Chapter 182-550 WAC
HOSPITAL SERVICES

Last Update: 11/23/22

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-550-2511 Acute PM&R definitions. [WSR 11-14-075, recodified as § 182-550-2511, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2511, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2511, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-2570 LTAC program definitions. [WSR 11-14-075, recodified as § 182-550-2570, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-21-039, § 388-550-2570, filed 10/8/08, effective 11/8/08; WSR 07-11-129, § 388-550-2570, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2570, filed 7/3/02, effective 8/3/02.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-2800 Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients. [WSR 11-14-075, recodified as § 182-550-2800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-2800, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2800, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518, § 204, Part II. WSR 07-06-043, § 388-550-2800, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-550-2800, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 04-19-113, § 388-550-2800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 02-21-019, § 388-550-2800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-2800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-2800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3010 Payment method—Per diem payment. [WSR 11-14-075, recodified as § 182-550-3010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3010, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3010, filed 6/28/07, effective 8/1/07.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3020 Payment method—Bariatric surgery—Per case payment. [WSR 11-14-075, recodified as § 182-550-3020, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR

09-12-063, § 388-550-3020, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3020, filed 6/28/07, effective 8/1/07.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3100 Calculating DRG relative weights. [WSR 11-14-075, recodified as § 182-550-3100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.04.050. WSR 04-13-048, § 388-550-3100, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3150 Base period costs and claims data. [WSR 11-14-075, recodified as § 182-550-3150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3150, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3200 Medicaid cost proxies. [WSR 11-14-075, recodified as § 182-550-3200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3200, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3250 Indirect medical education costs—Conversion factors, per diem rates, and per case rates. [WSR 11-14-075, recodified as § 182-550-3250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3250, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3300 Hospital peer groups and cost caps. [WSR 11-14-075, recodified as § 182-550-3300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3300, filed 6/28/07, effective 8/1/07; WSR 06-08-046, § 388-550-3300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-3300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-3300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3350 Outlier costs. [WSR 11-14-075, recodified as § 182-550-3350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3350, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3450 Payment method for calculating medicaid DRG conversion factor rates. [WSR 11-14-075, recodified as § 182-550-3450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3450, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3460 Payment method—Per diem rate. [WSR 11-14-075, recodified as § 182-550-3460, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3460, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3460, filed 6/28/07, effective 8/1/07.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3500 Hospital annual inflation adjustment determinations. [WSR 11-14-075, recodified as § 182-550-3500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-3840 Payment adjustment for potentially preventable readmissions. [Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-09-068, § 182-550-3840, filed 4/18/16, effective 5/19/16;

WSR 15-24-096, § 182-550-3840, filed 12/1/15, effective 1/1/16.] Repealed by WSR 18-11-074, filed 5/16/18, effective 7/1/18. RCW 41.05.021 and 41.05.160.

182-550-4600 Hospital selective contracting program. [WSR 11-14-075, recodified as § 182-550-4600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-12-040, § 388-550-4600, filed 5/30/07, effective 7/1/07; WSR 06-08-046, § 388-550-4600, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4600, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-5125 Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH). [WSR 11-14-075, recodified as § 182-550-5125, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5125, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5125, filed 3/30/06, effective 4/30/06.] Repealed by WSR 14-16-019, filed 7/24/14, effective 8/24/14. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155.

182-550-6350 Outpatient sleep apnea/sleep study programs. [WSR 11-14-075, recodified as § 182-550-6350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-6350, filed 6/20/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.] Repealed by WSR 13-07-029, filed 3/13/13, effective 4/13/13. Statutory Authority: RCW 41.05.021.

182-550-7050 OPPS—Definitions. [WSR 11-14-075, recodified as § 182-550-7050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. WSR 10-08-023, § 388-550-7050, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7050, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7050, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.] Repealed by WSR 14-12-047, filed 5/29/14, effective 7/1/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

182-550-7100 OPPS—Exempt hospitals. [WSR 11-14-075, recodified as § 182-550-7100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7100, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7100, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.] Repealed by WSR 14-14-049, filed 6/25/14, effective 7/26/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW.

WAC 182-550-1000 Applicability. The medicaid agency pays for hospital services provided to eligible clients when:

(1) The eligible client is a patient in an acute care hospital and the hospital meets the definition of hospital or psychiatric hospital in RCW 70.41.020, chapter 182-500 or WAC 182-550-1050;

(2) The services are medically necessary as defined under WAC 182-500-0070; and

(3) The conditions, exceptions and limitations in this chapter are met.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1000, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-1000, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1050 Hospital services definitions. The following definitions and abbreviations, those found in chapter 182-500 WAC, Medical definitions, and definitions and abbreviations found in other sections of this chapter apply to this chapter. When a term is not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the medical definitions found in *Taber's Cyclopedic Medical Dictionary* apply.

"Accommodation costs" - The expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Accredited" 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" - A medical condition of severe intensity with sudden onset. For the purposes of the acute physical medicine and rehabilitation (Acute PM&R) program, acute means an intense medical episode, not longer than three months.

"Acute care" - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional to maintain their health status.

"Acute physical medicine and rehabilitation (acute PM&R)" - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an 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. Acute PM&R is a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"Administrative day" or **"administrative days"** - 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 agency's statewide medicaid average daily nursing facility rate.

"Aggregate cost" - The total cost or the sum of all constituent costs.

"Aggregate operating cost" - The total cost or the sum of all operating costs.

"All-patient DRG grouper (AP-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions between August 1, 2007, and June 30, 2014.

"All-patient refined DRG grouper (APR-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions on and after July 1, 2014.

"Allowable" - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

"Allowed amount" - The initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or charge," that the agency allows as the basis for payment computation before final adjustments, deductions, and add-ons.

"Allowed charges" - The total billed charges for allowable services.

"Allowed covered charges" - The total billed charges for services minus the billed charges for noncovered services, denied services, or both.

"Ambulatory payment classification (APC)" - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Ambulatory surgery" - A surgical procedure that is not expected to require an inpatient hospital admission.

"Ancillary services" - Additional or supporting services provided by a hospital to a client during the client's hospital stay. These services include, but are not limited to: Laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" - The level of care required to best manage a client's illness or injury based on:

(1) The severity of illness and the intensity of services required to treat the illness or injury; or

(2) A condition-specific episode of care.

"Audit" - An assessment, evaluation, examination, or investigation of a health care provider's accounts, books, and records, including:

(1) Health, financial, and billing records pertaining to billed services paid by the agency through Washington apple health, by a person not employed or affiliated with the provider, to verify the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical, and health records, including mathematical computations and special studies conducted supporting the medicare cost report (Form 2552-96 and 2552-10 or successor form), submitted to the agency to establish program rates for payment to hospital providers.

"Authorization" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

"Bad debt" - An operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Bedside nursing services" - Services included under the room and board services paid to the facility and provided by nursing service personnel. These services include, but are not limited to: Medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing and other point of care testing, catheterizations, tube feedings and irrigations, and equipment monitoring services.

"Billed charge" - The charge submitted to the agency by the provider.

"Bordering city hospital" - A hospital located in one of the cities listed in WAC 182-501-0175.

"Budget neutral" - A condition in which a claims model produces aggregate payments to hospitals that are the same under two separate payment systems. See also **"budget neutrality factor."**

"Budget neutrality factor" - A multiplier used by the agency to ensure that modifications to the payment method and rates are budget neutral. See also **"budget neutral."**

"Budget target" - Funds appropriated by the legislature or through the agency's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjuster" - A multiplier applied to the outpatient prospective payment system (OPPS) payment to ensure aggregate payments do not exceed the established budget target.

"Bundled services" - Interventions integral to or related to the major procedure. The agency does not pay separately for these services.

"Case mix" - A relative value assigned to a DRG or classification of patients in a medical care environment representing the resource intensity demands placed on an institution.

"Case mix index (CMI)" - The average relative weight of all cases treated in a hospital during a defined period.

"Centers for Medicare and Medicaid Services (CMS)" - See WAC 182-500-0020.

"Charity care" - See chapter 70.170 RCW.

"Children's health insurance program (CHIP)" - The federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen. Part of Washington apple health.

"Children's hospital" - A hospital primarily serving children.

"Client" - A person who receives or is eligible to receive services through agency programs.

"Commission on accreditation of rehabilitation facilities (CARF)" - See http://www.carf.org/home/.

"CMS PPS input price index" - A measure, expressed as a percentage, of the annual inflationary costs for hospital services.

"Comprehensive hospital abstract reporting system (CHARS)" - The department of health's (DOH's) inpatient hospital data collection, tracking, and reporting system.

"Condition-specific episode of care" - Care provided to a client based on the client's primary condition, complications, comorbidities, standard treatments, and response to treatments.

"Contract hospital" - A hospital contracted by the agency to provide specific services.

"Conversion factor" - A hospital-specific dollar amount that is used in calculating inpatient payments.

"Core provider agreement (CPA)" - The basic contract the agency holds with providers serving Washington apple health clients.

"Cost report" - See **"medicare cost report."**

"Costs" - Agency-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report."

"Covered charges" - Billed charges submitted to the agency on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" - See **"hospital covered service"** and WAC 182-501-0050.

"Critical border hospital" - An acute care hospital located in a bordering city (see WAC 182-501-0175 for list) that the agency has, through analysis of admissions and hospital days, designated as critical to provide health care for Washington apple health clients.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Deductible" - The dollar amount a client is responsible for before an insurer, such as medicare, starts paying or the initial specific dollar amount for which the client is responsible.

"Department of social and health services (DSHS)" - The Washington state agency that provides food assistance, financial aid, medical

and behavioral health care, and other services to eligible children, families, and vulnerable adults and seniors of Washington state.

"Diabetes education program" - A comprehensive, multidisciplinary program of instruction offered by a DOH-approved diabetes education provider to diabetic clients for managing diabetes. This includes instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" - A set of numeric or alphanumeric characters assigned by the current published ICD-CM coding guidelines used by the agency as a shorthand symbol to represent the nature of a disease or condition.

"Diagnosis-related group (DRG)" - A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use. Classification of patients is based on the current published ICD-CM coding guidelines used by the agency, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

"Direct medical education costs" - The direct costs of providing an approved medical residency program as recognized by medicare.

"Discharging hospital" - The institution releasing a client from the acute care hospital setting.

"Discount factor" - The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Disproportionate share hospital (DSH) payment" - A supplemental payment made by the agency to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan. See WAC 182-550-4900.

"Disproportionate share hospital (DSH) program" - A program through which the agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients in accordance with legislative direction and established payment methods. See 1902 (a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4900 through 182-550-5400.

"Dispute conference" - See **"hospital dispute conference."**

"Distinct unit" - A distinct area for psychiatric, rehabilitation, or withdrawal management services which has been certified by medicare within an acute care hospital or approved by the agency within a children's hospital.

"Division of behavioral health and recovery services (DBHR)" - The division within HCA that administers mental health, problem gambling, and substance abuse programs authorized by chapters 43.20A, 71.05, 71.24, 71.34, and 70.96A RCW.

"DRG" - See **"diagnosis-related group."**

"DRG allowed amount" - The DRG relative weight multiplied by the conversion factor.

"DRG average length-of-stay" - The agency's average length-of-stay for a DRG classification established during an agency DRG rebasing and recalibration project.

"DRG-exempt services" - Services paid through methods other than DRG, such as per diem rate, per case rate, or ratio of costs-to-charges (RCC).

"DRG payment" - The total payment made by the agency for a client's inpatient hospital stay. The DRG payment is the DRG allowed

amount plus the high outlier minus any third-party liability, client participation, medicare payment, and any other adjustments applied by the agency.

"DRG relative weight" - A factor used in the calculation of DRG payments. As of July 1, 2014, the medicaid agency uses the 3M™ Corporation's national weights developed for the all-patient refined-diagnosis-related group (APR-DRG) software.

"Enhanced ambulatory patient groupings (EAPG)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after July 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency room" or **"emergency facility"** or **"emergency department"** - A distinct hospital-based facility which provides unscheduled services to clients who require immediate medical attention. An emergency department must be capable of providing emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week. A physically separate extension of an existing hospital emergency department may be considered a freestanding emergency department as long as the extension provides comprehensive emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week.

"Emergency services" - Health care services required by and provided to a client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are considered emergency services by the agency.

"Equivalency factor (EF)" - A factor that may be used by the agency in conjunction with other factors to determine the level of a state-administered program payment. See WAC 182-550-4800.

"Exempt hospital - DRG payment method" - A hospital that for a certain client category is reimbursed for services to Washington apple health clients through methodologies other than those using DRG conversion factors.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Experimental service" - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 182-531-0050. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the federal Food and Drug Administration (FDA) or other requisite government body if approval is required.

"Fee-for-service" - See WAC 182-500-0035.

"Fiscal intermediary" - Medicare's designated fiscal intermediary for a region or category of service, or both.

"Fixed per diem rate" - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

"Formal release" - When a client:

(1) Discharges from a hospital or distinct unit;

(2) Dies in a hospital or distinct unit;

(3) Transfers from a hospital or distinct unit as an acute care transfer; or

(4) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility.

"Global surgery days" - The number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

"Graduate medical education costs" - The direct and indirect costs of providing medical education in teaching hospitals. See "direct medical education costs" and "indirect medical education costs."

"Grouper" - See **"all-patient DRG grouper (AP-DRG)"** and **"all-patient refined DRG grouper (APR-DRG)."**

"Health care authority (medicaid agency)" - The Washington state agency that administers Washington apple health.

"High outlier" - A DRG claim classified by the agency as being allowed a high outlier payment that is paid under the DRG payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the agency. See WAC 182-550-3700.

"Hospice" - A medically directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice.

"Hospital" - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a medicare or state-certified distinct rehabilitation unit, a "psychiatric hospital" as defined in this section, or any other distinct unit of the hospital.

"Hospital covered service" - Any service, treatment, equipment, procedure, or supply provided by a hospital, covered under a Washington apple health program, and within the scope of an eligible client's Washington apple health program.

"Hospital cost report" - See **"cost report."**

"Hospital readmission" - A situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital.

"Indirect medical education costs" - The indirect costs of providing an approved medical residency program as recognized by medicare.

"Inflation adjustment" - For cost inflation, this is the hospital inflation adjustment. This adjustment is determined by using the inflation factor method approved by the legislature. For charge inflation, this is the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) Hospital Census and Charges by Payer report.

"Inpatient hospital admission" - A formal admission to a hospital based on an evaluation of the client using objective clinical indicators to provide medically necessary, acute inpatient care. These indicators include assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury. All applicable indicators must be documented in the client's health record. The decision to admit a client to inpatient status should be based on the con-

dition-specific episode of care, severity of illness presented, and the intensity of services rendered. The agency does not deem inpatient hospital admissions as covered or noncovered solely on the basis of the length of time the client actually spends in the hospital. Generally, a client remains overnight and occupies a bed. Inpatient status can apply even if the client is discharged or transferred to another acute hospital and does not actually use a hospital bed overnight. For the agency to recognize a stay as inpatient there must be a physician admission order in the client's medical record indicating the status as inpatient.

"Inpatient medicaid DRG conversion factor" - A dollar amount that represents selected hospitals' average costs of treating medicaid and CHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay medicaid and CHIP claims under the DRG payment method. See WAC 182-550-3800 for how this conversion factor is calculated.

"Inpatient services" - Health care services provided to a client during hospitalization whose condition warrants formal admission and treatment in a hospital.

"Inpatient state-administered program conversion factor" - A DRG conversion factor reduced from the inpatient medicaid DRG conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims under the DRG payment method.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases (ICD-9-CM and ICD-10-CM)" - The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding).

"Length of stay (LOS)" - The number of days of inpatient hospitalization, calculated by adding the total number of days from the admission date to the discharge date, and subtracting one day.

"Long-term acute care (LTAC) services" - Inpatient intensive long-term care services provided in agency-approved LTAC hospitals to eligible Washington apple health clients who meet criteria for level 1 or level 2 services. See WAC 182-550-2565 through 182-550-2596.

"LTAC level 1 services" - LTAC services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one of the following:

(1) Ventilator weaning care; or

(2) Care for a client who has:

(a) Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and

(b) At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

"LTAC level 2 services" - LTAC services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

(1) Ventilator care for a client who is ventilator-dependent and is not weanable and has complex medical needs; or

(2) Care for a client who:

(a) Has a tracheostomy;

(b) Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and

(c) Has at least one comorbid condition (such as quadriplegia).

"Major diagnostic category (MDC)" - One of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG and APR-DRG classification systems.

"Medical care services (MCS)" - See WAC 182-500-0070.

"Medical education costs" - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical visit" - Diagnostic, therapeutic, or consultative services provided to a client by a health care professional in an outpatient setting.

"Medicare cost report" - The medicare cost report (Form 2552-96 or Form 2552-10), or successor document, completed and submitted annually by a hospital provider.

"Medicare crossover" - A claim involving a client who is eligible for both medicare benefits and medicaid.

"Medicare physician fee schedule (MPFS)" - The official CMS publication of relative value units and medicare payment policy indicators for the resource-based relative value scale (RBRVS) payment program.

"Medicare Part A" - See WAC 182-500-0070.

"Medicare Part B" - See WAC 182-500-0070.

"Medicare payment principles" - The rules published in the federal register regarding payment for services provided to medicare clients.

"Military hospital" - A hospital reserved for the use of military personnel, their dependents, and other authorized users.

"Modifier" - A two-digit alphabetic and/or numeric identifier added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National Correct Coding Initiative (NCCI)" - A national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the *American Medical Associations' Current Procedural Terminology (CPT®)* manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National Drug Code (NDC)" - The eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The eleven-digit NDC is composed of a five-four-two grouping. The first five digits comprise the labeler code assigned to the manufacturer by the FDA. The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"National payment rate (NPR)" - A rate for a given procedure code, published by CMS, that does not include a state- or location-specific adjustment.

"National Provider Identifier (NPI)" - A standard, unique identifier for health care providers assigned by CMS. The agency's Provider-One system pays for inpatient and outpatient services using only one NPI per provider. The agency may make an exception for inpatient claims billed with medicare-certified, distinct unit NPIs.

"Nationwide rate" - See **"national payment rate (NPR)."**

"NCCI edit" - A software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency fee schedules, billing instructions, and other publications. The agency has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards, or agency policy.

"Newborn" or **"neonate"** or **"neonatal"** - A person younger than twenty-nine days old.

"Nonallowed service or charge" - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160.

"Noncovered charges" - Billed charges a provider submits to the agency on a claim and indicates them on the claim as noncovered.

"Noncovered service or charge" - A service or charge the agency 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.

"Nursing service personnel" - A group of health care professionals that includes, but is not limited to: Registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant/nursing assistant certified (CNA/NAC).

"Observation services" - A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed forty-eight hours. The agency or the agency's designee may determine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service.

"Operating costs" - All expenses incurred providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Out-of-state hospital" - Any hospital located outside the state of Washington and the bordering cities designated in WAC 182-501-0175. For Washington apple health clients requiring psychiatric services, an "out-of-state hospital" is any hospital located outside the state of Washington.

"Outliers" - Cases with extraordinarily high costs when compared to other cases in the same DRG.

"Outpatient" - A client who is receiving health care services, other than inpatient services, in a hospital setting.

"Outpatient care" - See **"outpatient hospital services."**

"Outpatient enhanced ambulatory payment grouper (EAPG)" - A software program the agency uses for classifying and editing in enhanced ambulatory payment grouping-based OPPS.

"Outpatient hospital" - A hospital authorized by DOH to provide outpatient services.

"Outpatient hospital services" - Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services.

"Outpatient prospective payment system (OPPS) conversion factor" - See **"outpatient prospective payment system (OPPS) rate."**

"Outpatient prospective payment system (OPPS) rate" - A hospital-specific multiplier assigned by the agency that is one of the components of the APC payment calculation.

"Outpatient surgery" - A surgical procedure that is not expected to require an inpatient hospital admission.

"Pass-throughs" - Certain drugs, devices, and biologicals, as identified by CMS, for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own APC.

"Per diem" - A method which uses a daily rate to calculate payment for services provided as a "hospital covered service."

"PM&R" - See **"Acute PM&R."**

"Point of care testing (POCT)" - A test designed to be used at or near the site where the patient is located, that does not require permanent dedicated space, and that is performed outside the physical facilities of the clinical laboratory.

"Primary care case management (PCCM)" - The coordination of health care services under the agency's Indian health center or tribal clinic managed care program. See WAC 182-538-068.

"Principal diagnosis" - The condition chiefly responsible for the admission of the patient to the hospital.

"Prior authorization" - See WAC 182-500-0085.

"Private room rate" - The rate customarily charged by a hospital for a one-bed room.

"Prospective payment system (PPS)" - A payment system in which what is needed to calculate payments (methods, types of variables, and other factors) is set in advance and is knowable by all parties before care is provided. In a retrospective payment system, what is needed (actual costs or charges) is not available until after care is provided.

"Prosthetic device" or **"prosthetic"** - A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Psychiatric hospital" - A medicare-certified distinct psychiatric unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital. Eastern state hospital and western state hospital are excluded from this definition.

"Public hospital district" - A hospital district established under chapter 70.44 RCW.

"Ratable" - A factor used to calculate inpatient payments for state-administered programs.

"Ratio of costs-to-charges (RCC)" - A method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the percentage applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the agency, and payment to the hospital for some DRG-exempt services.

"Rebasing" - The process used by the agency to update hospital payment policies, related variables (rates, factors, thresholds, multipliers, and caps), and system processes (edits, adjudication, grouping, etc.).

"Recalibration" - The process of recalculating DRG relative weights using historical data.

"Rehabilitation units" - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet agency and medicare criteria for distinct rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Reserve days" - The days beyond the ninetieth day of hospitalization of a medicare patient for a benefit period or incidence of illness. See also **"lifetime hospitalization reserve."**

"Revenue code" - A nationally assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" - Routine supplies and services provided to a client during the client's hospital stay. This includes, but is not limited to, a regular or special care hospital room and related furnishings, room supplies, dietary and bedside nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" - See WAC 182-549-1100.

"Rural hospital" - An acute care health care facility capable of providing or assuring availability of inpatient and outpatient hospital health services in a rural area.

"Semi-private room rate" - A rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Significant procedure" - A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

"Specialty hospitals" - Children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

"Spenddown" - See chapter 182-519 WAC.

