term acute care (LTAC) facility, or a skilled nursing facility, (SNF), each of these admissions is considered a separate event. Whether HCA or the managed care organization (MCO) pays depends on the date of admission compared to the date of Medicaid eligibility and the date of enrollment with MCO.

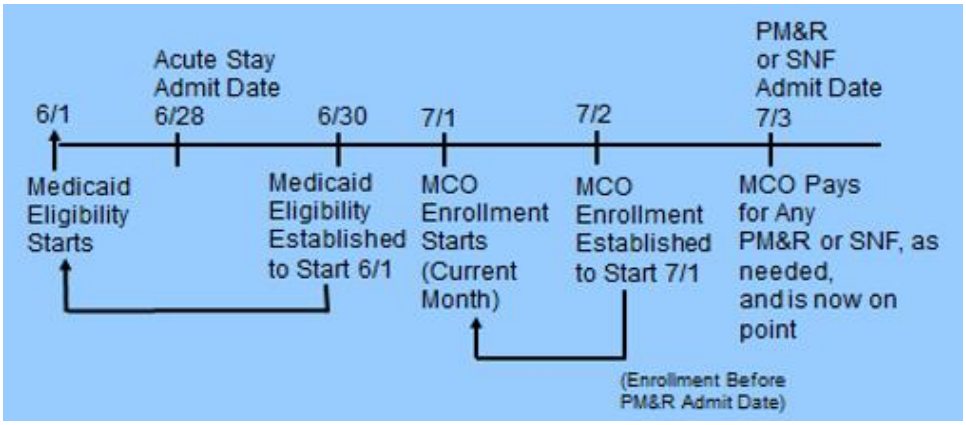
HCA does not pay:

- For an admission to an acute PM&R facility, LTAC facility, or SNF, if the MCO enrollment is effective the same month as the date of admission to this facility.
- For a covered service that is the responsibility of the HCA-contracted MCO.

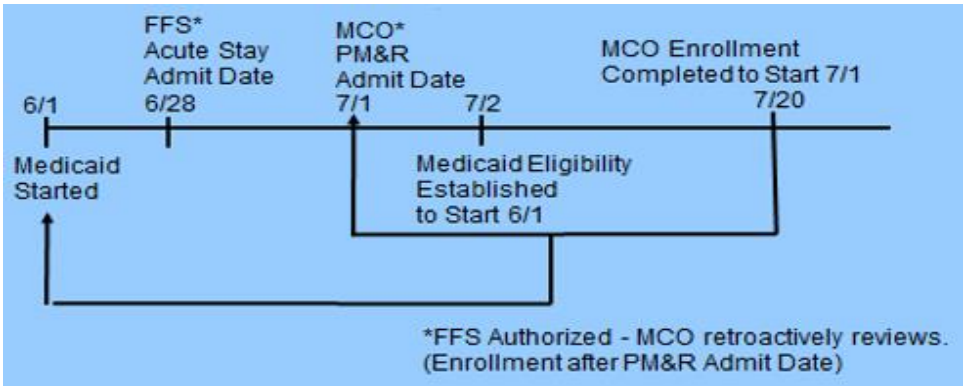
Scenario 1: If the effective date for the client's Medicaid eligibility and MCO enrollment is before an acute care admission date, the MCO is responsible.



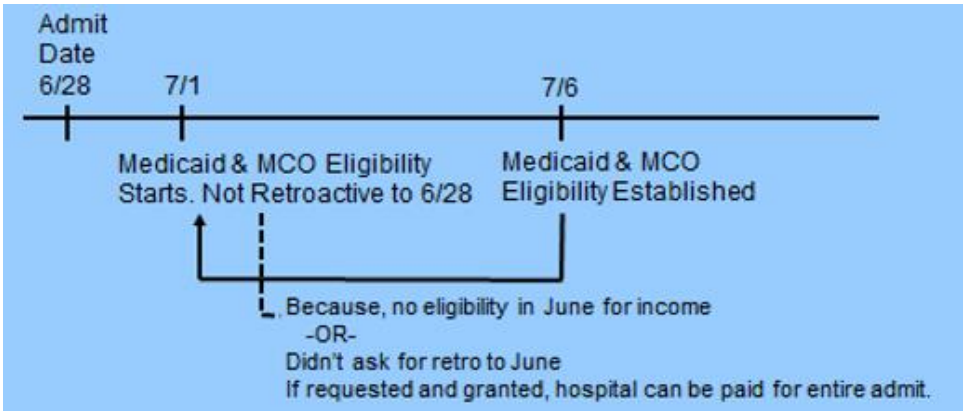
Scenario 2: If the MCO enrollment effective date is after an acute care admission date, the HCA fee-for-service (FFS) program is responsible for the acute care admission. The MCO is responsible for any subsequent admissions for PM&R, LTAC, or SNF services occurring after the MCO enrollment effective date.



