

WSR 25-06-026

EXPEDITED RULES

HEALTH CARE AUTHORITY

[Filed February 25, 2025, 9:41 a.m.]

Title of Rule and Other Identifying Information: WAC 182-550-2561 The agency's prior authorization requirements for acute PM&R services, and 182-550-2590 Agency prior authorization requirements for Level 1 and Level 2 LTAC services.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The health care authority (agency) is revising these two sections to update outdated terminology (fair hearings to administrative hearings) and also to remove the outdated options for requesting prior authorization.

Reasons Supporting Proposal: The term "fair hearing" is outdated. Chapter 182-526 WAC is titled "Administrative" hearings. The agency is removing "fax, electronic mail, or telephone." These were only examples of ways to submit prior authorization. The agency's billing guide contains the correct process/method for requesting prior authorization.

Statutory Authority for Adoption: RCW 34.05.353 (1)(c), 41.05.021, and 41.05.160.

Statute Being Implemented: RCW 34.05.353 (1)(c), 41.05.021, and 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Freudenstein, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Heather Zagar, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-5282.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The expedited rule-making process is appropriate because the proposed rules clarify the language without changing its effect.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9727, email arc@hca.wa.gov, BEGINNING February 26, 2025, AND RECEIVED BY May 6, 2025.

February 25, 2025  
Wendy Barcus  
Rules Coordinator

RDS-6200.1

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.