"State plan" - The plan filed by the agency with CMS, Department of Health and Human Services (DHHS), outlining how the state will administer medicaid and CHIP services, including the hospital program.

"Status indicator (SI)" - A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method.

"Subacute care" - Care provided to a client which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Substance use disorder (SUD)" - See RCW 71.05.020.

"Survey" - An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with program requirements.

"Swing bed" - An inpatient hospital bed certified by CMS for either acute inpatient hospital or skilled nursing services.

"Swing-bed day" - A day in which a client is receiving skilled nursing services in a hospital-designated swing bed at the hospital's census hour.

"Total patient days" - All patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" - To move a client from one acute care setting to a higher level acute care setting for emergency care or to a post-acute, lower level care setting for ongoing care.

"Transferring hospital" - The hospital or distinct unit that transfers a client to another acute care or subacute facility or distinct unit, or to a nonhospital setting.

"UB-04" - The uniform billing document required for use nationally by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing for services provided to patients. This document includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and modified by the Washington state payer group or the agency.

"Vendor rate increase" - An adjustment determined by the legislature, that may be used to periodically increase rates for payment to vendors, including health care providers, that do business with the state.

"Washington apple health program" - Any health care program administered through the medicaid agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-1050, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-1050, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-1050, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-1050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-052, § 388-550-1050, filed 6/28/07, effective 8/1/07; WSR 04-20-057, § 388-550-1050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-1050, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-1050, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652. WSR 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1100 Hospital care—General. (1) The medicaid agency:

(a) Pays for an eligible Washington apple health client's admission to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered under WAC 182-501-0050, 182-501-0060 and 182-501-0065;

(ii) Are medically necessary as defined in WAC 182-500-0070;

(iii) Are determined according to WAC 182-501-0165 when prior authorization is required;

(iv) Are authorized when required under this chapter; and

(v) Meet applicable state and federal requirements.

(b) For hospital admissions, defines "attending physician" as the client's primary care provider, or the primary provider of care to the client at the time of admission.

(2) Medical record documentation of hospital services must meet the requirements in WAC 182-502-0020.

(3) The agency:

(a) Pays for a hospital covered service provided to an eligible apple health client enrolled in an agency-contracted managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the agency and meets prior authorization requirements. (See WAC 182-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to an apple health client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 182-550-4700 apply. The agency's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The agency pays up to twenty-six days of inpatient hospital care for hospital-based withdrawal management, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the chemical-using pregnant (CUP) women program.

See WAC 182-533-0701 through 182-533-0730.

(5) The agency pays for inpatient hospital withdrawal management of acute alcohol or other drug intoxication when the services are provided to an eligible client:

(a) In a withdrawal management unit in a hospital that has a withdrawal management provider agreement with the agency to perform these services and the services are approved by the division of behavioral health and recovery (DBHR) within the health care authority (HCA); or

(b) In an acute hospital and all the following criteria are met:

(i) The hospital does not have a withdrawal management specific provider agreement with DBHR;

(ii) The hospital provides the care in a medical unit;

(iii) Nonhospital-based withdrawal management is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from the agency or the agency's designee as an inpatient stay is not indicated;

(v) The client's stay qualifies as an inpatient stay;

(vi) The client is not participating in the agency's chemical-using pregnant (CUP) women program; and

(vii) The client's principal diagnosis meets the agency's medical inpatient withdrawal management criteria listed in the agency's published billing instructions.

(6) The agency covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

(a) Are provided under chapter 182-535 WAC; and

(b) Are billed on the American Dental Association (ADA) or health care financing administration (HCFA) claim form.

(7) The agency pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room, when:

(a) The covered dental-related services are medically necessary and provided under chapter 182-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least one of the following is true:

(i) The dental-related service(s) is provided to an eligible apple health client on an emergency basis;

(ii) The client is eligible under the division of developmental disability program;

(iii) The client is age eight or younger; or

(iv) The dental service is prior authorized by the agency.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 182-550-2600.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-1100, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-1100, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1100, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-053, § 388-550-1100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-1100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a person eligible under a Washington apple health (WAH) program that is paid by the agency's fee-for-services payment system must be within the scope of the person's WAH program. Coverage restriction includes, but is not limited to the following:

(1) Persons enrolled with the agency's managed care organization (MCO) plans are subject to the respective plan's policies and procedures for coverage of hospital services;

(2) Persons covered by primary care case management are subject to the persons' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for persons described in subsections (1) and (2) of this section, see WAC 182-538-100;

(4) Health care services provided by a hospital located out-of-state are:

(a) Not covered for persons eligible under the medical care services (MCS) program. However, persons eligible for MCS are covered for

that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and CHIP persons without prior authorization, based on the medical necessity and utilization review standards and limits established by the agency.

(ii) Nonemergency out-of-state care for medicaid and CHIP persons when prior authorized by the agency based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC 182-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and CHIP clients based on authorization by a division of behavioral health and recovery (DBHR) designee.

(5) See WAC 182-550-1100 for hospital services for chemical-using pregnant (CUP) women;

(6) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a DBHR designee. See WAC 182-550-2600;

(7) For persons eligible for both medicare and medicaid (dual eligibles), the agency pays deductibles and coinsurance, unless the person has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the agency pays for hospitalization for such persons subject to agency rules. See also chapter 182-502 WAC;

(8) The agency does not pay for covered inpatient hospital services for a WAH client:

(a) Who is discharged from a hospital by a physician because the person no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(9) If the hospital's utilization review committee determines the person's stay is beyond the period of medical necessity, as described in subsection (8) of this section, the hospital must:

(a) Inform the person in a written notice that the agency is not responsible for payment (42 C.F.R. 456);

(b) Comply with the requirements in WAC 182-502-0160 in order to bill the person for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the agency.

(10) Other coverage restrictions, as determined by the agency.

[Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-1200, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1300 Revenue code categories and subcategories. (1) Revenue code categories and subcategories listed in this chapter are published in the UB-92 or UB-04 National Uniform Billing Data Element Specifications Manual.

(2) The medicaid agency requires a hospital provider to report and bill all hospital services provided to Washington apple health clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1300, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1300, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-044, § 388-550-1300, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals. (1) The medicaid agency requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or health care common procedure coding system (HCPCS) codes in addition to the required revenue codes on an outpatient claim line when using any of the following revenue code categories and subcategories:

(a) "IV therapy," only subcategories "general classification" and "infusion pump";

(b) "Medical/surgical supplies and devices," only subcategory "other supplies/devices";

(c) "Oncology";

(d) "Laboratory";

(e) "Laboratory pathological";

(f) "Radiology - Diagnostic";

(g) "Radiology - Therapeutic and/or chemotherapy administration";

(h) "Nuclear medicine";

(i) "CT scan";

(j) "Operating room services," only subcategories "general classification" and "minor surgery";

(k) "Blood and blood components";

(l) "Administration, processing, and storage for blood components";

(m) "Other imaging services";

(n) "Respiratory services";

(o) "Physical therapy";

(p) "Occupational therapy";

(q) "Speech therapy - Language pathology";

(r) "Emergency room," only subcategories "general classification" and "urgent care";

(s) "Pulmonary function";

(t) "Audiology";

(u) "Cardiology";

(v) "Ambulatory surgical care";

(w) "Clinic," only subcategories "general classification" and "other clinic";

(x) "Magnetic resonance technology (MRT)";

(y) "Medical/surgical supplies - Extension," only subcategory "surgical dressings";

(z) "Pharmacy - Extension" subcategories "Erythropoietin (EPO) less than ten thousand units," "Erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(aa) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(bb) "EKG/ECG (electrocardiogram)";

(cc) "EEG (electroencephalogram)";

(dd) "Gastro-intestinal services";

(ee) "Specialty room - Treatment/observation room," subcategory "treatment room and observation room";

(ff) "Telemedicine," only subcategory "other telemedicine";

(gg) "Extra-corporeal shock wave therapy (formerly lithotripsy)";

(hh) "Acquisition of body components," only subcategories "general classification" and "cadaver donor";

(ii) "Hemodialysis - Outpatient or home," only subcategory "general classification";

(jj) "Peritoneal dialysis - Outpatient or home," only subcategory "general classification";

(kk) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," only subcategory "general classification";

(ll) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," only subcategory "general classification";

(mm) "Miscellaneous dialysis," only subcategories "general classification" and "ultrafiltration";

(nn) "Behavioral health treatments/services," only subcategory "electroshock therapy";

(oo) "Other diagnostic services";

(pp) "Other therapeutic services," only subcategories "general classification," "cardiac rehabilitation," and "other therapeutic service"; and

(qq) Other revenue code categories and subcategories identified and published by the agency.

(2) For an outpatient claim line requiring a CPT or HCPCS code, the agency denies payment if the required code is not reported on the line.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1350, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1350, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-044, § 388-550-1350, filed 9/10/03, effective 10/11/03.]

WAC 182-550-1400 Covered and noncovered revenue codes categories and subcategories for inpatient hospital services. Subject to the limitations and restrictions listed, this section identifies covered and noncovered revenue code categories and subcategories for inpatient hospital services.

(1) The medicaid agency pays for an inpatient hospital covered service in the following revenue code categories and subcategories when the hospital provider accurately bills:

(a) "Room & board - Private (one bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(b) "Room & board - Semi-private (two bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(c) "Room & board - Semi-private - (three and four beds)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(d) "Room & board - Deluxe private," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(e) "Nursery," only subcategories "general classification," "newborn - level I," "newborn - level II," "newborn - level III," and "newborn - level IV";

(f) "Intensive care unit," only subcategories "general classification," "surgical," "medical," "pediatric," "intermediate ICU," "burn care," and "trauma";

(g) "Coronary care unit," only subcategories "general classification," "myocardial infarction," "pulmonary care," and "intermediate CCU";

(h) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(i) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery" and "IV therapy/supplies";

(j) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(k) "Oncology," only subcategory "general classification";

(l) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "nonroutine dialysis," "hematology," "bacteriology & microbiology," and "urology";

(m) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(n) "Radiology - Diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X-ray";

(o) "Radiology - Therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy administration - injected," "chemotherapy administration - oral," "radiation therapy," and "chemotherapy administration - IV";

(p) "Nuclear medicine," only subcategories "general classification," "diagnostic," "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(q) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(r) "Operating room services," only subcategories "general classification" and "minor surgery";

(s) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(t) "Administration, processing and storage for blood and blood component," only subcategories "general classification" and "administration";

(u) "Other imaging services," only subcategories "general classification," "diagnostic mammography," "ultrasound," and "positron emission tomography";

(v) "Respiratory services," only subcategories "general classification," "inhalation services" and "hyperbaric oxygen therapy";

(w) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(x) "Speech therapy - Language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(y) "Emergency room," only subcategories "general, urgent care classification" and "urgent care";

(z) "Pulmonary function," only subcategory "general classification";

(aa) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(bb) "Ambulatory surgical care," only subcategory "general classification";

(cc) "Outpatient services," only subcategory "general classification";

(dd) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - Brain (including brainstem)," "MRI - Spinal cord (including spine)," "MRI-other," "MRA - Head and neck," "MRA - Lower extremities," and "MRA-other";

(ee) "Medical/surgical supplies - Extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(ff) "Pharmacy-extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(gg) "Cast room," only subcategory "general classification";

(hh) "Recovery room," only subcategory "general classification";

(ii) "Labor room/delivery," only subcategory "general classification," "labor," "delivery," and "birthing center";

(jj) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(kk) "EEG (Electroencephalogram)," only subcategory "general classification";

(ll) "Gastro-intestinal services," only subcategory "general classification";

(mm) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(nn) "Extra-corporeal shock wave therapy (formerly lithotripsy)," only subcategory "general classification";

(oo) "Inpatient renal dialysis," only subcategories "general classification," "inpatient hemodialysis," "inpatient peritoneal (non-CAPD)," "inpatient continuous ambulatory peritoneal dialysis (CAPD)," and "inpatient continuous cycling peritoneal dialysis (CCPD)";

(pp) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(qq) "Miscellaneous dialysis," only subcategory "ultra filtration";

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," and "pregnancy test"; and

(ss) "Other therapeutic services," only subcategory "general classification."

(2) The agency pays for an inpatient hospital covered service in the following revenue code subcategories only when the hospital provider is approved by the agency to provide the specific service:

(a) "All-inclusive rate," only subcategory "all-inclusive room & board plus ancillary";

(b) "Room & board - Private (one bed)," only subcategory "psychiatric";

(c) "Room & board - Semi-private (two beds)," only subcategories "psychiatric," " withdrawal management," "rehabilitation," and "other";

(d) "Room & board - Semi-private three and four beds," only subcategories "psychiatric" and " withdrawal management";

(e) "Room & board - Deluxe private," only subcategory "psychiatric";

(f) "Room & board - Ward," only subcategories "general classification" and " withdrawal management";

(g) "Room & board - Other," only subcategories "general classification" and "other";

(h) "Intensive care unit," only subcategory "psychiatric";

(i) "Coronary care unit," only subcategory "heart transplant";

(j) "Operating room services," only subcategories "organ transplant-other than kidney" and "kidney transplant";

(k) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate" and "evaluation or reevaluation";

(l) "Clinic," only subcategory "chronic pain clinic";

(m) "Ambulance," only subcategory "neonatal ambulance services";

(n) "Behavioral health treatment/services," only subcategory "electroshock treatment"; and

(o) "Behavioral health treatment/services - Extension," only subcategory "rehabilitation."

(3) The agency pays revenue code category "occupational therapy," subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation" when:

(a) A client is in an acute PM&R facility;

(b) A client is age twenty or younger; or

(c) The diagnosis code is listed in the agency's published billing instructions.

(4) The agency does not pay for inpatient hospital services in the following revenue code categories and subcategories:

(a) "All-inclusive rate," subcategory "all-inclusive room and board";

(b) "Room & board - Private (one bed)" subcategories "hospice," " withdrawal management," "rehabilitation," and "other";

(c) "Room & board - Semi-private (two bed)," subcategory "hospice";

(d) "Room & board - Semi-private - (three and four beds)," subcategories "hospice," "rehabilitation," and "other";

(e) "Room & board - Deluxe private," subcategories "hospice," " withdrawal management," "rehabilitation," and "other";

(f) "Room & board - Ward," subcategories "medical/surgical/gyn," "OB," "pediatric," "psychiatric," "hospice," "oncology," "rehabilitation," and "other";

(g) "Room & board - Other," subcategories "sterile environment," and "self care";

(h) "Nursery," subcategory "other nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit," subcategory "other intensive care";

(l) "Coronary care unit," subcategory "other coronary care";

(m) "Special charges";

(n) "Incremental nursing charge";

(o) "All-inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotics devices," "oxygen - take home," and "other supplies/devices";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)";

(u) "Laboratory," subcategories "renal patient (home)," and "other laboratory";

(v) "Laboratory pathology," subcategory "other laboratory - pathological";

(w) "Radiology - Diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - Therapeutic," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategory "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture," and "other anesthesia";

(cc) "Blood and blood components";

(dd) "Administration, processing and storage for blood and blood components," subcategory "other processing and storage";

(ee) "Other imaging services," subcategories "screening mammography," and "other imaging services";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy," subcategory "other physical therapy";

(hh) "Occupational therapy," subcategory "other occupational therapy";

(ii) "Speech therapy - Language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening," and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services," subcategory "other outpatient service";

(pp) "Clinic," subcategories "general classification," "dental clinic," "psychiatric clinic," "OB-gyn clinic," "pediatric clinic," "urgent care clinic," "family practice clinic," and "other clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance," subcategories "general classification," "supplies," "medical transport," "heart mobile," "oxygen," "air ambulance," "pharmacy," "telephone transmission EKG," and "other ambulance";

(tt) "Home health (HH) skilled nursing";

(uu) "Home health (HH) medical social services";

(vv) "Home health (HH) - Aide";

(ww) "Home health (HH) - Other visits";

(xx) "Home health (HH) - Units of service";

(yy) "Home health (HH) - Oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";

(aaa) "Medical" "medical/surgical supplies - extension," subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Specialty room - Treatment/observation room," subcategory "other specialty rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine";

(ppp) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis," subcategory "other inpatient dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - Outpatient or home";

(ttt) "Peritoneal dialysis - Outpatient or home";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home";

(www) "Miscellaneous dialysis," subcategories "general classification," "home dialysis aid visit," and "other miscellaneous dialysis";

(xxx) "Behavioral health treatments/services," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive

outpatient services - substance use disorder (SUD)," "community behavioral health program (day treatment)";

(yyy) "Behavioral health treatment/services" - (extension), subcategories "rehabilitation," "partial hospitalization - less intensive," "partial hospitalization - intensive," "individual therapy," "group therapy," "family therapy," "bio feedback," "testing," and "other behavioral health treatment/services";

(zzz) "Other diagnostic services," subcategories "general classification," "pap smear," "allergy test," and "other diagnostic service";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services," subcategories "recreational therapy," "cardiac rehabilitation," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," and "other therapeutic services";

(cccc) "Other therapeutic services - extension," subcategories "athletic training" and "kinesiotherapy";

(dddd) "Professional fees";

(eeee) "Patient convenience items"; and

(ffff) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-1400, filed 7/21/21, effective 8/21/21; WSR 15-18-065, § 182-550-1400, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1400, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-045, § 388-550-1400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-1400, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services. (1) The medicaid agency pays for an outpatient hospital covered service in the following revenue code categories and subcategories when the hospital provider accurately bills:

(a) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(b) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery," and "IV therapy/supplies";

(c) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant," and "other supplies/devices";

(d) "Oncology," only subcategory "general classification";

(e) "Durable medical equipment (other than renal)," only subcategory "general classification";

(f) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "renal patient (home)," "nonroutine dialysis," "hematology," "bacteriology and microbiology," and "urology";

(g) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(h) "Radiology - Diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X-ray";

(i) "Radiology - Therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(j) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(k) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(l) "Operating room services," only subcategories "general classification" and "minor surgery";

(m) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(n) "Administration, processing and storage for blood and blood components," only subcategories "general classification" and "administration";

(o) "Other imaging," only subcategories "general classification," "diagnostic mammography," "ultrasound," "screening mammography," and "positron emission tomography";

(p) "Respiratory services," only subcategories "general classification," "inhalation services," and "hyperbaric oxygen therapy";

(q) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(r) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(s) "Speech therapy - Language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(t) "Emergency room," only subcategories "general classification" and "urgent care";

(u) "Pulmonary function," only subcategory "general classification";

(v) "Audiology," only subcategories "general classification," "diagnostic," and "treatment";

(w) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(x) "Ambulatory surgical care," only subcategory "general classification";

(y) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - Brain (including brainstem)," "MRI - Spinal cord (including spine)," "MRI-other," "MRA - Head and neck," "MRA - Lower extremities" and "MRA-other";

(z) "Medical/surgical supplies - Extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(aa) "Pharmacy - Extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(bb) "Cast room," only subcategory "general classification";

(cc) "Recovery room," only subcategory "general classification";

(dd) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(ee) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(ff) "EEG (Electroencephalogram)," only subcategory "general classification";

(gg) "Gastro-intestinal services," only subcategory "general classification";

(hh) "Specialty room - Treatment/observation room," only subcategories "treatment room," and "observation room";

(ii) "Telemedicine," only subcategory "other telemedicine";

(jj) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "general classification";

(kk) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(ll) "Hemodialysis - Outpatient or home," only subcategory "general classification";

(mm) "Peritoneal dialysis - Outpatient or home," only subcategory "general classification";

(nn) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," only subcategory "general classification";

(oo) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," only subcategory "general classification";

(pp) "Miscellaneous dialysis," only subcategories "general classification," and "ultra filtration";

(qq) "Behavioral health treatments/services," only subcategory "electroshock treatment"; and

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," "pap smear," and "pregnancy test."

(2) The agency pays for an outpatient hospital covered service in the following revenue code subcategories only when the outpatient hospital provider is approved by the agency to provide the specific service:

(a) "Clinic," subcategories "general classification," "dental clinic," and "other clinic"; and

(b) "Other therapeutic services," subcategories, "general classification," "education/training," "cardiac rehabilitation," and "other therapeutic service."