Scenario 3: If the MCO enrollment is effective the month following the acute care admission date, but Medicaid eligibility is established back to the first of the month in which the admission occurred, the HCA FFS program is responsible for the acute care stay and any other admissions (PM&R, LTAC, SNF) that begin before the MCO enrollment effective date. The MCO pays for any PM&R, LTAC, or SNF admissions that begin after the MCO enrollment effective date.



Scenario 4: If the effective dates for the client's Medicaid eligibility and MCO enrollments are after the acute medical, PM&R, LTAC, or SNF admission date and no retroactive eligibility is granted back to the date of admission, the HCA FFS program is responsible for the admission and all days until the client's discharge. However, HCA will prorate and pay only for those dates the client is eligible for Medicaid.



How does HCA determine payment?

The Health Care Authority's payment for Acute PM&R services provided by Acute PM&R facilities is described below:

- HCA pays a rehabilitation facility a per diem rate as described in WAC 182-550-3000. Payment is calculated based on client length of stay and the provider specific rehab per diem rate.
- HCA pays the per diem rate in effect at the time services are provided, minus the sum of the following:
  - Client liability, whether or not collected by the contracted provider
  - Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from the following:
  - Insurers and indemnitors:
    - Other federal or state medical care programs;
    - Payments made to the provider on behalf of the client by people or organizations not liable for the client's financial obligations; and
    - Any other contractual or legal entitlement of the client, including but not limited to the following:
      - Crime victim's compensation
      - Worker's compensation
      - Individual or group insurance
      - Court-ordered dependent support arrangements

- The tort liability of any third party

HCA may authorize administrative days for a client who meets 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))

How does HCA pay for administrative day(s)?

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

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

How does HCA pay for ambulance transportation services provided to clients receiving Acute PM&R Services?

HCA pays for transportation services provided to a client receiving Acute PM&R services in a rehabilitation facility according to chapter 182-546 WAC.

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's ProviderOne Billing and Resource Guide webpage and scroll down to Paperless billing at HCA.

For providers approved to bill paper claims, visit the same webpage and scroll down to Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the Health Care Authority'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 HCA for services provided in an HCA-approved Acute PM&R facility?

Bill HCA 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).

HCA pays for covered revenue codes only. See HCA's Inpatient Hospital Services Billing Guide for a complete list.

Note: In order to receive the correct payment for services, claims submitted for rehabilitative services must include both the appropriate ICD-10 diagnosis code and procedure code. Failure to include this information may result in the claim grouping to an incorrect DRG, which will result in a less than expected reimbursement rate. If this occurs, the provider will be responsible for contacting HCA for claims adjustment.

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

To receive payment for medical administrative days the hospital must bill administrative days with revenue code 0169 and all associated charges for those days on a claim separate from the acute care stay.

For the acute care stay claim, the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for administrative days.

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

- On a separate claim from the Acute PM&R portion of the stay
- Using the authorization number assigned by the Health Care Authority
- Using the facility's Acute PM&R provider NPI

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

- Use the ProviderOne PA Pend Forms Submission Barcode Sheet
    - Enter the 9-digit reference number from the authorization letter into the Authorization Reference # field
    - Click on the Print Cover Sheet button
    - Choose Yes when asked whether or not you want to allow the document to print

Fax the barcode sheet as the FIRST page (no coversheet), then the supporting documents (HCA 13-838 and medical justification) to 1-866-668-1214

The documents will then be added to the authorization