(3) The agency does not pay for outpatient hospital services in the following revenue code categories and subcategories:

(a) "All-inclusive rate";

(b) "Room & board - Private (one bed)";

(c) "Room & board - Semi-private (two beds)";

(d) "Room & board - Semi-private (three and four beds)";

(e) "Room & board - Deluxe private";

(f) "Room & board - Ward";

(g) "Room & board - Other";

(h) "Nursery";

(i) "Leave of absence";

(j) "Subacute care";
(k) "Intensive care unit";
(l) "Coronary care unit";
(m) "Special charges";
(n) "Incremental nursing charge rate";
(o) "All-inclusive ancillary";
(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";
(q) "IV therapy," subcategory "other IV therapy";
(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotic devices," and "oxygen - take home";
(s) "Oncology," subcategory "other oncology";
(t) "Durable medical equipment (other than renal)," subcategories "rental," "purchase of new DME," "purchase of used DME," "supplies/drugs for DME effectiveness (home health agency only)," and "other equipment";
(u) "Laboratory," subcategory "other laboratory";
(v) "Laboratory pathology," subcategory "other laboratory pathological";
(w) "Radiology - Diagnostic," subcategory "other radiology - diagnostic";
(x) "Radiology - Therapeutic and/or chemotherapy administration," subcategory "other radiology - therapeutic";
(y) "Nuclear medicine," subcategory "other nuclear medicine";
(z) "CT scan," subcategory "other CT scan";
(aa) "Operating room services," subcategories "organ transplant - other than kidney," "kidney transplant," and "other operating room services";
(bb) "Anesthesia," subcategories "acupuncture" and "other anesthesia";
(cc) "Blood and blood components";
(dd) "Administration, processing and storage for blood and blood component," subcategory "other processing and storage";
(ee) "Other imaging," subcategory "other imaging service";
(ff) "Respiratory services," subcategory "other respiratory services";
(gg) "Physical therapy services," subcategory "other physical therapy";
(hh) "Occupational therapy services," subcategory "other occupational therapy";
(ii) "Speech therapy - Language pathology," subcategory "other speech-language pathology";
(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening" and "other emergency room";
(kk) "Pulmonary function," subcategory "other pulmonary function";
(ll) "Audiology," subcategory "other audiology";
(mm) "Cardiology," subcategory "other cardiology";
(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";
(oo) "Outpatient services";
(pp) "Clinic," subcategories "chronic pain center," "psychiatric clinic," "OB-GYN clinic," "pediatric clinic," "urgent care clinic," and "family practice clinic";
(qq) "Free-standing clinic";

(rr) "Osteopathic services";
(ss) "Ambulance";
(tt) "Home health (HH) - Skilled nursing";
(uu) "Home health (HH) - Medical social services";
(vv) "Home health (HH) - Aide";
(ww) "Home health (HH) - Other visits";
(xx) "Home health (HH) - Units of service";
(yy) "Home health (HH) - Oxygen";
(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";
(aaa) "Medical/surgical supplies - Extension," only subcategory "FDA investigational devices";
(bbb) "Home IV therapy services";
(ccc) "Hospice services";
(ddd) "Respite care";
(eee) "Outpatient special residence charges";
(fff) "Trauma response";
(ggg) "Cast room," subcategory "other cast room";
(hhh) "Recovery room," subcategory "other recovery room";
(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";
(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";
(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";
(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";
(mmm) "Speciality room - Treatment/observation room," subcategories "general classification" and "other speciality rooms";
(nnn) "Preventive care services";
(ooo) "Telemedicine," subcategory "general classification";
(ppp) "Extra-corporal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";
(qqq) "Inpatient renal dialysis";
(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";
(sss) "Hemodialysis - Outpatient or home," subcategories "hemodialysis/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient hemodialysis (home)";
(ttt) "Peritoneal dialysis - Outpatient or home," subcategories "peritoneal/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient peritoneal dialysis (home)";
(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," subcategories "CAPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient CAPD (home)";
(vvv) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," subcategories "CCPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient CCPD (home)";
(www) "Miscellaneous dialysis," subcategories "home dialysis aid visit" and "other miscellaneous dialysis";
(xxx) "Behavioral health treatments/services," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive

outpatient services - chemical dependency," and "community behavioral health program (day treatment)";

(yyy) "Behavioral health treatment/services (extension)";

(zzz) "Other diagnostic services," subcategories "allergy test" and "other diagnostic services";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services - extension," subcategories "recreational therapy," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," "athletic training," and "kinesiotherapy";

(cccc) "Professional fees";

(dddd) "Patient convenience items"; and

(eeee) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1500, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1500, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-046, § 388-550-1500, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1600 Specific items/services not covered. The medicaid agency does not pay for an inpatient or outpatient hospital service, treatment, equipment, drug, or supply that is not listed or referred to as a covered service in this chapter. The following list of noncovered items and services is not intended to be all-inclusive. Noncovered items and services include, but are not limited to:

(1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;

(2) Telephone/telegraph services or television/radio rentals;

(3) Medical photographic or audio/videotape records;

(4) Crisis counseling;

(5) Psychiatric day care;

(6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;

(7) Standby personnel and travel time;

(8) Routine hospital medical supplies and equipment such as bed scales;

(9) Handling fees and portable X-ray charges;

(10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;

(11) Cafeteria charges; and

(12) Services and supplies provided to nonpatients, such as meals and "father packs."

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1600, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1600, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090,

74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1650 Adverse events, hospital-acquired conditions, and present on admission indicators. Refer to WAC 182-502-0022 for the payment policy for provider preventable conditions.

[Statutory Authority: 42 C.F.R. § 447.26. WSR 13-11-051, § 182-550-1650, filed 5/14/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-550-1650, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and Centers for Medicare and Medicaid Services (CMS). WSR 09-24-061, § 388-550-1650, filed 11/25/09, effective 1/1/10.]

WAC 182-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services. (1) This section applies to the agency's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to Washington apple health (medicaid) clients receiving services through the fee-for-service program. For clients enrolled in an agency-contracted managed care organization (MCO), see chapters 182-538 and 182-538D WAC. See chapter 182-546 WAC for transportation services.

(2) All hospital services paid for by the agency are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The agency will deny, recover, or adjust hospital payments if the agency or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The agency may perform one or more types of UR described in subsection (6) of this section.

(6) The agency's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review"——An evaluation performed by the agency or its designee during a client's course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review"——An evaluation performed by the agency or its designee prior to the provision of health care services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"——An evaluation performed by the agency or its designee following the provision of health care services that includes both a post-payment retrospective UR (performed after health care services are provided and paid), and a prepayment

retrospective UR (performed after health care services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the agency or its designee notifies the appropriate oversight entity if either of the following is identified:

(a) A quality of care concern; or

(b) Fraudulent conduct.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-18-059, § 182-550-1700, filed 8/26/21, effective 9/26/21. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-1700, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-1700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1700, filed 6/22/07, effective 8/1/07; WSR 04-20-058, § 388-550-1700, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-1700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1800 Hospital specialty services not requiring prior authorization. The medicaid agency pays for certain specialty services without requiring prior authorization when such services are provided consistent with agency medical necessity and utilization review standards. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 182-550-1900(2) under the conditions established in WAC 182-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 182-550-2400;

(3) Polysomnograms and multiple sleep latency tests, as described under WAC 182-531-1500;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 182-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 182-550-6450.

[Statutory Authority: RCW 41.05.021. WSR 13-07-029, § 182-550-1800, filed 3/13/13, effective 4/13/13. WSR 11-14-075, recodified as § 182-550-1800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1800, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1900 Transplant coverage. (1) The medicaid agency pays for medically necessary transplant procedures only for eligible Washington apple health clients who are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the alien emergency medical (AEM) program are not eligible for transplant coverage.

(2) The agency covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the agency as a "center of excellence" for transplant procedures and meet that hospital's criteria for establishing appropriateness and the medical necessity of the procedures:

(a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas, and small bowel;

(b) Bone marrow and peripheral stem cell (PSC);

(c) Skin grafts; and

(d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the agency pays facility charges only to those hospitals that meet the standards and conditions:

(a) Established by the agency; and

(b) Specified in WAC 182-550-2100 and 182-550-2200.

(4) The agency pays for skin grafts and corneal transplants to any qualified hospital, subject to the limitations in this chapter.

(5) The agency deems organ procurement fees as being included in the payment to the transplant hospital. The agency may make an exception to this policy and pay these fees separately to a transplant hospital when an eligible medical client is covered by a third-party payer that will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The agency, without requiring prior authorization, pays for up to fifteen matched donor searches per client approved for a bone marrow transplant. The agency requires prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The agency does not pay for experimental transplant procedures. In addition, the agency considers as experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The agency pays for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

(9) The agency pays for bone marrow, PSC, skin grafts, and corneal transplants when medically necessary.

(10) The agency may conduct a postpayment retrospective utilization review as described in WAC 182-550-1700, and may adjust the payment if the agency determines the criteria in this section are not met.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1900, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1900, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2100 Requirements——Transplant hospitals. This section applies to requirements for hospitals that perform the medicaid agency-approved transplants described in WAC 182-550-1900(2).

(1) The agency requires instate transplant hospitals to meet the following requirements to be paid for transplant services provided to Washington apple health clients. A hospital must have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type of transplant procedure to be performed, except that the agency does not require CON approval for a hospital that provides peripheral stem cell (PSC), skin graft or corneal transplant services;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that the agency does not require UNOS approval for a hospital that provides PSC, skin graft, or corneal transplant services; and

(c) Been approved by the agency as a center of excellence transplant center for the specific organ or procedure the hospital proposes to perform.

(2) The agency requires an out-of-state transplant center, including bordering city and critical border hospitals, to be a medicare-certified transplant center in a hospital participating in that state's medicaid program. All out-of-state transplant services, excluding those provided in agency-approved centers of excellence (COE) in bordering city and critical border hospitals, must be prior authorized.

(3) The agency considers a hospital for approval as a transplant center of excellence when the hospital submits to the agency a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members must be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The agency considers this requirement met when the hospital submits to the agency a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams must include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times; and

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.

(c) Other resources that the transplant hospital must have include:

(i) Pathology resources for studying and reporting the pathological responses of transplantation;

(ii) Infectious disease services with both the professional skills and the laboratory resources needed to identify and manage a whole range of organisms; and

(iii) Social services resources.

(d) An organ procurement coordinator;

(e) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(f) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(g) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

(h) Extensive blood bank support;

(i) Patient management plans and protocols; and

(j) Written policies safeguarding the rights and privacy of patients.

(4) In addition to the requirements of subsection (3) of this section, the transplant hospital must:

(a) Satisfy the annual volume and survival rates criteria for the particular transplant procedures performed at the hospital, as specified in WAC 182-550-2200(2).

(b) Submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the hospital:

(i) Participates in the national donor procurement program and network; and

(ii) Systematically collects and shares data on its transplant programs with the network.

(5) The agency applies the following specific requirements to a PSC transplant hospital:

(a) A PSC transplant hospital must be an agency-approved COE to perform any of the following PSC services:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A PSC transplant hospital may purchase PSC processing and harvesting services from other agency-approved processing providers.

(6) The agency does not pay a PSC transplant hospital for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2100, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2100, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2200 Transplant requirements——COE. (1) The medicaid agency measures the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the agency, the agency applies these criteria to a hospital during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria must include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE must meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant hospital within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the agency for conditional approval as a transplant COE. The agency considers the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the department of health (DOH).

(4) An in-state hospital granted conditional approval by the agency as a transplant COE must meet the agency's criteria, as established in this chapter, within one year of the conditional approval. The agency must automatically revoke such conditional approval for any hospital that fails to meet the agency's published criteria within the allotted one year period, unless:

(a) The hospital submits a written request for extension of the conditional approval thirty calendar days before the expiration date; and

(b) The request is granted by the agency.

(5) A transplant center of excellence must meet medicare's survival rate requirements for the transplant procedures performed at the hospital.

(6) A transplant COE must submit to the agency annually, at the same time the hospital submits a copy of its medicare cost report (Form 2552-96) documentation showing:

(a) The numbers of transplants performed at the hospital during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7) Transplant hospitals must:

(a) Submit to the agency, within sixty days of the date of the hospital's approval as a COE, a complete set of the comprehensive patient selection criteria and treatment protocols used by the hospital for each transplant procedure it has been approved to perform.

(b) Submit to the agency annual updates to the documents listed in (a) of this subsection, or when the hospital makes a change to the criteria or protocols.

(c) Notify the agency if no changes occurred during a reporting period.

(8) The agency evaluates compliance with the provisions of WAC 182-550-2100(3) based on the protocols and criteria submitted to the

agency by a transplant COE under subsection (7) of this section. The agency terminates a hospital's designation as a transplant COE if a review or audit finds that hospital in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9) The agency:

(a) Provides notification to a transplant COE it finds in noncompliance with subsection (8) of this section, and may allow from the date of notification sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) Does not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 182-502-0030;

(c) Requires, within six months of submitting a plan to correct a breach of compliance, a center to report that:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting the breach of compliance exists.

(10) The agency periodically reviews the list of approved transplant COEs. The agency may limit the number of hospitals it designates as a transplant COE or contracts with to provide services to Washington apple health clients if, in the agency's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The agency pays an agency-approved COE for covered transplant procedures using methods identified in chapter 182-550 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2200, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-2200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2301 Hospital and medical criteria requirements for bariatric surgery. (1) The medicaid agency pays a hospital for bariatric surgery and bariatric surgery-related services only when the surgery is provided in an inpatient hospital setting and only when:

(a) The client:

(i) Qualifies for bariatric surgery by successfully completing all requirements under WAC 182-531-1600; and

(ii) Continues to meet the criteria to qualify for bariatric surgery under WAC 182-531-1600 up to the actual surgery date.

(b) The hospital:

(i) Is accredited by the metabolic and bariatric surgery accreditation and quality improvement program (MBSAQIP); and

(ii) Receives prior authorization from the agency before performing a bariatric surgery for a Washington apple health client.

(2) See WAC 182-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(3) Authorization does not guarantee payment. Authorization for bariatric surgery and bariatric surgery-related services is valid only if:

(a) The client is eligible on the date of admission and date of service; and

(b) The hospital and professional providers meet the criteria in this section and other applicable WAC to perform bariatric surgery or to provide bariatric surgery-related services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-24-107, § 182-550-2301, filed 12/6/17, effective 1/6/18; WSR 15-18-065, § 182-550-2301, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2301, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2301, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-550-2301, filed 5/20/05, effective 6/20/05.]

WAC 182-550-2400 Inpatient chronic pain management services. (1) The medicaid agency pays a hospital that is specifically approved by the agency to provide inpatient chronic pain management services, an all-inclusive per diem facility fee. The agency pays professional fees for chronic pain management services to performing providers under the agency's fee schedule.

(2) A client qualifies for inpatient chronic pain management services when all the following apply:

(a) The client has had pain for at least three months and has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done concerning the pain problem; and

(c) A client with active substance abuse must have completed a withdrawal management program, if appropriate, and must be free from drugs and/or alcohol for at least six months.

(3) The agency:

(a) Covers inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) Pays for only one inpatient hospital stay, up to a maximum of twenty-one consecutive days, for chronic pain management training per a client's lifetime.

(c) Does not require prior authorization for chronic pain management services.

(d) Does not pay for services unrelated to the chronic pain management services that are provided during the client's inpatient stay, unless the hospital requests and receives prior authorization from the agency.

(4) All applicable claim payment adjustments for client responsibility, third party liability, medicare crossover, etc., apply to the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-2400, filed 7/21/21, effective 8/21/21; WSR 15-18-065, § 182-550-2400, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2400, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530

and 43.20B.020. WSR 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2431 Hospice services—Inpatient payments. See chapter 182-551 WAC Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2431, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2431, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

WAC 182-550-2500 Inpatient hospice services. (1) The medicaid agency pays hospice agencies participating in the Washington apple health program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of the inpatient services; and

(b) The services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies must bill the agency for their services using revenue codes. The agency pays hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The agency pays hospital providers directly according to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2500, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-2500, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. Acute physical medicine and rehabilitation (acute PM&R) is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation. The medicaid agency requires prior authorization for acute PM&R services. (See WAC 182-550-2561 for prior authorization requirements.)

(1) An interdisciplinary team coordinates individualized acute PM&R services at an agency-approved rehabilitation hospital to achieve the following for a client:

(a) Improved health and welfare; and

(b) Maximum physical, social, psychological, and educational or vocational potential.

(2) The agency determines and authorizes a length of stay based on:

(a) The client's acute PM&R needs; and

(b) Community standards of care for acute PM&R services.

(3) When the agency's authorized acute period of rehabilitation ends, the hospital provider discharges the client to the client's residence, or to an appropriate level of care. Therapies may continue to help the client achieve maximum potential through other agency programs such as:

(a) Home health services;

(b) Nursing facilities;

(c) Outpatient physical, occupational, and speech therapies; or

(d) Neurodevelopmental centers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2501, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2501, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2501, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2501, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2521 Client eligibility requirements for acute PM&R services. (1) Only a client who is eligible for one of the Washington apple health programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC 182-550-2501, 182-550-2511, 182-550-2531, 182-550-2541, 182-550-2551, 182-550-2561, 182-550-3381, and other rules:

(a) Categorically needy program (CNP);

(b) Children's health insurance program (CHIP);

(c) Medically needy program (LCP-MNP);

(d) Alien emergency medical (AEM)(CNP);

(e) Alien emergency medical (AEM)(LCP-MNP);

(f) Medical care services.

(2) If a client is enrolled in an agency managed care organization (MCO) plan at the time of acute care admission, that plan pays for and coordinates acute PM&R services as appropriate.

[Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-2521, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-2521, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2521, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2521, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2521, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2531 Requirements for becoming an acute PM&R provider. (1) Before August 1, 2007, only an in-state or bordering city hospital may apply to become a medicaid agency-approved acute PM&R hospital. After July 31, 2007, an in-state, bordering city or critical

border hospital may apply to become an agency-approved acute PM&R hospital. To apply, the agency 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
P.O. Box 45506
Olympia, WA 98504-5506

(2) A hospital that applies to become an agency-approved acute PM&R facility must provide the agency with documentation that confirms the facility is all the following:

(a) A medicare-certified hospital;

(b) Accredited by the joint commission on accreditation of health care organizations (JCAHO);

(c) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010;

(d) Commission on accreditation of rehabilitation facilities (CARF) accredited as a comprehensive integrated inpatient rehabilitation program or as a pediatric family centered rehabilitation program, unless subsection (3) of this section applies;

(e) For dates of admission before July 1, 2007, contracted under the agency's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the agency; and

(f) Operating per the standards set by DOH (excluding the certified rehabilitation registered nurse (CRRN) requirement) in either:

(i) WAC 246-976-800 Level I trauma rehabilitation designation; or

(ii) WAC 246-976-800 Level II trauma rehabilitation designation.

(3) A hospital not yet accredited by CARF:

(a) May apply for or be awarded a twelve-month conditional written approval by the agency if the facility:

(i) Provides the agency with documentation that it has started the process of obtaining full CARF accreditation; and

(ii) Is actively operating under CARF standards.

(b) Must obtain full CARF accreditation within twelve 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 approval.

(4) A hospital qualifies as an agency-approved acute PM&R hospital when:

(a) The hospital meets all the applicable requirements in this section; and

(b) The agency provides written notification that the hospital qualifies to be paid for providing acute PM&R services to eligible Washington apple health clients.

(5) The agency-approved acute PM&R hospitals must meet the general requirements in chapter 182-502 WAC Administration of medical programs——Providers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-10-058, § 182-550-2531, filed 5/2/17, effective 6/2/17; WSR 15-18-065, § 182-550-2531, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2531, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2531, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090,

74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2531, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2541 Quality of care—Agency-approved acute PM&R hospital. (1) To ensure quality of care, the medicaid agency may conduct reviews (e.g., post-pay, on-site) of any agency-approved acute PM&R hospital.

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

(a) Provide a resolution to either a complaint or grievance or both; and

(b) Comply with applicable CARF standards for adults or pediatrics as appropriate.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of health care organizations (JCAHO);

(c) CARF;

(d) The agency; or

(e) Other agencies with review authority for the medicaid agency's programs.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2541, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2541, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2541, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2541, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2551 When the medicaid agency authorizes acute PM&R services. (1) Acute PM&R services may be authorized when all of the following are met:

(a) The client has all of the following:

(i) Extensive or complex medical needs;

(ii) Nursing needs; and

(iii) Therapy needs.

(b) The client has a new or recent significant impairment in two or more of the following areas:

(i) Mobility and strength;

(ii) Self-care/ADLs (activities of daily living);

(iii) Communication; or

(iv) Cognitive/perceptual functioning.

(c) The client has a new or recent onset of one of the following conditions:

(i) Brain injury caused by trauma or disease.

(ii) Spinal cord injury resulting in:

(A) Quadriplegia; or
(B) Paraplegia.
(iii) Extensive burns.
(iv) Bilateral limb loss.
(v) Stroke or aneurysm with resulting hemiplegia or cognitive deficits, including speech and swallowing deficits.
(vi) Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits.
(vii) Skin flap surgery after severe pressure ulcer for a client who:
(A) Requires close observation by a surgeon; and
(B) Is ready to mobilize or be upright in a chair.
(viii) Acute inflammatory demyelinating polyneuropathy (AIDP).
(2) If the client does not meet the clinical criteria set forth in this section, the agency will evaluate the request for medical necessity according to the process in WAC 182-501-0165.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-10-058, § 182-550-2551, filed 5/2/17, effective 6/2/17. WSR 11-14-075, recodified as § 182-550-2551, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2551, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

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-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 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 hearing under chapter 182-526 WAC. After receiving a request for a fair 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 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2561, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2561, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-12-039, § 388-550-2561, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-2561, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2565 The long-term acute care (LTAC) program—General. The long-term acute care (LTAC) program is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a medicaid agency-approved LTAC hospital during the acute phase of a client's care. The agency requires prior authorization for LTAC stays. See WAC 182-550-2590 for prior authorization requirements.

(1) A facility's multidisciplinary team coordinates individualized LTAC services at an agency-approved LTAC hospital.

(2) The agency determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in WAC 182-550-2590.

(3) When the agency-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2565, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2565, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-2565, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2565, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2575 Client eligibility requirements for LTAC services. Only a client who is eligible for one of the following programs may receive LTAC services, subject to the restrictions and limitations in WAC 182-550-1050, 182-550-2565, 182-550-2580, 182-550-2585, 182-550-2590, 182-550-2595, 182-550-2596, and other rules:

(1) Categorically needy program (CNP);

(2) State children's health insurance program (SCHIP);

(3) Limited casualty program - Medically needy program (LCP-MNP);

(4) Alien emergency medical (AEM)(CNP); or

(5) Alien emergency medical (AEM)(LCP-MNP).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2575, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2575, filed 6/30/11, effective 7/1/11. Statutory Au-

thority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-2575, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2575, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2580 Requirements for becoming an LTAC hospital. (1) To apply to become a medicaid agency-approved long-term acute care (LTAC) hospital, the agency requires a hospital to:

(a) Submit a letter of request to:

LTAC Program Manager
Division of Health Care Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia WA 98504-5506; and

(b) Include in the letter required under (a) of this subsection, documentation that confirms the hospital is:

(i) Medicare-certified for LTAC;

(ii) Accredited by the joint commission on accreditation of health care organizations (JCAHO);

(iii) Licensed as an acute care hospital by the department of health (DOH) under chapter 246-320 WAC (if an in-state hospital), or by the state in which the hospital is located (if an out-of-state hospital); and

(iv) Enrolled with the agency as a medicaid participating provider.

(2) A hospital qualifies as an agency-approved LTAC hospital when:

(a) The hospital meets all the requirements in this section;

(b) The agency's clinical staff has conducted an on-site visit and recommended approval of the hospital's request for LTAC designation; and

(c) The agency provides written notification to the hospital that it qualifies for payment when providing LTAC services to eligible Washington apple health clients.

(3) Agency-approved LTAC hospitals must meet the general requirements in chapter 182-502 WAC.

(4) The agency may, in its sole discretion, approve a hospital located in Idaho or Oregon that is not in a designated bordering city as an LTAC hospital if:

(a) The hospital meets the requirements of this section; and

(b) The hospital provider signs a contract with the agency agreeing to the payment rates established for LTAC services in accordance with WAC 182-550-2595.

(5) The agency does not have any legal obligation to approve any hospital or other entity as an LTAC hospital.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2580, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2580, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-21-039, § 388-550-2580, filed 10/8/08, effective 11/8/08; WSR 07-11-129, § 388-550-2580, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2580, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2585 LTAC hospitals—Quality of care. (1) To ensure quality of care, the medicaid agency may conduct post-pay or on-site reviews of any agency-approved LTAC hospital. See chapter 182-502A WAC for additional information on audits conducted by agency staff.

(2) A provider of LTAC services must act on any reports of substandard care or violations of the hospital's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or grievance or both.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of health care organizations (JCAHO);

(c) The agency; or

(d) Other agencies with review authority for the agency's programs.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2585, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2585, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-2585, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2585, filed 7/3/02, effective 8/3/02.]

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 thirty-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 hearing under chapter 182-526 WAC. After receiving a request for a fair hearing, the agency may re-

quest 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 hearing conducted according to chapter 182-526 WAC.

(4) The agency may authorize an administrative day rate payment, as well as payment for 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-18-026, § 182-550-2590, filed 8/28/19, effective 9/28/19; WSR 15-18-065, § 182-550-2590, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2590, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-21-039, § 388-550-2590, filed 10/8/08, effective 11/8/08; WSR 07-11-129, § 388-550-2590, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 02-14-162, § 388-550-2590, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2595 Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate. (1) In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the following (see the medicaid agency's LTAC billing instructions for applicable revenue codes):

(a) Room and board - Rehabilitation;

(b) Room and board - Intensive care;

(c) Pharmacy - Up to and including two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and epogen or neupogen therapy;

(d) Medical/surgical supplies and devices;

(e) Laboratory - General;

(f) Laboratory - Chemistry;

(g) Laboratory - Immunology;

(h) Laboratory - Hematology;

(i) Laboratory - Bacteriology and microbiology;

(j) Laboratory - Urology;

(k) Laboratory - Other laboratory services;

(l) Respiratory services;

(m) Physical therapy;

(n) Occupational therapy; and

(o) Speech-language therapy.

(2) The agency pays the LTAC hospital for services covered by the LTAC fixed per diem rate by the rate in effect at the date of admission, minus the sum of:

(a) Client liability, whether or not collected by the provider; and

(b) Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:

(i) Insurers and indemnitors;

(ii) Other federal or state health care programs;

(iii) Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and

(iv) Any other contractual or legal entitlement of the client, including, but not limited to:

(A) Crime victims' compensation;

(B) Workers' compensation;

(C) Individual or group insurance;

(D) Court-ordered dependent support arrangements; and

(E) The tort liability of any third party.

(3) The agency may make annual rate increases to the LTAC fixed per diem rate by using a vendor rate increase. The agency may rebase the LTAC fixed per diem rate periodically.

(4) When the agency establishes a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2595, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2595, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-2595, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 03-02-056, § 388-550-2595, filed 12/26/02, effective 1/26/03; WSR 02-14-162, § 388-550-2595, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2596 Services and equipment covered by the agency but not included in the LTAC fixed per diem rate. (1) The medicaid agency uses the ratio of costs-to-charges (RCC) payment method to pay an LTAC hospital for the following that are not included in the LTAC fixed per diem rate:

(a) Pharmacy - After the first two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and epogen or neupogen therapy;

(b) Radiology services;

(c) Nuclear medicine services;

(d) Computerized tomographic (CT) scan;

(e) Operating room services;

(f) Anesthesia services;

(g) Blood storage and processing;

(h) Blood administration;

(i) Other imaging services - Ultrasound;

(j) Pulmonary function services;

(k) Cardiology services;

(l) Recovery room services;

(m) EKG/ECG services;

(n) Gastro-intestinal services;

(o) Inpatient hemodialysis; and

(p) Peripheral vascular laboratory services.

(2) The agency uses the appropriate inpatient or outpatient payment method described in other published WAC to pay providers other than LTAC hospitals for services and equipment that are covered by the agency but not included in the LTAC fixed per diem rate. The provider

must bill the agency directly and the agency pays the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC hospital, or related to transporting a client to another facility after discharge from the LTAC hospital:

(a) Are not covered or reimbursed through the LTAC fixed per diem rate;

(b) Are not payable directly to the LTAC hospital;

(c) Are subject to the provisions in chapter 182-546 WAC; and

(d) Must be billed directly to the:

(i) Agency by the transportation company to be reimbursed if the client required ambulance transportation; or

(ii) Agency's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 182-546 WAC, if the client:

(A) Required nonemergency transportation; or

(B) Did not have a medical condition that required transportation in a prone or supine position.

(4) The agency evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves the services beyond those limitations or restrictions under WAC 182-501-0165 and 182-501-0169.

(5) When the agency established a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2596, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2596, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-11-129, § 388-550-2596, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-550-2596, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. WSR 03-02-056, § 388-550-2596, filed 12/26/02, effective 1/26/03; WSR 02-14-162, § 388-550-2596, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2598 Critical access hospitals (CAHs). (1) The following definitions and abbreviations and those found in chapter 182-500 WAC and WAC 182-182-1050 apply to this section:

(a) "CAH" see "critical access hospital."

(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled medicare cost report (Form 2552-96) after the end of the CAH's HFY.

(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.

(d) "HFY" see "hospital fiscal year."

(e) "Hospital fiscal year" means each individual hospital's medicare cost report fiscal year.

(f) "Interim CAH payment" means the actual payment the medicaid agency makes for claims submitted by a CAH for service provided during

its current HFY, using the appropriate weighted costs-to-charges (WCC) rate, as determined by the agency.

(g) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's medicare cost report.

(h) "Weighted costs-to-charges (WCC) rate" means a rate the agency uses to determine a CAH payment. See subsection (5) of this section for how the agency calculates a WCC rate.

(i) "WCC rate" see "weighted costs-to-charges rate."

(2) To be paid as a CAH by the agency, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the agency upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 182-502 WAC. For information on audits and the audit appeal process, see chapter 182-502A WAC.

(3) The agency pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service Washington apple health clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using weighted costs-to-charges WCC rates and a retrospective cost settlement process. The agency pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, WCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The agency considers managed care health options and MHD designee WCC payment rates to be cost. Cost settlements are not performed by the agency for managed care claims.

(5) The agency prospectively calculates fee-for-service and managed care inpatient and outpatient WCC rates separately for each CAH.

(a) Before the agency's calculation of the prospective interim inpatient WCC and outpatient WCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the agency:

(i) Within twenty working days of receiving the request from the agency, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the medicare cost report the CAH initially submits to the medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same medicare cost report;

(iii) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's medicare cost report;

(iv) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the agency provides to

the CAH from the agency's CAH WCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the agency that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the agency's CAH WCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The agency:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH WCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely submit the document, the agency may use the CAH WCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH WCC rate calculation model when the agency calculates the WCC rates. This is a standard the agency follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH WCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the medicare cost report. (For example, a CAH reports to the agency that in the agency's standard radiology cost center grouping in the CAH WCC rate calculation model, the hospital has established three costs centers in the medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the agency combines these three cost centers under the standard radiology cost center grouping. No unbundling of the standard cost center grouping is allowed.)

(c) The agency:

(i) Obtains from its medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:

(A) Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);

(D) Claim allowed charges, third party liability, client paid amounts, and agency paid amounts; and

(E) Units of service.

(ii) Obtains Level III trauma payment data from the department of health (DOH).

(iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.

(iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:

(A) Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and

(D) Claim allowed charges.

(v) Separates the inpatient claims data and outpatient hospital claims data;

(vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" medicare cost report the CAH initially submits to the agency.

(vii) Uses the claims classifications and cost center combinations as defined in the agency's CAH WCC rate calculation model;

(viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;

(x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);

(xi) Determines the agency-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;

(xii) Sums all:

(A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.

(B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.

(xiii) Sums all:

(A) Agency-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

(B) Agency-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.

(xiv) Multiplies each hospital's total agency-weighted costs from (c)(xiii) of this subsection by the centers for medicare and medicaid services (CMS) medicare market basket inflation rate to update costs from the HFY to the rate setting period. The medicare market basket inflation rate is published and updated by CMS periodically;

(xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is not submitted timely by the hospital (see (a)(i) of this subsection), the agency will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(B) The outpatient WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective WCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) MCO clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(7) For a newly licensed hospital that is also a CAH, the agency uses the current statewide average WCC rates for the initial prospective WCC rates.

(8) For a CAH that comes under new ownership, the agency uses the prior owner's WCC rates until:

(a) The new owner submits its first "as filed" medicare cost report to the medicare fiscal intermediary, and at the same time to the agency, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The agency has calculated new WCC rates based on the new owner's "as filed" medicare cost report and other timely submitted documents.

(9) In addition to the prospective managed care inpatient and outpatient WCC rates, the agency:

(a) Incorporates the WCC rates into the calculations for the agency's MCO capitated premium that will be paid to the MCO plan; and

(b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient WCC rates applicable to managed care claims. For purposes of this section, the agency considers the WCC rates used to pay CAHs for care given to clients enrolled in an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the agency uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" medicare cost report data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the agency:

(a) Compares actual agency total interim CAH payments to the agency-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, agency claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The agency recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The agency performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the agency uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the agency by the sixtieth day of the hospital's receipt of that medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for agency programs.

(14) The agency pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than WCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the agency uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission after July 31, 2007, the agency uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The agency may conduct a post pay or on-site review of any CAH.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2598, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2598, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-054, § 388-550-2598, filed 6/28/07, effective 8/1/07; WSR 07-03-077, § 388-550-2598, filed 1/17/07, effective 2/17/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.5225. WSR 06-04-089, § 388-550-2598, filed 1/31/06, effective 3/3/06; WSR 05-01-026, § 388-550-2598, filed 12/3/04, effective 1/3/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.5225, and HB 1162, 2001 2nd sp.s. c 2. WSR 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]

WAC 182-550-2600 Inpatient psychiatric services. (1) The medicaid agency, on behalf of the mental health division (MHD), regional support networks (RSNs) and prepaid inpatient health plans (PIHPs), pays for covered inpatient psychiatric services for a voluntary or involuntary inpatient psychiatric admission of an eligible Washington apple health client, subject to the limitation and restrictions in this section and other published rules.

(2) The following definitions and abbreviations and those found in WAC 182-550-1050 apply to this section (where there is any discrepancy, this section prevails):

(a) "Authorization number" refers to a number that is required on a claim in order for a provider to be paid for providing psychiatric inpatient services to a Washington apple health client. An authorization number:

(i) Is assigned when the certification process and prior authorization process has occurred;

(ii) Identifies a specific request for the provision of psychiatric inpatient services to a Washington apple health client;

(iii) Verifies when prior or retrospective authorization has occurred;

(iv) Will not be rescinded once assigned; and

(v) Does not guarantee payment.

(b) "Certification" means a clinical determination by an MHD designee that a client's need for a voluntary or involuntary inpatient psychiatric admission, length of stay extension, or transfer has been reviewed and, based on the information provided, meets the requirements for medical necessity for inpatient psychiatric care. The certification process occurs concurrently with the prior authorization process.

(c) "IMD" See "institution for mental diseases."

(d) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services. The MHD designates whether a facility meets the definition for an IMD.

(e) "Involuntary admission" refer to chapters 71.05 and 71.34 RCW.

(f) "Mental health division (MHD)" is the unit within the department of social and health services (DSHS) authorized to contract for and monitor delivery of mental health programs. MHD is also known as the state mental health authority.

(g) "Mental health division designee" or "MHD designee" means a professional contact person authorized by MHD, who operates under the direction of a regional support network (RSN) or a prepaid inpatient health plan (PIHP).

(h) "PIHP" see "prepaid inpatient health plan."

(i) "Prepaid inpatient health plan (PIHP)" see WAC 388-865-0300.

(j) "Prior authorization" means an administrative process by which hospital providers must obtain an MHD designee's for a client's inpatient psychiatric admission, length of stay extension, or transfer. The prior authorization process occurs concurrently with the certification process.

(k) "Regional support network (RSN)" see WAC 388-865-0200.

(l) "Retrospective authorization" means a process by which hospital providers and hospital unit providers must obtain an MHD designee's certification after services have been initiated for a Washington apple health client. Retrospective authorization can be before discharge or after discharge. This process is allowed only when circumstances beyond the control of the hospital or hospital unit provider prevented a prior authorization request, or when the client has been determined to be eligible for Washington apple health after discharge.

(m) "RSN" see "regional support network."

(n) "Voluntary admission" refer to chapters 71.05 and 71.34 RCW.

(3) The following department of health (DOH)-licensed hospitals and hospital units are eligible to be paid for providing inpatient psychiatric services to eligible Washington apple health clients, subject to the limitations listed:

(a) Medicare-certified distinct part psychiatric units;

(b) State-designated pediatric psychiatric units;

(c) Hospitals that provide active psychiatric treatment outside of a medicare-certified or state-designated psychiatric unit, under the supervision of a physician according to WAC 246-322-170; and

(d) Free-standing psychiatric hospitals approved as an institution for mental diseases (IMD).

(4) An MHD designee has the authority to approve or deny a request for initial certification for a client's voluntary inpatient psychiatric admission and will respond to the hospital's or hospital unit's request for initial certification within two hours of the request. An MHD designee's certification and authorization, or a denial, will be provided within twelve hours of the request. Authorization must be requested before admission. If the hospital chooses to admit the client without prior authorization due to staff shortages, the request for an initial certification must be submitted the same calendar day (which begins at midnight) as the admission. In this case, the hospital assumes the risk for denial as the MHD designee may or may not authorize the care for that day.

(5) To be paid for a voluntary inpatient psychiatric admission:

(a) The hospital provider or hospital unit provider must meet the applicable general conditions of payment criteria in WAC 182-502-0100; and

(b) The voluntary inpatient psychiatric admission must meet the following:

(i) For a client eligible for Washington apple health, the admission to voluntary inpatient psychiatric care must:

(A) Be medically necessary as defined in WAC 182-500-0070;

(B) Be ordered by an agent of the hospital who has the clinical or administrative authority to approve an admission;

(C) Be prior authorized and meet certification and prior authorization requirements as defined in subsection (2) of this section. See subsection (8) of this section for a voluntary inpatient psychiatric admission that was not prior authorized and requires retrospective authorization by the client's MHD designee; and

(D) Be verified by receipt of a certification form dated and signed by an MHD designee (see subsection (2) of this section). The form must document at least the following:

(I) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(II) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170);

(III) The inpatient services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning;

(IV) The client has been diagnosed as having an emotional or behavioral disorder, or both, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; and

(V) The client's principle diagnosis must be an MHD covered diagnosis.

(ii) For a client eligible for both medicare and a Washington apple health program, the agency pays secondary to medicare.

(iii) For a client eligible for both medicare and a Washington apple health program and who has not exhausted medicare lifetime benefits, the hospital provider or hospital unit provider must notify the MHD designee of the client's admission if the dual eligibility status is known. The admission:

(A) Does not require prior authorization by an MHD designee; and

(B) Must be under medicare standards.

(iv) For a client eligible for both medicare and a Washington apple health program who has exhausted medicare lifetime benefits, the admission must have prior authorization by an MHD designee.

(v) When a liable third party is identified (other than medicare) for a client eligible for a Washington apple health program, the hospital provider or hospital unit provider must obtain an MHD designee's authorization for the admission.

(6) To be paid for an involuntary inpatient psychiatric admission:

(a) The involuntary inpatient psychiatric admission must be under the admission criteria specified in chapters 71.05 and 71.34 RCW; and

(b) The hospital provider or hospital unit provider:

(i) Must be certified by the MHD under chapter 388-865 WAC;

(ii) Must meet the applicable general conditions of payment criteria in WAC 182-502-0100; and

(iii) When submitting a claim, must include a completed and signed copy of an Initial Certification Authorization form Admission to Inpatient Psychiatric Care form, or an Extension Certification Authorization for Continued Inpatient Psychiatric Care form.

(7) To be paid for providing continued inpatient psychiatric services to a Washington apple health client who has already been admitted, the hospital provider or hospital unit provider must request from an MHD designee within the time frames specified, certification and authorization as defined in subsection (2) of this section for any of the following circumstances:

(a) If the client converts from involuntary (legal) status to voluntary status, or from voluntary to involuntary (legal) status as described in chapter 71.05 or 71.34 RCW, the hospital provider or hospital unit provider must notify the MHD designee within twenty-four hours of the change. Changes in legal status may result in issuance of a new certification and authorization. Any previously authorized days under the previous legal status that are past the date of the change in legal status are not billable;

(b) If an application is made for determination of a patient's Washington apple health eligibility, the request for certification and prior authorization must be submitted within twenty-four hours of the application;

(c) If there is a change in the client's principal ICD-10-CM diagnosis to an MHD covered diagnosis, the request for certification and prior authorization must be submitted within twenty-four hours of the change;

(d) If there is a request for a length of stay extension for the client, the request for certification and prior authorization must be submitted before the end of the initial authorized days of services (see subsections (11) and (12) of this section for payment methodology and payment limitations);

(e) If the client is to be transferred from one community hospital to another community hospital for continued inpatient psychiatric care, the request for certification and prior authorization must be submitted before the transfer; or

(f) If a client who has been authorized for inpatient care by the MHD designee has been discharged or left against medical advice prior to the expiration of previously authorized days, a hospital provider or hospital unit provider must notify the MHD designee within twenty-four hours of discharge. Any previously authorized days past the date the client was discharged or left the hospital are not billable.

(8) An MHD designee has the authority to approve or deny a request for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when the hospital provider or hospital unit provider did not notify the MHD designee within the notification time frames stated in this section. For a retrospective certification request before discharge, the MHD designee responds to the hospital or hospital unit within two hours of the request, and provides certification and authorization or a denial within twelve hours of the request. For retrospective certification requests after the discharge, the hospital or hospital unit must submit all the required clinical information to the MHD designee within thirty days of discharge. The MHD designee provides a response within thirty days of the receipt of the required clinical documentation. All retrospective certifications must meet the requirements in this section. An authorization or denial is based on the client's condition and the services provided at the time of admission and over the course of the hospital stay, until the date of notification or discharge, as applicable.

(9) To be paid for a psychiatric inpatient admission of an eligible Washington apple health client, the hospital provider or hospital unit provider must submit on the claim form the authorization (see subsection (2)(a) for definition of prior authorization and retrospective authorization).

(10) The agency uses the payment methods described in WAC 182-550-2650 through 182-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to Washington apple health clients, unless otherwise specified in this section.

(11) Covered days for a voluntary psychiatric admission are determined by an MHD designee utilizing MHD approved utilization review criteria.

(12) The number of initial days authorized for an involuntary psychiatric admission is limited to twenty days from date of detention. The hospital provider or hospital unit provider must submit the Extension Certification Authorization for Continued Inpatient Psychiatric Care form twenty-four hours before the expiration of the previously authorized days. Extension requests may not be denied for a person detained under ITA unless a less restrictive alternative is identified by the MHD designee and approved by the court. Extension requests may not be denied for youths detained under ITA who have been referred to the children's long-term inpatient program unless a less restrictive alternative is identified by the MHD designee and approved by the court.

(13) The agency pays the administrative day rate and pays for pharmacy services and pharmaceuticals for any authorized days that meet the administrative day definition in WAC 182-550-1050 when all the following conditions are met:

(a) The client's legal status is voluntary admission;

(b) The client's condition is no longer medically necessary;

(c) The client's condition no longer meets the intensity of service criteria;

(d) Less restrictive alternative treatments are not available, posing barrier to the client's safe discharge; and

(e) The hospital or hospital unit and the MHD designee mutually agree that the administrative day is appropriate.

(14) The hospital provider or hospital unit provider will use the MHD approved due process for conflict resolution regarding medical necessity determinations provided by the MHD designee.

(15) In order for an MHD designee to implement and participate in a Washington apple health client's plan of care, the hospital provider or hospital unit provider must provide any clinical and cost of care information to the MHD designee upon request. This requirement applies to all Washington apple health clients admitted for:

(a) Voluntary inpatient psychiatric services; and

(b) Involuntary inpatient psychiatric services, regardless of payment source.

(16) If the number of days billed exceeds the number of days authorized by the MHD designee for any claims paid, the agency will recover any unauthorized days paid.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-18-026, § 182-550-2600, filed 8/28/19, effective 9/28/19; WSR 15-18-065, § 182-550-2600, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-053, § 388-550-2600, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2650 Base community psychiatric hospitalization payment method for medicaid and CHIP clients and nonmedicaid and non-CHIP clients. (1) Effective for dates of admission from July 1, 2005, through June 30, 2007, and in accordance with legislative directive, the agency implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and children's health insurance program (CHIP) clients and one for nonmedicaid and non-CHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and CHIP clients and nonmedicaid and non-CHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid or non-CHIP client" is defined as a client eligible under the medical care services (MCS) program, as determined by the agency.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and CHIP covered patients, paid to hospitals that accept commitments under the Involuntary Treatment Act (ITA).

(b) The nonmedicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC 182-500-0070. In addition, the agency considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The agency does not consider withdrawal management to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate division of behavioral health and recovery (DBHR) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 182-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a DBHR designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the agency or the agency's designee.

(v) Meet the criteria in WAC 182-550-2600.

(4) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and agency-covered services.

(5) The medicaid base community psychiatric hospitalization payment rate applies only to a medicaid or CHIP client admitted to a non-state-owned free-standing psychiatric hospital located in Washington state.

(6) The nonmedicaid base community psychiatric hospitalization payment rate applies only to a nonmedicaid or CHIP client admitted to a hospital:

(a) Designated by the agency as an ITA-certified hospital; or

(b) That has an agency-certified ITA bed that was used to provide ITA services at the time of the nonmedicaid or non-CHIP admission.

(7) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the agency pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using the agency-specific nondiagnosis related group (DRG) payment method.

(ii) For nonmedicaid and non-CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the agency-specified non-DRG payment method if no relative weight exists for the DRG in the agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The agency-specified non-DRG payment method if no relative weight exists for the DRG in the agency's payment system.

(ii) For nonmedicaid and CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the agency-specified non-DRG payment method if no relative weight exists for the DRG in the agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A nonstate-owned free-standing psychiatric hospital as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and CHIP clients, except the base community inpatient psychiatric hospital payment rate is the nonmedicaid rate, and the RCC allowable is the state-administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 182-550-4650.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 182-550-4650 in conjunction with the nonmedicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using the agency-specified non-DRG payment method.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid using the agency-specified non-DRG payment method.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-2650, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-2650, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-2650, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-2650, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-053, § 388-550-2650, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518, § 204, Part II. WSR 07-06-043, § 388-550-2650, filed 3/1/07, effective 4/1/07.]

WAC 182-550-2750 Hospital discharge planning services. For discharge planning service requirements, see chapter 246-318 WAC.

[WSR 11-14-075, recodified as § 182-550-2750, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2900 Payment limits—Inpatient hospital services. (1) To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the medicaid agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of that hospital, as defined in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the agency or the agency's designee under WAC 182-550-2600, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received prior authorization for an extended LOS from the agency or the agency's designee as specified in WAC 182-550-4300(4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. An agency designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(f) Two separate inpatient hospitalizations if a client is readmitted to the same or affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines that one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000 (7)(f) for the agency's review of fourteen-day readmissions.

(g) Inpatient claims for fourteen-day readmissions considered to be provider preventable as described in WAC 182-550-2950.

(h) A client's day(s) of absence from the hospital or distinct unit.

(i) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

(j) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

(k) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before thirty-nine weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

(3) This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in sixty-calendar-day intervals, unless the client is discharged before the next sixty-calendar-day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the agency is not the primary payer:

(i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(4) The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less upon the client's formal release from the hospital or distinct unit.

(5) To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:

(a) Under the current national uniform billing data element specifications:

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved or modified, or both, by the Washington state payer group or the agency; and

(iii) In effect on the date of the client's admission.

(b) Under the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) Under the agency's published billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation

for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate NUBC revenue code specific to the service or treatment provided to the client.

(6) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by 42 C.F.R. Sec. 447.271.

(7) The agency allows hospitals an administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care, as provided in WAC 182-550-4550.

(8) The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client participation (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B; and

(c) Any other adjustments as determined by the agency.

(10) The agency pays hospitals less for services provided to clients eligible under state-administered programs, as provided in WAC 182-550-4800.

(11) All hospital providers must present final charges to the agency according to WAC 182-502-0150.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-18-059, § 182-550-2900, filed 8/26/21, effective 9/26/21; WSR 19-18-026, § 182-550-2900, filed 8/28/19, effective 9/28/19; WSR 19-13-006, § 182-550-2900, filed 6/6/19, effective 7/7/19; WSR 18-11-074, § 182-550-2900, filed 5/16/18, effective 7/1/18; WSR 15-24-021, § 182-550-2900, filed 11/19/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-2900, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-2900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-2900, filed 6/28/07, effective 8/1/07; WSR 04-20-058, § 388-550-2900, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-2900, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2950 Payment limits—Provider preventable fourteen-day readmissions. (1) **Introduction.** The rules in this section establish the medicaid agency's payment policy for inpatient claims for provider preventable fourteen-day readmissions and do not apply to any other rules regarding payment for hospital admissions.

(2) **Applicability.** The rules in this section apply to inpatient hospital claims made for clients enrolled in the fee-for-service program and to clients enrolled in an agency-contracted managed care organization (MCO).

(a) The rules in this section do not apply to:

(i) Professional claims submitted for services rendered in the inpatient setting during a readmission; or

(ii) Claims submitted by critical access hospitals.

(b) The rules in this section apply only to provider preventable readmissions and not to other types of fourteen-day hospital inpatient readmissions that do not qualify for payment for other reasons.

(3) **Provider preventable readmission.**

(a) For the purpose of this section, readmission means an inpatient hospital admission to the same or an affiliated hospital within fourteen calendar days of a discharge from a prior admission and clinically related to the prior admission.

(b) Inpatient claims from hospitals for fourteen-day readmissions that the agency or the agency's designee considers to be provider preventable do not qualify for payment.

(c) A readmission is provider preventable if the agency or the agency's designee determines there is a reasonable expectation the hospital could have prevented the readmission by one or more of the following:

(i) Quality of care provided during the index (initial) hospitalization. The quality of care provided during the index hospitalization must follow current, evidence-based standards of care for the health care specialty at issue and must be:

(A) Safely administered without physically harming the client;

(B) Free from medical error that subsequently results in readmission due to that error;

(C) Evidence based, producing outcomes that are supported by evidence and effective in treating the client. The quality of care must follow the hospital's current standards for care of the client's diagnosis during that treatment period;

(D) Client-centered, focusing on the client's individual needs. The quality of care must be appropriate for the diagnosis and involve the patient in the planning of their care;

(E) Timely, with treatment that did not result in a delay of care, and the client was not prematurely discharged;

(F) Medically necessary for treatment of a diagnosis recognized by the current International Statistical Classification of Diseases and Related Health Problems (ICD); and

(G) Equitable in quality for all clients, regardless of differences in personal characteristics or beliefs.

(ii) Discharge planning. Discharge planning must occur as directed in the Centers for Medicare and Medicaid Services' (CMS) interpretive guidelines for 42 C.F.R. Sec. 482.43, in Publication #100-07 State Operations Manual (Rev. 183, October 12, 2018), Appendix A, Section 482.43, Conditions of Participation: Discharge planning (CMS Manual). Discharge planning must include, but is not limited to:

(A) A clearly written discharge plan that actively involves the client or client's representative in the discharge process; and

(B) An assessment of the client's capability for postdischarge care and follow up including, but not limited to:

(I) The client's functional status and cognitive ability;

(II) The type of posthospital care the client requires, and whether such care requires the services of health care professionals or facilities;

(III) The availability of the required posthospital health care services to the client; and

(IV) The availability and capability of family, or friends, or both to provide follow-up care in the home.

(iii) Discharge process. Upon discharge, the provider must meet the following discharge components:

(A) Provide the client with all required prescriptions and provide education regarding the appropriate use of these medications; and

(B) Provide the client with written instructions in the client's primary language.

(I) If written instructions cannot be provided, the hospital must provide verbal instructions through an interpreter and document that the client's questions were answered.

(II) Written instructions must include home care instructions including, but not limited to:

• Contact numbers for discharge-related questions;

• Information describing when the client should call the provider with concerns and when to call 911;

• Dietary restrictions;

• Wound care, when applicable; and

• Activity limitations.

(iv) Postdischarge follow-up. Postdischarge follow-up documents must include:

(A) A complete discharge summary, including case management discharge summaries and a risk assessment score that is accessible by outpatient clinics for ease in care coordination.

(B) Dates and contact numbers for follow-up appointments arranged with the primary care provider for all intensive and high-risk clients before the client leaves the hospital.

(C) Arrangements for medical supplies, equipment, and home care services, as needed, before the client leaves the hospital.

(4) **Exclusions.** The following types of inpatient readmission claims are exempt or do not qualify as provider preventable readmissions:

(a) Inpatient psychiatric care;

(b) Readmissions not clinically related to the index (initial) admission;

(c) Readmissions that are planned or scheduled including, but not limited to:

(i) Admissions for repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis, or other planned treatments for renal failure;

(ii) Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case; or

(iii) Planned admissions on the same day to a different hospital unit for continuing care (including transfers for mental health, chem-

ical dependency, rehabilitation, and similar transfers that may be technically coded as discharge/admission for billing purposes).

(d) Admissions for required cancer treatments, including treatment-related toxicities or care for advanced-stage cancer;

(e) End of life and hospice care;

(f) Claims for clients who left against medical advice from index admission;

(g) Obstetrical claim admissions after an antepartum admission;

(h) Claims for readmission with a primary diagnosis of mental health or substance use disorder;

(i) Neonatal inpatient services;

(j) Transplant services, when the admission occurs within one hundred eighty days of transplant;

(k) Claims from a different hospital system other than where the index admission occurred;

(l) Claims to resume care for a client because the client did not comply with the discharge plan; or

(m) Readmissions resulting from the client's refusal of the recommended discharge plan and the index hospital making a less appropriate alternative plan to accommodate client preferences.

(5) **Postpayment utilization review.** The agency or the agency's designee performs a postpayment utilization review of the index hospital admission and all fourteen-day readmissions to determine what claims may qualify for recovery.

(6) **Client financial responsibility.** Clients are not financially liable for claims denied based on provider preventable fourteen-day readmissions that would have otherwise been paid by the agency or the agency's designee.

(7) **Dispute resolution.**

(a) Fee-for-service readmissions. If a hospital disputes a determination regarding fee-for-service readmissions, the agency follows the process in chapter 182-502A WAC and the administrative hearing procedure described in chapter 182-526 WAC.

(b) Managed care organization readmissions. MCOs must have an internal dispute resolution process for disputes arising out of a readmission. A hospital must access the MCO's internal dispute resolution process to dispute a provider preventable readmission determination by the MCO, as described in the hospital's individual contract with the MCO.

(c) Final determination review process. If the hospital has exhausted the MCO's internal dispute resolution process and the hospital continues to dispute the determination, the MCO and agency will follow the process regarding the fourteen-day readmission review program as described in the apple health managed care contract.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-13-006, § 182-550-2950, filed 6/6/19, effective 7/7/19.]

WAC 182-550-3000 Payment method. (1) The medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 182-550-4300 and 182-550-4400.

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For

the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, withdrawal management, or CUP) times covered allowable days	182-550-2600 and 182-550-3381
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300

Payment Method	General Description of Payment Formula	WAC Reference
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges;

(f) A client is discharged from an inpatient hospital stay and, within fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or the agency's designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and all readmissions to determine which inpatient hospital stays qualify for payment. The review may determine:

(i) If both admissions qualify for separate reimbursement;

(ii) If both admissions must be combined to be reimbursed as one payment; or

(iii) Which inpatient hospital stay qualifies for individual payment.

(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition described in WAC 182-502-0022). The agency or the agency's designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments; or

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

(b) The agency will apply the inpatient adjustment factor when the agency determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

(9) The agency does not pay for a client's day of absence from the hospital.

(10) The agency pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described under WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described under WAC 182-550-4000.

(14) The agency's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the agency would have paid using medicare payment principles.

(15) When hospital ownership changes, the agency's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(16) Hospitals participating in the apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(21) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-3000, filed 7/21/21, effective 8/21/21; WSR 19-04-004, § 182-550-3000, filed 1/23/19, effective 3/1/19; WSR 18-11-074, § 182-550-3000, filed 5/16/18, effective 7/1/18; WSR 15-24-096, § 182-550-3000, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3000, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3000, filed 6/30/11, effective 7/1/11. Statutory Authority:

RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3381 Payment method for acute PM&R services and administrative day services. This section describes the agency's payment method for acute physical medicine and rehabilitation (PM&R) services provided by acute PM&R hospitals.

(1) The agency pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See chapter 182-550 WAC and WAC 182-550-3000.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Social services (e.g., discharge planning);

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When the agency authorizes administrative day(s) for a client as described in WAC 182-550-2561(8), the agency pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed for the client's use during the administrative portion of the client's stay.

(4) The agency pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital according to chapter 182-546 WAC.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3381, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3381, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3381, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. WSR 03-06-047, § 388-550-3381, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 182-550-3400 Case-mix index. (1) The medicaid agency calculates the case-mix index (CMI) for each individual hospital to measure the relative cost for treating medicaid and CHIP cases in a given hospital. The CMI represents the relative acuity of the claims.

(2) Using medicaid and children's health insurance program (CHIP) admissions data from the individual hospital and the hospital's base period cost report, the agency calculates the CMI by:

(a) Multiplying the number of medicaid and CHIP admissions to the hospital for a specific diagnosis-related group (DRG) classification by the relative weight for that DRG classification. The agency repeats this process for each DRG billed by the hospital;

(b) Adding together the products in (a) of this subsection for all of the medicaid and CHIP admissions to the hospital in the base year; and

(c) Dividing the sum obtained in (b) of this subsection by the corresponding number of medicaid and CHIP hospital admissions.

(3) The agency recalculates each hospital's CMI during inpatient hospital rebasing, or as needed.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3400, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3400, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3470 Payment method—Bariatric surgery—Per case rate. (1) Effective through June 30, 2019, the medicaid agency:

(a) Pays for bariatric surgery provided in designated agency-approved hospitals when all criteria established in WAC 182-550-2301 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC 182-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the agency determines the per case rate by using a hospital-specific medicare fee schedule rate the agency used to pay for bariatric surgery.

(3) For dates of admission after July 31, 2007, the agency determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the agency's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the agency:

(i) Inflates the hospital-specific operating, capital, and direct medical education routine costs from the hospital's medicare cost report fiscal year to the mid-point of the state fiscal year.

(ii) Divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index in effect for the medicare inpatient prospective payment system federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations.

(b) To determine the statewide standardized weighted average cost per case by using the adjusted hospital-specific operating and capital costs derived in (a) of this subsection, the agency:

(i) Adjusts the hospital-specific operating and capital costs to remove the indirect costs associated with approved medical education programs; then

(ii) Calculates the operating standardized amount by dividing statewide aggregate adjusted operating costs by the statewide aggregate number cases in the base year claims data; then

(iii) Calculates the capital standardized amount by dividing statewide aggregate adjusted capital costs by the statewide aggregate number of cases in the base year claims data.

(c) To make hospital-specific adjustments to the statewide operating and capital standardized amounts, the agency:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all instate hospitals operating standardized amount after making adjustments for the wage index and the indirect medical education. The agency:

(A) To determine the labor portion, uses the factor established by medicare multiplied by the statewide operating standardized amount, then multiplies the labor portion of the operating standardized amount by (1.0 plus the most currently available hospital-specific medicare wage index); then

(B) Adds the nonlabor portion of the operating standardized amount to the labor portion derived in (c)(i)(A) of this subsection; then

(C) Multiplies the amount derived in (c)(i)(B) of this subsection by 1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor to derive the operating standardized amount for bariatric services; then

(D) Adjusts the hospital-specific operating standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(E) Calculates the statewide bariatric operating payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(i)(D) of this subsection for each hospital approved by the agency to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of instate hospitals approved by the agency to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all instate hospitals capital standardized amount after adjusting for the indirect medical education. The agency:

(A) Multiplies the amount derived in (b)(iii) of this subsection by (1.0 plus the most currently available hospital-specific medicare capital indirect medical education factor) to derive the adjusted indirect medical education capital standardized amount for bariatric services.

(B) Adjusts the hospital-specific capital standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(C) Calculates the statewide bariatric capital payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(ii)(B) of this subsection for each hospital approved by the agency to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of instate hospitals approved by the agency to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the instate hospitals hospital-specific direct medical education weighted cost per case multiplied by the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system

implementation year. The agency calculates the statewide bariatric direct medical education standardized payment per case by:

(A) Multiplying the hospital-specific direct medical education weighted cost per case for each hospital approved by the agency to provide bariatric services by the CMS PPS input price index; then

(B) Totaling the hospital-specific amounts derived in (iii)(A) of this subsection for each hospital approved by the agency to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the agency sums for each hospital the instate statewide bariatric operating payment per case, the instate statewide bariatric capital payment per case, and the hospital-specific direct medical education payment per case. (For critical border hospitals, the direct medical education payment per case is limited at the highest direct medical education payment per case amount for the instate hospitals approved by the agency to provide bariatric services.)

(e) The agency adjusts the hospital-specific bariatric payment per case amount by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services.

(f) The agency may make other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes as directed by the legislature).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-04-004, § 182-550-3470, filed 1/23/19, effective 3/1/19; WSR 15-18-065, § 182-550-3470, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-3470, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3470, filed 6/28/07, effective 8/1/07.]

WAC 182-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit to any of the following:

(a) Another acute care hospital or distinct unit;

(b) A skilled nursing facility (SNF);

(c) An intermediate care facility (ICF);

(d) Home care under the medicaid agency's home health program;

(e) A long-term acute care facility (LTAC);

(f) Hospice (facility-based or in the client's home);

(g) A hospital-based, medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 182-550-3000); or

(h) A nursing facility certified under medicaid but not medicare.

(2) The medicaid agency pays a transferring hospital the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) The prorated DRG payment, which the agency calculates by:

(i) Using the average length of stay (ALOS) for the assigned DRG:

(A) The agency uses the 3M national average length of stay for paying inpatient claims.

(B) The agency publishes ALOS values on its website;

(ii) Dividing the hospital's allowed payment amount for the assigned DRG by the ALOS in (b)(i) of this subsection;

(iii) Determining the client length of stay as all medically necessary days at the transferring hospital, plus one day; and

(iv) Multiplying the number in (b)(ii) of this subsection by the length of stay determined in (b)(iii) of this subsection.

(3) The agency applies the outlier payment method if a transfer case qualifies as a high outlier. To qualify for a high outlier, the costs (ratio of cost-to-charges multiplied by covered allowed charges) for the transfer must exceed the outlier threshold. The threshold is the prorated DRG amount plus forty thousand dollars. The prorated amount is the lesser of:

(a) The per diem DRG allowed amount (hospital's rate multiplied by relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client's length of stay plus one day; or

(b) The total DRG payment allowed amount calculation for the claim.

(4) The agency does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(5) The agency pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the agency's maximum payment to a discharging hospital.

(6) The agency pays an intervening hospital a per diem payment based on the method described in subsection (2) of this section.

(7) The transfer payment policy described in this section does not apply to claims grouped into DRG classifications the agency pays based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(8) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

(d) Any other adjustments as determined by the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-043, § 182-550-3600, filed 5/30/18, effective 7/1/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3600, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-3600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3600, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-3600, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3700 DRG high outliers. (1) The medicaid agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier criteria are met.

(a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission. The outlier threshold amount is depicted in the following table:

Dates of Admission	Pediatric	Nonpediatric
February 1, 2011 - July 31, 2012	Base DRG * 1.50	Base DRG * 1.75
August 1, 2012 - June 30, 2013	Base DRG * 1.429	Base DRG * 1.667
July 1, 2013 - June 30, 2014	Base DRG * 1.563	Base DRG * 1.823
July 1, 2014, and after	Base DRG + $40,000	Base DRG + $40,000

(b) The agency calculates the estimated costs of the claim by multiplying the total submitted charges, minus the nonallowed charges on the claim, by the hospital's ratio of costs-to-charges (RCC).

(c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria used to determine whether the claim qualifies for high outlier payment is the prorated DRG amount for the claim before the transfer payment.

(2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.

(a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:

(i) Pediatric services, including all claims submitted by children-specialty hospitals;

(ii) Burn services; and

(iii) Nonpediatric services.

(b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:

(i) Severity of illness (SOI) of one or two; or

(ii) SOI of three or four.

AP-DRG Dates of Admission	Pediatric	Burn	Nonpediatric
Before August 1, 2012	CAT * 0.95	CAT * 0.90	CAT * 0.85
August 1, 2012 - June 30, 2013	CAT * 0.998	CAT * 0.945	CAT * 0.893
July 1, 2013 - June 30, 2014	CAT * 0.912	CAT * 0.864	CAT * 0.816
APR-DRG Dates of Admission	**SOI 1 or 2**	**SOI 3 or 4**	
July 1, 2014, and after	CAT * 0.80	CAT * 0.95	

(3) For state-administered programs (SAP), the agency applies the hospital-specific ratable to the outlier adjustment factor.

(4) This subsection contains examples of outlier claim payment calculations.

DRG SOI	DRG Allowed Amount	Threshold[1]	Cost[2]	Outlier Percent	Ratable	Base DRG	Outlier[3]	Claim Payment[4]
1	$10,000	$50,000	$100,000	0.80	n/a	$10,000	$40,000	$50,000
3	$10,000	$50,000	$100,000	0.95	n/a	$10,000	$47,500	$57,500

1 Threshold = $40,000 + base DRG
2 Cost = Billed charges - noncovered charges - denied charges
3 Outlier = (cost - threshold) * outlier percent
4 Claim payment = base DRG + outlier

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 182-550-3000(8), the agency may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the outlier adjustment factors described in this section.

(6) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

(d) Any other adjustments as determined by the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-043, § 182-550-3700, filed 5/30/18, effective 7/1/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3700, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-3700, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 03-13-053, § 388-550-3700, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-3700, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303 and 447.2652. WSR 99-06-046, § 388-550-3700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3800 Rebasing. The medicaid agency redesigns (rebases) the medicaid inpatient payment system as needed. The base inpatient conversion factor and per diem rates are only updated during a detailed rebasing process, or as directed by the state legislature. Inpatient payment system factors such as the ratio of costs-to-charges (RCC), weighted costs-to-charges (WCC), and administrative day rate are rebased on an annual basis. As part of the rebasing, the agency does all of the following:

(1) Gathers data. The agency uses the following data resources considered to be the most complete and available at the time:

(a) One year of fee-for-service (FFS) paid claim data from the agency's medicaid management information system (MMIS). The agency excludes:

(i) Claims related to state programs and paid at the Title XIX reduced rates from the claim data; and

(ii) Critical access hospital claims paid per WAC 182-550-2598; and

(b) The hospital's most current medicare cost report data from the health care cost report information system (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS). If the hospital's medicare cost report from HCRIS is not available, the agency uses the medicare cost report provided by the hospital.

(c) FFS and managed care encounter data.

(2) Estimates costs. The agency uses one of two methods to estimate costs. The agency may perform an aggregate cost determination by multiplying the ratio of costs-to-charges (RCC) by the total billed charges, or the agency may use the following detailed costing method:

(a) The agency identifies routine and ancillary cost for operating capital, and direct medical education cost components using different worksheets from the hospital's medicare cost report;

(b) The agency estimates costs for each claim in the dataset as follows:

(i) Accommodation services. The agency multiplies the average hospital cost per day reported in the medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service; and

(ii) Ancillary services. The agency multiplies the RCC reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, or clinic) by the allowed charges reported at the claim line level by type of service; and

(c) The agency uses the following standard cost components for accommodation and ancillary services for estimating costs of claims:

(i) Routine cost components:

(A) Routine care;

(B) Intensive care;

(C) Intensive care-psychiatric;

(D) Coronary care;

(E) Nursery;

(F) Neonatal ICU;

(G) Alcohol/substance abuse;

(H) Psychiatric;

(I) Oncology; and

(J) Rehabilitation.

(ii) Ancillary cost components:

(A) Operating room;

(B) Recovery room;

(C) Delivery/labor room;

(D) Anesthesiology;

(E) Radio, diagnostic;

(F) Radio, therapeutic;

(G) Radioisotope;

(H) Laboratory;

(I) Blood administration;

(J) Intravenous therapy;

(K) Respiratory therapy;

(L) Physical therapy;

(M) Occupational therapy;

(N) Speech pathology;

(O) Electrocardiography;

(P) Electroencephalography;

(Q) Medical supplies;

(R) Drugs;

(S) Renal dialysis/home dialysis;

(T) Ancillary oncology;

(U) Cardiology;

(V) Ambulatory surgery;

(W) CT scan/MRI;

(X) Clinic;

(Y) Emergency;

(Z) Ultrasound;
(AA) NICU transportation;
(BB) GI laboratory;
(CC) Miscellaneous; and
(DD) Observation beds.

(3) Specifies resource use with relative weights. The agency uses national relative weights designed by 3M™ Corporation as part of its all-patient refined-diagnostic related group (APR-DRG) payment system. The agency periodically reviews and determines the most appropriate APR-DRG grouper version to use.

(4) Calculates base payment factors. The agency calculates the average, or base, DRG conversion factor and per diem rates. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter. The agency models the rebased system to be budget neutral on a prospective basis, including global adjustments to the budget target determined by the agency. The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients. The agency will publish base rate factors on its website.

(5) To maintain budget neutrality, the agency makes global adjustments as needed.

(a) Claims paid under the DRG, rehab per diem, and withdrawal management per diem payment methods were reduced to support an estimated three million five hundred thousand dollar increase in psychiatric payments to acute hospitals.

(b) Claims for acute hospitals paid under the psychiatric per diem method were increased by a factor to inflate estimated system payments by three million five hundred thousand dollars.

(c) Effective for dates of admission on and after October 1, 2017, the agency increased psychiatric per diem rates as directed by the legislature. The increase applies to any hospital with two hundred or more psychiatric bed days.

(i) The agency prioritized the increase for hospitals not currently paid based on provider-specific costs using a similar methodology to set rates for existing inpatient facilities utilizing cost report information for hospital fiscal years ending in 2016.

(ii) The distribution of funds for each fiscal year is as follows:

(A) Free-standing psychiatric hospitals receive 68.15 percent of the statewide average cost per day.

(B) All other hospitals receive the greater of 78.41 percent of their provider-specific cost, or their current medicaid psychiatric per diem rate.

(iii) The agency set the increased rates to assure that the distribution of funds does not exceed the amounts provided by the legislature.

(iv) The agency conducts annual reviews for updated cost information to determine whether new and existing providers meet the two hundred or more bed criteria.

(v) The agency will apply the same cost percentage criteria for future rebasing of the psychiatric per diem rates.

(6) Effective July 1, 2020, the agency sets psychiatric per diem rates specific to long-term civil commitments separately from other psychiatric per diem rates.

(a) In order to qualify for a provider-specific long-term civil commitment psychiatric per diem, the provider must be contracted with the agency to provide long-term civil commitment beds.

(b) The agency sets the provider-specific rate at the time of contracting.

(c) The agency sets the rate for acute care hospitals with distinct psychiatric units as follows:

(i) Hospitals that have a 12-month medicare cost report with at least 200 psychiatric bed days on file with the agency receive a long-term psychiatric per diem rate equivalent to the costs documented on the medicare cost report.

(ii) Hospitals that do not have a 12-month cost report with at least 200 bed days on file with the agency receive a long-term psychiatric per diem rate equivalent to the greater of the average of all acute care hospitals providing long-term psychiatric services in-state, provider-specific long-term psychiatric per diem rates, or the current short-term psychiatric per diem. The long-term psychiatric rate is applied to any hospital that accepts patients committed to a psychiatric facility for a period of 90 days or greater. The agency sets the rate so as not to exceed the amount provided by the legislature.

(d) The agency sets the rates for free-standing psychiatric hospitals as follows:

(i) Hospitals without an existing long-term rate receive a per diem rate equivalent to either the greater of the short-term rate or the state-wide average long-term psychiatric rate for free-standing psychiatric hospitals.

(ii) Hospitals that have an existing long-term per diem will continue to receive the $940 established for July 1, 2021. In addition to the $940 per diem rate, the hospital may submit supplemental cost data with the cost report to the agency for consideration. If approved, the agency will make appropriate adjustments to the medicaid inpatient psychiatric per diem payment rate of the hospital. Adjustment of costs may include any of the following:

(A) Costs associated with professional services and fees not accounted for in the hospital's medicare cost report or reimbursed separately;

(B) Costs associated with the hospital providing the long-term psychiatric patient access to involuntary treatment court services that are not reimbursed separately;

(C) Other costs associated with caring for long-term psychiatric patients that are not reimbursed separately.

(iii) The agency sets the rate so as to not exceed the amount provided by the legislature.

(7) Determines provider specific adjustments. The following adjustments are applied to the base factor or rate established in subsection (4) of this section:

(a) Wage index adjustments reflect labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(i) The agency determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(ii) The amount in (a)(i) of this subsection is multiplied by the most recent wage index information published by CMS at the time the rates are set; then

(iii) The agency adds the nonlabor portion of the base rate to the amount in (a)(ii) of this subsection to produce a hospital-specific wage adjusted factor.

(b) Indirect medical education factors are applied to the hospital-specific base factor or rate. The agency uses the indirect medical education factor established by medicare on the most currently available medicare cost report that exists at the time the rates are set; and

(c) Direct medical education amounts are applied to the hospital-specific base factor or rate. The agency determines a percentage of direct medical education costs to overall costs using the most currently available medicare cost report that exists at the time the rates are set.

(8) The final, hospital-specific rate is calculated using the base rate established in subsection (4) of this section along with any applicable adjustments in subsections (6) and (7) of this section.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 2021 c 334 §§ 211(46) and 215(66). WSR 22-03-008, § 182-550-3800, filed 1/6/22, effective 2/6/22. Statutory Authority: RCW 41.05.021, 41.05.160 and 2020 c 357 § 215 (24)(b). WSR 21-02-087, § 182-550-3800, filed 1/6/21, effective 2/6/21. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-043, § 182-550-3800, filed 5/30/18, effective 7/1/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3800, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 05-06-044, § 388-550-3800, filed 2/25/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-3800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3830 Adjustments to inpatient rates. (1) The medicaid agency updates all of the following components of a hospital's specific diagnosis-related group (DRG) factor and per diem rates at rebase:

(a) Wage index adjustment;

(b) Direct graduate medical education (DGME); and

(c) Indirect medical education (IME).

(2) Effective January 1, 2015, the agency updates the sole community hospital adjustment.

(3) The agency does not update the statewide average DRG factor between rebasing periods, except:

(a) To satisfy the budget neutrality conditions in WAC 182-550-3850; and

(b) When directed by the legislature.

(4) The agency updates the wage index to reflect current labor costs in the core-based statistical area (CBSA) where a hospital is located. The agency:

(a) Determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(b) Multiplies the amount in (a) of this subsection by the most recent wage index information published by the Centers for Medicare and Medicaid Services (CMS) when the rates are set; then

(c) Adds the nonlabor portion of the base rate to the amount in (b) of this subsection to produce a hospital-specific wage adjusted factor.

(5) DGME. The agency obtains DGME information from the hospital's most recently filed medicare cost report that is available in the CMS health care cost report information system (HCRIS) dataset.

(a) The hospital's medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(b) If a hospital's medicare cost report is not available on HCRIS, the agency may use the CMS Form 2552-10 to calculate DGME.

(c) If a hospital has not submitted a CMS medicare cost report in more than eighteen months from the end of the hospital's cost reporting period, the agency considers the current DGME costs to be zero.

(d) The agency calculates the hospital-specific DGME by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report.

(6) IME. The agency sets the IME adjustment equal to the "IME adjustment factor for Operating PPS" available in the most recent CMS final rule impact file on CMS's website as of May 1st of the rate-setting year.

(7) The agency considers an in-state hospital to qualify for a rate enhancement if all of the following conditions apply. The hospital must:

(a) Be certified by CMS as a sole community hospital as of January 1, 2013;

(b) Have a level III adult trauma service designation from the department of health as of January 1, 2014;

(c) Have less than one hundred fifty acute care licensed beds in fiscal year 2011;

(d) Be owned and operated by the state or a political subdivision;

(e) Not participate in the certified public expenditures (CPE) payment program defined in WAC 182-550-4650; and

(f) Accept single bed certification patients as of July 1, 2021, according to RCW 71.05.745.

(8) If an in-state hospital qualifies for the rate enhancement in subsection (7) of this section, effective:

(a) January 1, 2015, through June 30, 2018, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25.

(b) July 1, 2018, through June 30, 2023, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.50.

(c) July 1, 2023, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 2021 c 334 §§ 211(46) and 215(66). WSR 22-03-008, § 182-550-3830, filed 1/6/22, effective 2/6/22. Statutory Authority: RCW 41.05.021, 41.05.160, and 2019 c 415 § 211(14). WSR 20-01-075, § 182-550-3830, filed 12/11/19, effective 1/11/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-09-022, § 182-550-3830, filed 4/11/18, effective 5/12/18; WSR 15-10-014, § 182-550-3830, filed 4/23/15, effective 5/24/15; WSR 14-22-003, § 182-550-3830, filed 10/22/14, effective 11/22/14.]

WAC 182-550-3850 Budget neutrality adjustment and measurement. (1) The medicaid agency measures the effectiveness of budget neutral rebasing by applying a budget neutrality adjustment factor to the base

payment rates for both inpatient and outpatient hospitals as needed to maintain aggregate payments under rebased payment systems.

(a) The agency performs budget-neutrality adjustments and measurement by prospectively adjusting conversion factors and rates to offset unintentional aggregate payment system decreases or increases. The agency publishes conversion factors and rates which reflect any required budget neutrality adjustment.

(b) The following rates and factors are not adjusted by the BNAF:

(i) Inpatient per diem;

(ii) Ratio of costs-to-charges (RCC);

(iii) Critical access hospital (CAH) weighted costs-to-charges (WCC);

(iv) Inpatient pain management and rehabilitation (PM&R);

(v) Per-case rates;

(vi) Administrative day rates;

(vii) Long-term acute care (LTAC);

(viii) Chemical-using pregnant women (CUP);

(ix) Outlier parameters;

(x) Outpatient services paid at the resource-based relative value scale (RBRVS) fee;

(xi) Outpatient corneal transplants; and

(xii) Diabetic education.

(2) The agency measures budget neutrality on an ongoing basis after rebased system implementation as follows:

(a) The agency gathers inpatient and outpatient claims and encounter data from the rebased system implementation date to the end of the measurement period.

(i) The first measurement period is the initial six months following rebased payment system implementation.

(ii) Additional measurement periods occur no more frequently than quarterly thereafter.

(iii) The agency performs a final measurement period for data received through June 30, 2016.

(b) The agency sums the aggregate payment amounts separately for inpatient and outpatient services. The agency will make the following adjustments to the base data:

(i) The agency removes any reductions due to third-party liability (TPL), client responsibility, and client spenddown from the payment summary;

(ii) The agency removes any increase awarded by RCW 74.09.611(2) from inpatient services;

(iii) The agency includes any outpatient service lines which are bundled under the enhanced ambulatory patient group (EAPG) system, but would be otherwise payable under the ambulatory payment classification (APC) system; and

(iv) Other adjustments as necessary.

(c) The agency processes all claims and encounters using the rates, factors, and policies which were in effect on June 30, 2014, with the following exceptions:

(i) The agency uses the RCC effective on the date of service;

(ii) The agency uses the most recent RBRVS values for any outpatient service paid using the RBRVS; and

(iii) The agency updates APC relative weights to reflect the most recent relative weights supplied by CMS;

(iv) The agency adjusts the outpatient budget target adjuster (BTA) to offset the inflation factor applied to OPPS in the CMS OPPS final rule; and

(v) The agency may include other adjustments as necessary to ensure accurate payment determination.

(d) The agency aggregates payment amounts calculated under (c) of this subsection separately for inpatient and outpatient services.

(3) The agency will modify the conversion factors and rates to reflect aggregate changes in the overall payment system as follows:

(a) If the amount calculated in subsection (2)(b) of this section is between ninety-nine percent and one hundred one percent of the amount calculated in subsection (2)(d) of this section, no adjustment will be made to the conversion factors and rates currently in effect;

(b) If the amount calculated in subsection (2)(b) of this section is greater than one hundred one percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure of one hundred one percent from the rebased payment system implementation date to the end of the subsequent six-month period;

(c) If the amount calculated in subsection (2)(b) of this section is less than ninety-nine percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure decrease of ninety-nine percent from the rebased payment system implementation date to the end of the subsequent six-month period.

(4) The agency applies adjustments to the BNAF to rates prospectively at the beginning of the calendar quarter following the measurement.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-3850, filed 6/25/14, effective 7/26/14.]

WAC 182-550-3900 Payment method—Bordering city hospitals and critical border hospitals. The agency uses the payment methods described in this section to pay bordering city hospitals and critical border hospitals for inpatient and outpatient claims. Bordering city hospitals and critical border hospitals are defined in WAC 182-550-1050.

(1) For inpatient hospital claims from bordering city hospitals, the agency calculates the payment for allowed covered charges related to medically necessary services, by using the lowest of the in-state inpatient hospital rates for the:

(a) Diagnosis-related group (DRG) conversion factor;

(b) Per diem payment method;

(c) Per case payment method; and

(d) Ratio of costs-to-charges (RCC) payment method.

(2) For outpatient hospital claims from bordering city hospitals, the agency calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the in-state outpatient hospital rates for the outpatient prospective payment system (OPPS). Refer to WAC 182-550-7000 through 182-550-7600.

(3) Designated critical border hospitals.

(a) The agency designates certain qualifying hospitals located out-of-state as critical border hospitals. A designated critical border hospital must:

(i) Be a bordering city hospital as described in WAC 182-550-1050; and

(ii) Have submitted at least ten percent of the total nonemergency inpatient hospital claims paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington apple health. Nonemergency inpatient hospital claims are defined as those that do not include emergency department charges (revenue code 045X series).

(b) The agency analyzes bordering city hospitals' base period claims data during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies or continues to qualify as a critical border hospital.

(4) Critical border hospitals - Inpatient hospital claim payment methods. The agency pays inpatient critical border hospital claims as follows:

(a) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. The rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital.

(b) The agency pays inpatient critical border hospital claims using the same payment methods and rates used for in-state hospital claims, including DRG, RCC, per diem, outliers, and per case rate, subject to the following:

(i) Inpatient payment rates used to pay critical border university hospitals for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an in-state university hospital;

(ii) Inpatient payment rates used to pay critical border Level 1 trauma centers for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an in-state Level 1 trauma center; and

(iii) Inpatient payment rates used to pay critical border hospitals that are not university hospitals or Level 1 trauma centers cannot exceed the highest corresponding in-state inpatient payment rate for in-state hospitals not designated as university hospitals or Level 1 trauma centers.

(5) Critical border hospitals - Outpatient hospital claim payment methods. The agency pays outpatient critical border hospital claims using the same payment methods used for in-state outpatient hospital claims (see WAC 182-550-7000 through 182-550-7600 and 182-550-4500), subject to the following:

(a) Outpatient rates used to pay critical border university hospitals for outpatient claims cannot exceed the highest corresponding rate for an in-state university hospital;

(b) Outpatient rates used to pay critical border Level 1 trauma centers for outpatient claims cannot exceed the highest corresponding rate for an in-state Level 1 trauma center; and

(c) Outpatient rates used to pay critical border hospitals that are not university hospitals or Level 1 trauma centers cannot exceed the highest corresponding rate for in-state hospitals not designated as university hospitals or Level 1 trauma centers.

(6) Critical border hospitals are eligible to receive payment for graduate medical education (GME). All other bordering city hospitals are not eligible to receive payment for GME.

(7) The agency makes:

(a) Claim payment adjustments, including but not limited to, third-party liability, medicare, and client responsibility; and

(b) Other necessary adjustments, as directed by the legislature (e.g., rate rebasing and other changes).

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3900, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3900, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3900, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4000 Payment method—Out-of-state hospitals. This section describes the payment methods the agency uses to pay hospitals located out-of-state for providing services to eligible Washington apple health clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 182-501-0175. Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC 182-550-3900. See also WAC 182-501-0180, health care services provided outside the state of Washington - General provisions, and WAC 182-502-0120, payment for health care services provided outside the state of Washington.

(1) Emergency hospital services.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals, the agency:

(i) Pays using the same methods used to pay in-state hospitals as specified in this chapter; and

(ii) Calculates the payment using the lowest in-state inpatient hospital rate corresponding to the payment method.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals, the agency pays an out-of-state hospital using the following methods:

(i) The agency's outpatient prospective payment system (OPPS) described in WAC 182-550-7000;

(ii) The maximum allowable fee schedule method described in WAC 182-550-6000. When the maximum allowable fee schedule method is used, the agency limits payment to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount; and

(iii) The hospital outpatient RCC payment method described in WAC 182-550-4500. When using the RCC payment method, the agency pays the lowest in-state hospital outpatient RCC, excluding weighted costs-to-charges (WCC) rates that are paid to in-state critical access hospitals.

(2) Nonemergency hospital services.

(a) The agency pays for:

(i) Contracted and prior authorized nonemergency hospital services according to the contract terms whether or not the hospital has signed a core provider agreement; and

(ii) Nonemergency hospital services authorized by the agency after the fact (subsequent to the date of admission, if the client is

still at the out-of-state hospital, or after the services have been provided) according to subsections (1) and (3) of this section.

(b) The agency does not pay for:

(i) Nonemergency hospital services provided to a Washington apple health client in a hospital located out-of-state unless the hospital is contracted and prior authorized by the agency or the agency's designee for the specific service provided to a specific client; and

(ii) Unauthorized nonemergency hospital services are not paid by the agency. See WAC 182-501-0182.

(3) The agency makes claim payment adjustments including, but not limited to, client responsibility, third-party liability, and medicare. All applicable adjustments are factored into the final hospital payment amount.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4000, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-4000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, the agency considers as new:

(a) A hospital which began services after the most recent rebasing; or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) With the exception of determining psychiatric per diem rates as directed by the Washington state legislature (see WAC 182-550-3800(6)), the agency determines a new hospital's conversion factor, per diem rate, or per case rate, to be the statewide average rate for the conversion factor, category of per diem rate, or per case rate adjusted by the geographically appropriate hospital specific medicare wage index.

(3) The agency determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC for all current Washington in-state hospitals.

(4) When a hospital changes ownership, the agency does not consider it a new hospital.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-03-009, § 182-550-4100, filed 1/6/22, effective 2/6/22. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4100, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050,

70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4200 Change in hospital ownership. (1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition, or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital must notify the medicaid agency in writing ninety days before the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the agency sets the new provider's cost-based conversion factor (CBCF), conversion factor, per diem rates, per case rate, at the same level as the prior owner's, except as provided in subsection (4) of this section.

(4) The agency sets for a hospital formed as a result of a merger:

(a) A blended CBCF, conversion factor, per diem rate, per case rate, based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 182-550-4500. Partial year cost reports will not be used for this purpose.

(5) The agency recaptures depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-4200, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4200, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-

charges (RCC) payment method described in WAC 182-550-4500, the per diem payment method described in WAC 182-550-3000, the per case rate payment method described in WAC 182-550-3000, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). Inpatient services provided by hospitals and units are exempt from the DRG payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) The agency exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to clients eligible for Washington apple health:

(a) Hospitals participating in the agency's certified public expenditure (CPE) payment program (see WAC 182-550-4650);

(b) Hospitals participating in the agency's critical access hospital program (see WAC 182-550-2598);

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000);

(d) Military hospitals when no other specific arrangements have been made with the agency. The agency, or the military hospital, may elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) Per diem payment method; or

(ii) DRG payment method; and

(e) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000). An agency designee that arranges to directly pay a hospital and/or a designated distinct psychiatric unit of a hospital may use the agency's payment methods or contract with the hospital to pay using different methods.

(3) Inpatient psychiatric services, Involuntary Treatment Act services, and withdrawal management services provided in out-of-state hospitals are not covered or paid by the agency or the agency's designee. The agency does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:

(a) Medical care services; and

(b) Other state-administered programs.

(4) The agency has established an average length of stay (ALOS) for each DRG classification and publishes it on the agency's website. The agency uses the DRG ALOS as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the agency's DRG ALOS benchmark or prior authorized LOS:

(a) For a psychiatric inpatient stay, the hospital must obtain approval for additional days beyond the prior authorized days from the agency or the agency's designee who prior authorized the admission. See WAC 182-550-2600;

(b) For an acute physical medicine and rehabilitation (PM&R) or a long term acute care (LTAC) stay, the hospital must obtain approval for additional days beyond the prior authorized days from the agency unit that prior authorized the admission. See WAC 182-550-2561 and 182-550-2590;

(c) For an inpatient hospital stay for withdrawal management for a chemical using pregnant (CUP) client, see WAC 182-550-1100;

(d) For other medical inpatient stays for withdrawal management, see WAC 182-550-1100;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC 182-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the agency may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-03-007, § 182-550-4300, filed 1/6/22, effective 2/6/22; WSR 21-15-128, § 182-550-4300, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4300, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4300, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4400 Services—Exempt from DRG payment. (1) Inpatient services are exempt from the diagnosis-related group (DRG) payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) Subject to the restrictions and limitations in this section, the agency exempts the following services for medicaid and CHIP clients from the DRG payment method. This policy also applies to covered services paid through medical care services (MCS) and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Withdrawal management services when provided in a hospital having a withdrawal management provider agreement with the agency to perform these services.

(b) Hospital-based intensive inpatient withdrawal management, medical stabilization, and drug treatment services provided to chemical-using pregnant (CUP) women by a certified hospital. These are medicaid program services and are not covered or funded by the agency through MCS or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. An agency designee that arranges to pay a hospital directly for psychiatric services may use the agency's payment methods or contract with the hospital to pay using different methods.

(e) Chronic pain management treatment provided in a hospital approved by the agency to provide that service.

(f) Administrative day services. The agency pays administrative days for one or more days of a hospital stay in which an acute inpa-

tient or observation level of care is not medically necessary, and a lower level of care is appropriate. The administrative day rate is based on the statewide average daily medicaid nursing facility rate, which is adjusted annually. The agency may designate part of a client's stay to be paid an administrative day rate upon review of the claim or the client's medical record, or both.

(g) Inpatient services recorded on a claim grouped by the agency to a DRG for which the agency has not published an all-patient DRG (AP-DRG) or all-patient refined DRG (APR-DRG) relative weight. The agency will deny payment for claims grouped to DRG 469, DRG 470, APR DRG 955, or APR DRG 956.

(h) Organ transplants that involve heart, intestine, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The agency pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method. The agency maintains a list of DRGs which qualify as transplants on the agency's website.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-4400, filed 7/21/21, effective 8/21/21; WSR 19-04-004, § 182-550-4400, filed 1/23/19, effective 3/1/19; WSR 16-04-051, § 182-550-4400, filed 1/28/16, effective 3/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4400, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4400, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-550-4400, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-4400, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4500 Payment method—Ratio of costs-to-charges (RCC). (1) The medicaid agency pays hospitals using the ratio of costs-to-charges (RCC) payment method for services exempt from the following payment methods:

(a) Ambulatory payment classification (APC);

(b) Diagnosis-related group (DRG);

(c) Enhanced ambulatory patient group (EAPG);

(d) Per case;

(e) Per diem; and

(f) Maximum allowable fee schedule.

(2) The agency:

(a) Determines the payment for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC by the allowed covered charges for medically necessary services; and

(ii) Outpatient claims by multiplying the hospital's outpatient RCC by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection:

(i) All applicable adjustments for client responsibility;

(ii) Any third-party liability;

(iii) Medicare payments; and

(iv) Any other adjustments as determined by the agency.

(c) Limits the RCC payment to the hospital's usual and customary charges for services allowed by the agency.

(3) The agency uses the RCC payment method to calculate the following:

(a) Payment for the following services:

(i) Organ transplant services (see WAC 182-550-4400 (4)(h));

(ii) Hospital services provided at a long-term acute care (LTAC) facility not covered under the LTAC per diem rate (see WAC 182-550-2596); and

(iii) Any other hospital service identified by the agency as being paid by the RCC payment method; and

(b) Costs for the following:

(i) High outlier qualifying claims (see WAC 182-550-3700); and

(ii) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments under WAC 182-550-4650(5).

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 182-550-3000(8), the agency may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection (3) of this section.

(5) This section explains how the agency calculates each in-state and critical border hospital's RCC. For noncritical border city hospitals, see WAC 182-550-3900. The agency:

(a) Divides adjusted costs by adjusted patient charges. The agency determines the allowable costs and associated charges.

(b) Excludes agency nonallowed costs and nonallowed charges, such as costs and charges attributable to a change in ownership.

(c) Bases the RCC calculation on data from the hospital's annual medicare cost report (Form 2552) and applicable patient revenue reconciliation data provided by the hospital. The medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC annually after the hospital sends its hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the agency. If medicare grants a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary, the agency may determine an alternate method to adjust the RCC.

(e) Limits a noncritical access hospital's RCC to one point zero (1.0).

(6) For a hospital formed as a result of a merger (see WAC 182-550-4200), the agency combines the previous hospital's medicare cost reports and follows the process in subsection (5) of this section. The agency does not use partial year cost reports for this purpose.

(7) For newly constructed hospitals and hospitals not otherwise addressed in this chapter, the agency annually calculates a weighted average in-state RCC by dividing the sum of agency-determined costs for all in-state hospitals with RCCs by the sum of agency-determined charges for all hospitals with RCCs.

(8) The agency calculates each hospital's outpatient RCC annually. The agency calculates:

(a) A hospital's outpatient RCC by multiplying the hospital's inpatient RCC by the outpatient adjustment factor (OAF); and

(b) The weighted average in-state hospital outpatient RCC by multiplying the in-state weighted average inpatient RCC by the OAF.

(9) The OAF:

(a) Is the ratio between the outpatient and inpatient RCC payments;

(b) Is updated annually to adjust for cost and charge inflation; and

(c) Must not exceed one point zero (1.0).

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4500, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-4500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-4500, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4550 Administrative day rate and swing bed day rate. (1) **Administrative day rate.**

(a) The medicaid agency allows hospitals an administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because:

(i) An appropriate placement outside the hospital is not available (no placement administrative day); or

(ii) The postpartum parent's newborn remains on an inpatient claim for monitoring post-in utero exposure to substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (newborn administrative day). "Postpartum parent" means the client who delivered the baby(ies).

(b) The agency uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1st of each year.

(c) The agency does not pay for ancillary services, except for pharmacy services and pharmaceuticals, provided during administrative days.

(d) The agency identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(e) The agency pays for up to five newborn administrative days. The agency pays for additional days with expedited prior authorization (EPA). For EPA, a hospital must establish that the clinically appropriate EPA criteria outlined in the agency's published billing guides have been met. The hospital must use the appropriate EPA number when billing the agency.

(f) The agency pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a no placement administrative day stay.

(g) The agency pays the hospital the newborn administrative day rate only if:

(i) The postpartum parent rooms in with their newborn and provides parental support/care; and

(ii) The hospital provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder.

(2) **Swing bed day rate.** The agency allows hospitals a swing bed day rate for those days when a client is receiving agency-approved nursing service level of care in a swing bed. The agency's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The agency does not pay a hospital the rate applicable to the acute inpatient level of care for those days of a hospital stay when a client is receiving agency-approved nursing service level of care in a swing bed.

(b) The agency's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 182-550-6000 and 182-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The agency allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving agency-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The agency does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-13-044, § 182-550-4550, filed 6/7/22, effective 10/1/22; WSR 19-18-026, § 182-550-4550, filed 8/28/19, effective 9/28/19; WSR 15-18-065, § 182-550-4550, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-4550, filed 5/28/09, effective 7/1/09.]

WAC 182-550-4650 "Full cost" public hospital certified public expenditure (CPE) payment program. (1) The medicaid agency's "full cost" public hospital certified public expenditure (CPE) inpatient payment program provides payments to participating government-operated hospitals based on the "full cost" of covered medically necessary services and requires the expenditure of local funds in lieu of state funds to qualify for federal matching funds. The agency's inpatient payments to participating hospitals equal the federal matching amount for allowable costs. The agency uses the ratio of costs-to-charges (RCC) method described in WAC 182-550-4500 to determine "full cost."

(2) To be eligible for the "full cost" public hospital CPE payment program, the hospital must be:

(a) Operated by a public hospital district in the state of Washington, not certified by the department of health (DOH) as a critical access hospital, and has not chosen to opt-out of the CPE payment program as allowed in subsection (6) of this section;

(b) Harborview Medical Center; or

(c) University of Washington Medical Center.

(3) Payments made under the inpatient CPE payment program are limited to medically necessary services provided to medical assistance clients eligible for inpatient hospital services.

(4) Each hospital described in subsection (2) of this section is responsible to provide certified public expenditures as the required state match for claiming federal medicaid funds.

(5) The agency determines the initial payment for inpatient hospital services under the CPE payment program by:

(a) Multiplying the hospital's medicaid RCC by the covered charges (to determine allowable costs), then;

(b) Subtracting the client's responsibility and any third party liability (TPL) from the amount derived in (a) of this subsection, then;

(c) Multiplying the state's federal medical assistance percentage (FMAP) by the amount derived in (b) of this subsection.

(6) A hospital may opt-out of the inpatient CPE payment program if the hospital:

(a) Meets the criteria for the inpatient rate enhancement under RCW 74.09.5225; or

(b) Is not eligible for public hospital disproportionate share hospital (PHDSH) payments under WAC 182-550-5400.

(7) To opt-out of the inpatient CPE payment program, the hospital must submit a written request to opt-out to the agency's chief financial officer by July 1st in order to be effective for January 1st of the following year.

(8) Hospitals participating in the inpatient CPE payment program must complete the applicable CPE medicaid cost reports as described in WAC 182-550-5410 for the inpatient fee-for-service cost settlements.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-09-079, § 182-550-4650, filed 4/20/22, effective 5/21/22. Statutory Authority: RCW 41.05.021, 41.05.160, and 74.09.5225(3). WSR 15-11-009, § 182-550-4650, filed 5/7/15, effective 6/7/15. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 433.51(b). WSR 12-04-022, § 182-550-4650, filed 1/25/12, effective 2/25/12. WSR 11-14-075, recodified as § 182-550-4650, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 06-08-046, § 388-550-4650, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4650, filed 6/1/05, effective 7/1/05.]

WAC 182-550-4670 CPE payment program——"Hold harmless" provision. To meet legislative requirements, the medicaid agency includes a "hold harmless" provision for eligible hospitals participating in certified public expenditure (CPE) payment programs under WAC 182-550-4650 and 182-550-5400. Under the provision and subject to legislative directives and appropriations, hospitals eligible for payments under CPE payment programs will receive no less in combined state and federal payments than they would have received under the methodologies otherwise in effect as described in this section. All hospital submissions pertaining to CPE payment programs including, but not limited to, cost report schedules, are subject to audit at any time by the agency or its designee.

(1) The agency:

(a) Uses historical cost and payment data trended forward to calculate prospective hold harmless grant payment amounts for the current state fiscal year (SFY); and

(b) Reconciles these hold harmless grant payment amounts when the actual claims data are available for the current fiscal year.

(2) For SFYs 2006 through 2009, the agency calculates what the hospital would have been paid under the methodologies otherwise in effect for the SFY as the sum of:

(a) The total payments for inpatient claims for patients admitted during the fiscal year, calculated by repricing the claims using:

(i) For SFYs 2006 and 2007, the inpatient payment method in effect during SFY 2005; or

(ii) For SFYs 2008 and 2009, the payment method that would otherwise be in effect during the CPE payment program year if the CPE payment program had not been enacted.

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(3) For SFY 2010 and beyond, the agency calculates what the hospital would have been paid under the methodologies otherwise in effect for the SFY as the sum of:

(a) The total of the inpatient claim payment amounts that would have been paid during the SFY had the hospital not been in the CPE payment program;

(b) One-half of the indigent assistance disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005; and

(c) All of the other disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005 to the extent the same disproportionate share hospital programs exist in the 2009-2011 biennium.

(4) For each SFY, the agency determines total state and federal payments made under the programs, including:

(a) Inpatient claim payments;

(b) Disproportionate share hospital (DSH) payments;

(c) Supplemental upper payment limit payments, as applicable; and

(d) The federal portion of medicaid program supplemental payments received by the hospitals.

(5) A hospital may receive a hold harmless grant, subject to legislative directives and appropriations, when the following calculation results in a positive number:

(a) For SFY 2006 through SFY 2009, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (2) of this section; or

(b) For SFY 2010 and beyond, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (3) of this section.

(6) The agency calculates interim hold harmless and final hold harmless grant amounts as follows:

(a) An interim hold harmless grant amount is calculated approximately ten months after the end of the SFY to include the paid claims for the same SFY admissions. Claims are subject to utilization review prior to the interim hold harmless calculation. Prospective grant payments made under subsection (1) of this section are deducted from the calculated interim hold harmless grant amount to determine the net grant payment amount due to or due from the hospital.

(b) The final hold harmless grant amount is calculated at such time as the final allowable federal portions of program payments are

determined. The procedure is the same as the interim grant calculation, but it includes all additional claims that have been paid or adjusted since the interim hold harmless calculation. Claims are subject to utilization review and audit prior to the final calculation of the hold harmless amount. Interim grant payments determined under (a) of this subsection are deducted from this final calculation to determine the net final hold harmless amount due to or due from the hospital.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2022 c 297 § 211(21). WSR 22-23-162, § 182-550-4670, filed 11/23/22, effective 1/1/23. Statutory Authority: RCW 41.05.021, 41.05.160, and 74.09.5225(3). WSR 15-11-009, § 182-550-4670, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-550-4670, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 10-11-032, § 388-550-4670, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-20-032, § 388-550-4670, filed 9/22/08, effective 10/23/08; WSR 07-14-090, § 388-550-4670, filed 6/29/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9). WSR 06-11-100, § 388-550-4670, filed 5/17/06, effective 6/17/06.]

WAC 182-550-4690 Authorization requirements and utilization review for hospitals eligible for CPE payments. This section does not apply to psychiatric certified public expenditure (CPE) inpatient hospital admissions. See WAC 182-550-2600.

(1) CPE inpatient hospital claims submitted to the medicaid agency must meet all authorization and program requirements in WAC and current agency-published issuances.

(2) The agency performs utilization reviews of inpatient hospital:

(a) Admissions under the requirements of 42 C.F.R. 456, subparts A through C; and

(b) Claims for compliance with medical necessity, appropriate level of care and the agency's (or an agency designee's) established length of stay (LOS) standards.

(3) For CPE inpatient admissions before August 1, 2007, the agency performs utilization reviews using the professional activity study (PAS) length of stay (LOS) standard in WAC 182-550-4300 on claims that qualified for ratio of costs-to-charges (RCC) payment before July 1, 2005.

(4) For claims identified in this subsection, the agency may request a copy of the client's hospital medical records and itemized billing statements. The agency sends written notification to the hospital detailing the agency's findings. Any day of a client's hospital stay that exceeds the LOS standard:

(a) Is paid under a non-DRG payment method if the agency determines it to be medically necessary for the client at the acute level of care;

(b) Is paid as an administrative day (see WAC 182-550-1050 and 182-550-4500(8)) if the agency determines it to be medically necessary for the client at the subacute level of care; and

(c) Is not eligible for payment if the agency determines it was not medically necessary.

(5) For CPE inpatient admissions after July 31, 2007, CPE hospital claims are subject to the same utilization review rules as non-CPE hospital claims.

(a) LOS reviews may be performed under WAC 182-550-4300.

(b) All claims are subject to the agency's medical necessity review under WAC 182-550-1700(2).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-01-204, § 182-550-4690, filed 12/23/15, effective 1/23/16; WSR 15-18-065, § 182-550-4690, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4690, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-20-032, § 388-550-4690, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9). WSR 06-11-100, § 388-550-4690, filed 5/17/06, effective 6/17/06.]

WAC 182-550-4700 Payment—Non-SCA participating hospitals. This section applies only for dates of admission before July 1, 2007. The hospital selective contracting program ends on June 30, 2007.

(1) In a selective contracting area (SCA), the medicaid agency pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) The agency pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the agency to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

County	Community Travel Distance Standard
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles

County	Community Travel Distance Standard
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his or her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain the services from a contracting hospital appropriate to the client's condition.

(3) The agency requires prior authorization for all nonemergent admissions to nonparticipating hospitals in an SCA. See WAC 182-550-1700.

(4) The agency pays a licensed hospital all applicable medicare deductible and coinsurance amounts for inpatient services provided to medicaid clients who are also beneficiaries of medicare Part A subject to the medicaid maximum allowable as established in WAC 182-550-1200 (8)(a).

(5) The agency pays any licensed hospital DRG-exempt services as listed in WAC 182-550-4400.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-4700, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-12-040, § 388-550-4700, filed 5/30/07, effective 7/1/07. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-4700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4800 Hospital payment methods—State-administered programs. This section does not apply to out-of-state hospitals unless they are border hospitals (critical or noncritical).

(1) The medicaid agency:

(a) Pays for services provided to a client eligible for a state-administered program (SAP) based on SAP rates;

(b) Establishes SAP rates independently from the process used in setting the medicaid payment rates;

(c) Calculates a ratable each year to adjust each hospital's SAP rates for their percentage of community-based dollars to the total revenues for all hospitals;

(d) Calculates an equivalency factor (EF) to keep the SAP payment rates at the same level before and after the medicaid rates were rebased.

(2) The agency has established the following:

(a) SAP diagnosis-related group (DRG) conversion factor (CF) for claims grouped under DRG classifications services;

(b) SAP per diem rates for claims grouped under the following specialty service categories:

(i) Chemical-using pregnant (CUP) women;

(ii) Detoxification;

(iii) Physical medicine and rehabilitation (PM&R); and

(iv) Psychiatric.

(c) SAP ratio of costs-to-charges (RCC) for claims grouped under transplant services.

(3) This subsection describes the SAP DRG CF and payment calculation processes used by the agency to pay claims using the DRG payment method. The agency pays for services grouped to a DRG classification provided to clients eligible for a SAP based on the use of a DRG CF, a DRG relative weight, and a maximum service adjustor. This process is similar to the payment method used to pay for medicaid and CHIP services grouped to a DRG classification.

(a) The agency's SAP DRG CF calculation process is as follows:

(i) The hospital's specific DRG CF used to calculate payment for a SAP claim is the medicaid DRG CF multiplied by the applicable EF multiplied by the ratable;

(ii) For hospitals that do not have a ratable or an EF, the SAP CF is the hospital's specific medicaid CF multiplied by the average EF and the average ratable; and

(iii) For noncritical border hospitals, the SAP DRG CF is the lowest in-state medicaid DRG CF multiplied by the average ratable and the average EF.

(b) The agency calculates the SAP DRG EF as follows:

(i) The hospital-specific current SAP DRG CF is divided by the rebased medicaid DRG CF and then divided by the ratable factor to compute the preliminary EF.

(ii) The current SAP DRG payment is determined by multiplying the hospital-specific SAP DRG CF by the APR-DRG relative weight.

(iii) The current aggregate DRG payment is determined by summing the current SAP DRG payments for all hospitals.

(iv) The hospital projected SAP DRG payment is determined by multiplying the hospital-specific current SAP DRG CF by the APR-DRG relative weights and the maximum service adjustor.

(v) The projected aggregate DRG payment is determined by summing the projected SAP program DRG payments for all hospitals.

(vi) The aggregate amounts derived in (b)(iii) and (v) of this subsection are compared to identify a neutrality factor that keeps the projected aggregate SAP DRG payment (based on APR-DRG relative weights) at the same level as the previous aggregate SAP DRG payment (based on APR-DRG relative weights).

(vii) The neutrality factor is multiplied by the hospital-specific preliminary EF to determine the hospital-specific final EF that is

used to determine the SAP DRG conversion factors for the rebased system implementation.

(c) The agency calculates the DRG payment for services paid under the DRG payment method as follows:

(i) The agency calculates the allowed amount for the inlier portion of the SAP DRG payment by multiplying the SAP DRG CF by the DRG relative weight and the maximum service adjustor.

(ii) SAP claims are also subject to outlier pricing. See WAC 182-550-3700 for details on outlier pricing.

(4) This subsection describes how the agency calculates the SAP per diem rate and payment for CUP, detoxification, PM&R, and psychiatric services.

(a) The agency calculates the SAP per diem rate for in-state and critical border hospitals by multiplying the hospital's specific medicaid per diem by the ratable and the per diem EF.

(b) The agency calculates the SAP per diem rate for noncritical border hospitals by multiplying the lowest in-state medicaid per diem rate by the average ratable and the average per diem EF.

(c) For hospitals with more than twenty nonpsychiatric SAP per diem paid services during SFY 2011, the agency calculates a per diem EF for each hospital using the individual hospital's claims as follows:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments by the total number of days associated with the payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payments (same claims used in (c)(i) of this subsection).

(iii) The agency divides the hospital estimated SAP average payment per day in (a) of this subsection by the hospital medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (c)(iii) of this subsection by the hospital-specific ratable factor to determine the EF.

(d) For hospitals with twenty or less nonpsychiatric SAP per diem paid services during SFY 2011, the EF is an average for all hospitals. The agency uses the following process to determine the average EF:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments for all hospitals by the total number of days associated with the aggregate payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payment (same claims used in (d)(i) of this subsection).

(iii) The agency divides the SAP average per day in (a) of this subsection by the medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (d)(iii) of this subsection by the hospital-specific ratable factor to determine the EF. The EF is an average based on claims for all the hospitals in the group.

(e) The agency uses a psychiatric EF to keep SAP psychiatric rates at the level required by the Washington state legislature. The agency's SAP psychiatric rates are eighty-five and four one hundredths of a percent (85.04%) of the agency's medicaid psychiatric rates. The factor is applied to all hospitals.

(f) The agency calculates the SAP per diem allowed amount for CUP, detoxification, PM&R, and psychiatric services by multiplying the hospital's SAP per diem rate by the agency's allowed patient days.

(g) The agency does not apply the high outlier or transfer policy to the payment calculations for CUP, detoxification, PM&R, and psychiatric services.

(5) The agency calculates the SAP RCC by multiplying the medicaid RCC by the hospital's ratable.

(6) The agency annually establishes the hospital-specific ratable factor used in the calculation of SAP payment rate based on the most current hospital revenue data available from the department of health (DOH). The agency uses the following process to determine the hospital ratable factor:

(a) The agency adds the hospital's medicaid revenue, medicare revenue, charity care, and bad debts as reported in DOH data.

(b) The agency determines the hospital's community care dollars by subtracting the hospital's low-income disproportionate share hospital (LIDSH) payments from the amount derived in (a) of this subsection.

(c) The agency calculates the hospital net revenue by subtracting the hospital-based physician revenue (based on information available from the hospital's medicare cost report or provided by the hospitals) from the DOH total hospital revenue report.

(d) The agency calculates the preliminary hospital-specific ratable by dividing the amount derived in (b) of this subsection by the amount derived in (c) of this subsection.

(e) The agency determines a neutrality factor by comparing the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the preliminary ratable to the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the prior year ratable. The neutrality factor is used to keep the projected SAP payments at the same current payment level.

(f) The agency determines the final hospital-specific ratable by multiplying the hospital-specific preliminary ratable by the neutrality factor.

(g) The agency applies to the allowable for each SAP claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(7) The agency does not pay a SAP claim paid by the DRG method at greater than the billed charges.

(8) SAP rates do not apply to the critical access hospital (CAH) program's weighted cost-to-charges, to the long-term acute care (LTAC) program's per diem rate, or to the certified public expenditure (CPE) program's RCC (except as the RCC applies to the CPE hold harmless described under WAC 182-550-4670).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-22-045, § 182-550-4800, filed 10/27/21, effective 11/27/21; WSR 19-04-004, § 182-550-4800, filed 1/23/19, effective 3/1/19; WSR 18-12-043, § 182-550-4800, filed 5/30/18, effective 7/1/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4800, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4800, filed 6/1/05,

effective 7/1/05. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 04-19-113, § 388-550-4800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 02-21-019, § 388-550-4800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-4800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652. WSR 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-4800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by Section 1902 (a)(13)(A) of the Social Security Act (42 U.S.C. 1396 (a)(13)(A)) and RCW 74.09.730, the medicaid agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 U.S.C. 1396r-4;

(b) It satisfies all the requirements of agency rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the twelve-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the SFY two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the agency which the agency uses to verify medicaid client eligibility and applicable inpatient days.

(e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the agency during a SFY. If a hospital does not qualify for DSH, the agency will not calculate the hospital-specific DSH cap and the hospital will not receive DSH payments.

(f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state ad-

ministered programs, medicare Part A, Title XXI, the refugee program and the TAKE CHARGE program.

(g) "Low income utilization rate (LIUR)" means the sum of the following two percentages used to determine whether a hospital is DSH-eligible:

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus

(ii) The ratio of inpatient charity care charges less inpatient cash subsidies received by the hospital from state and local governments, less contractual allowances and discounts, divided by total charges for inpatient services.

(h) "Medicaid inpatient utilization rate (MIPUR)" means the calculation (expressed as a percentage) used to determine whether a hospital is DSH-eligible. The numerator of which is the hospital's number of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the twelve-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Is not a small rural hospital as defined in (n) of this subsection; and

(iv) Is located in the state of Washington or in a designated bordering city. For DSH purposes, the agency considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(m) "Statewide disproportionate share hospital (DSH) cap" means the maximum amount per SFY that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(n) "Small rural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Has fewer than seventy-five acute beds;

(iv) Is located in the state of Washington; and

(v) Is located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(o) "Uninsured patient" means a person without creditable coverage as defined in 45 C.F.R. 146.113. (An "insured patient," for DSH program purposes, is a person with creditable coverage, even if the insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the agency considers only services that would have been covered and paid through the agency's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital must meet the criteria in this section:

(a) DSH application requirements.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the agency receives the hospital's DSH application by the deadline posted on the agency's website.

(b) The DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The agency reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the agency finds that a hospital's application is incomplete or contains incorrect information, the agency will notify the hospital. The hospital must submit a new, corrected application. The agency must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The agency must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(c) Official DSH application.

(i) The agency considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the agency finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC 182-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital satisfies the medicaid inpatient utilization rate (MIPUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a MIPUR of one percent or more; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's MIPUR, the agency uses inpatient days as follows:

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DSH reporting data file (DRDF) process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the agency uses paid medicaid days from MMIS.

(7) The agency administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Medical care services disproportionate share hospital (MCSDSH);

(c) Small rural disproportionate share hospital (SRDSH);

(d) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(e) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(f) Public hospital disproportionate share hospital (PHDSH);

(g) Children's health program disproportionate share hospital (CHPDSH); and

(h) Sole community disproportionate share hospital (SCDSH).

(8) The agency allows a hospital to receive any one or all of the DSH payment it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the agency calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The agency does not use base year data for MCSDSH and CHPDSH payments, which are calculated based on specific claims data.

(10) The agency's total DSH payments to a hospital for any given SFY cannot exceed the hospital-specific DSH cap for that SFY. Except for critical access hospitals (CAHs), the agency determines a hospital's DSH cap as follows. The agency:

(a) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the agency:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the agency's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the agency's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the agency will adjust DSH payments to each hospital to account for the amount overpaid. The agency makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) SCDSH;

(e) NRIADSH;

(f) MCSDSH;

(g) CHPDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the agency will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program regulations in the Washington Administrative Code for description of how amounts to be recouped are determined.

(15) The total amount the agency may distribute annually under a particular DSH program is capped by legislative appropriation. Any changes in payment amount to a hospital in a particular DSH program means a redistribution of payments within that DSH program. When necessary, the agency will recoup from hospitals to make additional payments to other DSH-eligible hospitals within that DSH program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH

program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

(b) If an individual hospital has been underpaid by a specified amount, the agency will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH program.

(c) This subsection does not apply to the DSH independent audit findings and recoupment process described in WAC 182-550-4940.

(17) All information related to a hospital's DSH application is subject to audit by the agency or its designee. The agency determines the extent and timing of the audits. For example, the agency or its designee may choose to do an audit of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the agency will recoup the overpayment amount as allowed in RCW 74.09.220 and chapter 41.05A RCW.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific SFY. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full SFY in which the rules are adopted.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. Part 455, Subpart F. WSR 15-01-037, § 182-550-4900, filed 12/8/14, effective 1/8/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4. WSR 14-08-038, § 182-550-4900, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.021. WSR 12-20-029, § 182-550-4900, filed 9/26/12, effective 10/27/12. WSR 11-14-075, recodified as § 182-550-4900, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 10-11-032, § 388-550-4900, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-4900, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4900, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. WSR 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. WSR 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4925 Eligibility for DSH programs—New hospital providers. To be eligible for disproportionate share hospital (DSH) payments, a new hospital provider must have claims data, audited financial statements, and an "as filed" or finalized medicare cost report for the hospital base year used by the medicaid agency in calculating

DSH payments for the state fiscal year (SFY) for which the hospital provider is applying. See WAC 182-550-4900(9).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-4925, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4925, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-4925, filed 6/29/07, effective 8/1/07.]

WAC 182-550-4935 DSH eligibility—Change in hospital ownership. (1) For purposes of eligibility for disproportionate share hospital (DSH) payments, a change in hospital ownership has occurred if any of the criteria in WAC 182-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the medicaid agency in writing no later than thirty days after the change in ownership becomes final. The notice must include the new entity's fiscal year end.

(3) A hospital that did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted, and changes ownership after that date is not eligible for DSH unless it continues to be classified as an acute care hospital serving pediatric and/or adult patients. See WAC 182-550-4900(5) for the obstetric services and utilization rate requirements for DSH eligibility.

(4) If the fiscal year reported on a hospital's medicare cost report does not exactly match the fiscal year reported on the hospital's DSH application to the agency, and if therefore the utilization data reported to the agency do not agree, the agency will use as the data source the document that gives the higher number of total inpatient hospital days for purposes of calculating the hospital's medicaid inpatient utilization rate (MIPUR). See WAC 182-550-4900 (6)(b).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-4935, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-4935, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-4935, filed 6/29/07, effective 8/1/07.]

WAC 182-550-4940 Disproportionate share hospital independent audit findings and recoupment process. (1) In order to comply with federal law and regulation (42 U.S.C. 1396r-4 (j)(2); 42 C.F.R. Part 455, Subpart D), the medicaid agency contracts with an independent auditor to conduct an annual, independent, certified audit of the agency's disproportionate share hospital (DSH) payments. Chapter 182-502A WAC is not applicable to the independent, certified audits described in this section.

(2) Hospitals must comply with the agency's or the auditor's requests for documentation. A hospital's failure to provide requested documentation may result in a finding that any or all of the DSH payments for the audited year are overpayments.

(3) Beginning in state fiscal year 2011, an audit finding that demonstrates DSH payments made to a hospital in that year exceeded the documented hospital-specific DSH cap (as defined in WAC

182-550-4900(3)), is considered a discovery of an overpayment under 42 C.F.R. Part 433, Subpart F.

(4) Hospitals must return overpayments to the agency for redistribution to qualifying hospitals. A qualifying hospital is defined as a disproportionate share hospital that has a positive hospital-specific DSH cap.

(5) The additional DSH payment to be given to each of the other qualifying hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program. Only the recouped payments are redistributed among those eligible DSH hospitals that have a remaining positive hospital-specific DSH cap.

(6) The independent auditor will provide preliminary audit results to each hospital that received DSH payments, including a statement as to whether the hospital's payments did or did not exceed the hospital's DSH cap. Hospitals identified as receiving DSH payments exceeding their hospital-specific DSH cap may request additional information on the preliminary audit results. The agency must receive the hospital's request for the additional information on the preliminary audit results no later than the last working day in November of the year in which the audit is conducted.

(7) In response to a hospital's timely request under subsection (6) of this section, the independent auditor will provide the hospital with at least the following information specific to the requesting hospital:

(a) Calculation of the medicaid inpatient utilization rate (MIUR);

(b) Regular inpatient and outpatient medicaid fee for service basic rate payments;

(c) Supplemental/enhanced inpatient and outpatient medicaid payments;

(d) Total medicaid payments;

(e) Total cost of care;

(f) Total cost of care of the uninsured; and

(g) A provider data summary schedule (PDSS) to compare to the agency's report required by 42 C.F.R. Sec. 447.299, Subpart E.

(8) Under this section, a hospital may only dispute an overpayment. An overpayment hearing is held under WAC 182-502-0230.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. Part 455, Subpart F. WSR 15-01-037, § 182-550-4940, filed 12/8/14, effective 1/8/15.]

WAC 182-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) The medicaid agency makes low income disproportionate share hospital (LIDSH) payments to qualifying hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an LIDSH payment, a hospital must:

(a) Not be a hospital eligible for public disproportionate share (PHDSH) payments (see WAC 182-550-5400);

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive LIDSH payments; and

(e) Meet at least one of the following requirements. The hospital must:

(i) Have a medicaid inpatient utilization rate (MIPUR) as defined in WAC 182-550-4900 (3)(h) at least one standard deviation above the mean medicaid inpatient utilization rate of in-state hospitals that receive medicaid payments; or

(ii) Have a low income utilization rate (LIUR) as defined in WAC 182-550-4900 (3)(g) that exceeds twenty-five percent.

(3) The agency pays hospitals qualifying for LIDSH payments from a legislatively appropriated pool. The maximum amount of LIDSH payments in any state fiscal year (SFY) is the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(4) The agency determines LIDSH payments to each LIDSH eligible hospital using the following factors from the specific hospital's base year as defined in WAC 182-550-4900 (3)(a):

(a) The hospital's medicaid inpatient utilization rate (MIPUR) (see WAC 182-550-4900 for how the agency calculates the MIPUR).

(b) The hospital's medicaid case mix index (CMI). The agency calculates the CMI by:

(i) Using the DRG weight for each of the hospital's paid inpatient claims assigned in the year the claim was paid;

(ii) Summing the DRG weights; and

(iii) Dividing this total by the number of claims.

The CMI the agency uses for LIDSH calculations is not the same as the CMI the agency uses in other hospital rate calculations.

(c) The number of the hospital's Title XIX medicaid discharges. The agency includes in this number only the discharges pertaining to Washington state medicaid clients.

(5) The agency calculates the LIDSH payment to an eligible hospital as follows.

(a) The agency:

(i) Divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(ii) Multiplies the result derived in (a) of this section by the CMI (see (4)(b) of this section), and then by the discharges (see (4)(c) of this section); then

(iii) Converts the product to a percentage of the sum of all such products for individual hospitals; and

(iv) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(b) If a hospital's calculated LIDSH payment is more than the hospital-specific DSH cap, the payment to the hospital is limited to the hospital-specific DSH cap, and the agency:

(i) Subtracts the LIDSH payment calculated for the hospital to determine the remaining LIDSH appropriation to distribute to the other qualifying hospitals; and

(ii) Proportionately distributes the remaining LIDSH appropriation under the factors in (a) of this subsection.

(6) A hospital receiving LIDSH payments must comply with an agency request for uninsured logs (uninsured logs are documentation of payments, charges, and other information for uninsured patients) to verify its hospital-specific DSH cap.

(7) The agency will not make changes in the LIDSH payment distribution after the applicable SFY has ended. The agency recalculates the LIDSH payment distribution only when the applicable SFY has not yet ended at the time the alleged need for an LIDSH adjustment is identi-

fied, and if the agency considers the recalculation necessary and appropriate under its regulations.

(8) Consistent with the provisions of subsection (7) of this section, the agency applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs under WAC 182-550-4900 (13) through (16).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5000, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). WSR 10-17-095, § 388-550-5000, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5000, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5000, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-5000, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. WSR 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5130 Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH) and institution for mental diseases (IMD) state grants. (1) A psychiatric hospital owned and operated by the state of Washington is eligible to receive payments under the institution for mental diseases disproportionate share hospital (IMDDSH) program.

(2) For the purposes of the IMDDSH program, the following definitions apply:

(a) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services.

(b) "Psychiatric community hospital" means a psychiatric hospital other than a state-owned and operated hospital.

(c) "Psychiatric hospital" means an institution which is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill people. The term applies to a medicare-certified distinct psychiatric care unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital.

(d) "State-owned and operated psychiatric hospital" means eastern state hospital and western state hospital.

(3) Except as provided in subsection (4) of this section, a psychiatric community hospital, regardless of location, is not eligible to receive:

(a) IMDDSH payments; or

(b) Any other disproportionate share hospital (DSH) payment from the medicaid agency. See WAC 182-550-4800 regarding payment for psychiatric claims for clients eligible under the medical care services programs.

(4) A psychiatric community hospital within the state of Washington that is designated by the agency as an IMD is eligible to receive IMDDSH payment if:

(a) IMDDSH funds remain available after the amounts appropriated for state-owned and operated psychiatric hospitals are exhausted; and

(b) The legislature provides funds specifically for this purpose.

(5) A psychiatric community hospital within the state of Washington that is designated by the agency as an IMD is eligible to receive a state grant amount from the agency if the legislature appropriates funds specifically for this purpose.

(6) An institution for mental diseases located out-of-state, including an IMD located in a designated bordering city, is not eligible to receive a Washington state grant amount.

(7) Under federal law, 42 U.S.C. 1396r-4 (h)(2), the state's annual IMDDSH expenditures are capped at thirty-three percent of the state's annual statewide DSH cap. This amount represents the maximum that the state can spend in any given fiscal year on IMDDSH, but the state is under no obligation to actually spend that amount.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5130, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5130, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5130, filed 6/29/07, effective 8/1/07.]

WAC 182-550-5150 Payment method—Medical care services disproportionate share hospital (MCSDSH). (1) A hospital is eligible for the medical care services disproportionate share hospital (MCSDSH) payment if the hospital:

(a) Meets the criteria in WAC 182-550-4900;

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The medicaid agency determines the MCSDSH payment for each eligible hospital in accordance with WAC 182-550-4800 for inpatient hospital claims submitted for medical care services (MCS) clients.

(3) The agency makes MCSDSH payments to a hospital on a claim-specific basis for inpatient services.

[Statutory Authority: RCW 41.05.021. WSR 12-20-029, § 182-550-5150, filed 9/26/12, effective 10/27/12. WSR 11-14-075, recodified as § 182-550-5150, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 10-11-032, § 388-550-5150, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5150, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5150, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-5150, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. WSR 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200,

[74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH). (1) The medicaid agency makes small rural disproportionate share hospital (SRDSH) payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRDSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRDSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for state fiscal year (SFY) 2010, which began July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(3) The agency pays hospitals qualifying for SRDSH payments from a legislatively appropriated pool. The agency determines each hospital's individual SRDSH payment from the total dollars in the pool using percentages established as follows:

(a) At the time the SRDSH payment is to be made, the agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The agency determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The agency:

(i) Identifies the medicaid payment amounts made by the agency to the individual hospital during the SFY two years before the current SFY for which DSH application is being made. These medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total medicaid payment amount determined in subsection (i) by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised medicaid payment amount; and

(iii) Divides the revised medicaid payment amount for the individual hospital by the sum of the revised medicaid payment amounts for all qualifying hospitals during the same period.

(4) The agency's SRDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured patients for that hospital unless an exception is required by federal statute or regulation.

(5) The agency reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5200, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). WSR 10-17-095, § 388-550-5200, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5200, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5200, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. WSR 04-12-044, § 388-550-5200, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-5200, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. WSR 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5210 Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH). (1) The medicaid agency makes small rural indigent assistance disproportionate share hospital (SRIADSH) program payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital that provided charity services to clients during the base year. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRIADSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by the Washington State office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population ceiling is increased by two percent.

(3) The agency pays hospitals qualifying for SRIADSH payments from a legislatively appropriated pool. The agency determines each hospital's individual SRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the SRIADSH payment is to be made, the agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The agency determines the average profitability margin for all hospitals qualifying for SRIADSH.

(c) Any qualifying hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other qualifying hospitals receive a profit factor of 1.0.

(d) The agency:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The agency's SRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for that hospital unless an exception is required by federal statute or regulation. The agency reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5210, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). WSR 10-17-095, § 388-550-5210, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5210, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5210, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-5210, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. WSR 04-12-044, § 388-550-5210, filed 5/28/04, effective 7/1/04.]

WAC 182-550-5220 Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH). (1) The medicaid agency makes nonrural indigent assistance disproportionate share hospital (NRIADSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an NRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(b) Not be designated as an "institution of mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC 182-550-4900 (3)(n); and

(e) Be an in-state or designated bordering city hospital that provided charity services to clients during the base year. For DSH purposes, the agency considers as nonrural any hospital located in a designated bordering city.

(3) The agency pays hospitals qualifying for NRIADSH payments from a legislatively appropriated pool. The agency determines each

hospital's individual NRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the NRIADSH payment is to be made, the agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The agency determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The agency:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the NRIADSH revised costs by dividing the hospital's revised cost amount by the total revised charity costs for all qualifying hospitals during the same period.

(4) The agency's NRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for the hospital unless an exception is required by federal statute or regulation. The agency reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5220, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). WSR 10-17-095, § 388-550-5220, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5220, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5220, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-5220, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. WSR 04-12-044, § 388-550-5220, filed 5/28/04, effective 7/1/04.]

WAC 182-550-5300 Payment method—Children's health program disproportionate share hospital (CHPDSH). (1) Effective July 1, 2011, a hospital is eligible for the children's health program disproportionate share hospital (CHPDSH) payment if funding is legislatively appropriated and if the hospital:

(a) Meets the criteria in WAC 182-550-4900;

(b) Is an in-state or designated bordering city hospital; or

(c) Provides services to low-income, children's health program (CHP) clients who, because of their citizenship status, are not eligible for medicaid nonemergency health coverage and who are encountering a nonemergency medical condition.

(2) Hospitals qualifying for CHPDSH payments will receive a per claim payment for inpatient and outpatient claims at the equivalent medicaid rate.

(3) The agency determines the CHPDSH payment for each eligible hospital in accordance with:

(a) WAC 182-550-2800 for inpatient hospital claims submitted for CHP clients; and

(b) WAC 182-550-7000 through 182-550-7600 and other sections in chapter 182-550 WAC that pertain to outpatient hospital claims submitted for CHP clients.

[Statutory Authority: RCW 41.05.021. WSR 12-20-029, § 182-550-5300, filed 9/26/12, effective 10/27/12.]

WAC 182-550-5380 Payment method—Sole community disproportionate share hospital (SCDSH). (1) The medicaid agency's sole community disproportionate share hospital (SCDSH) program is a program for in-state hospitals that:

(a) Were certified by the Centers for Medicare and Medicaid Services (CMS) as sole community hospitals as of January 1, 2013;

(b) Had less than one hundred fifty acute care licensed beds in state fiscal year (SFY) 2011;

(c) Qualify under Section 1923(d) of the Social Security Act;

(d) Are not participating in the certified public expenditure (CPE) program; and

(e) Are rural hospitals in Lewis County.

(2) The agency pays qualifying hospitals SCDSH payments from a legislatively appropriated pool. This distribution is based on the hospital's medicaid payments. To determine the hospital's SCDSH payments, the agency:

(a) Identifies the sum of the medicaid payments to the individual hospital during the SFY two years prior to the current SFY for which DSH application is being made. These medicaid payment amounts:

(i) Are based on historical data;

(ii) Include payments from the agency; and

(iii) Include payments reported on encounter data supplied by agency-contracted managed care organizations.

(b) Divides the medicaid payment amount in (a) of this subsection by the sum of the medicaid payment amounts for all qualifying hospitals during the same period to determine the hospital's percentage; and

(c) Applies this percentage to the total dollars in the pool to determine the hospital's SCDSH payment.

(3) The SCDSH payments to a hospital eligible under this program may not exceed the hospital's DSH cap calculated according to WAC 182-550-4900(10).

(4) SCDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the agency will recoup DSH payments in the order specified in WAC 182-550-4900 (13) and (14).

[Statutory Authority: RCW 41.05.021, 41.05.160 and 2014 c 221 §§ 10 and 11. WSR 14-23-003A, § 182-550-5380, filed 11/5/14, effective 1/1/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4. WSR 14-08-038, § 182-550-5380, filed 3/26/14, effective 4/26/14.]

WAC 182-550-5400 Payment method—Public hospital disproportionate share hospital (PHDSH). (1) The medicaid agency's public hospital disproportionate share hospital (PHDSH) program is a certified public expenditure program for government-operated hospitals. To be eligible for PHDSH, a hospital must qualify for disproportionate share hospital (DSH) payments under WAC 182-550-4900 and be:

(a) Operated by a public hospital district in the state of Washington and participating in the "full cost" public hospital certified public expenditure (CPE) payment program described in WAC 182-550-4650;

(b) Harborview Medical Center; or

(c) University of Washington Medical Center.

(2) The PHDSH payments to a hospital eligible under this program may not exceed the hospital's disproportionate share hospital (DSH) cap calculated according to WAC 182-550-4900(10). The hospital receives only the federal medical assistance percentage of the total computable payment amount.

(3) Hospitals receiving payment under the PHDSH program must provide the local match for the federal funds through certified public expenditures (CPE). Payments are limited to costs incurred by the participating hospitals.

(4) A hospital receiving payment under the PHDSH program must submit to the agency federally required medicaid cost report schedules apportioning inpatient and outpatient costs, beginning with the services provided during state fiscal year 2006. See WAC 182-550-5410.

(5) PHDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the agency will recoup PHDSH payments first, but only from hospitals that received total inpatient and DSH payments above the hold harmless level, and only to the extent of the excess amount above the hold harmless level. See WAC 182-550-4900 (13) and (14), and 182-550-4670.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 74.09.5225(3). WSR 15-11-009, § 182-550-5400, filed 5/7/15, effective 6/7/15. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 433.51(b). WSR 12-04-022, § 182-550-5400, filed 1/25/12, effective 2/25/12. WSR 11-14-075, recodified as § 182-550-5400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5400, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5400, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-5400, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-5400, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. WSR 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5410 CPE medicaid cost report and settlements. (1) For patients discharged after June 30, 2005, a certified public expenditure (CPE) hospital must annually submit to the medicaid agency federally required medicaid cost report schedules, using schedules approved by the centers for medicare and medicaid services (CMS), that

apportion inpatient and outpatient costs to medicaid clients and uninsured patients for the service year, as follows:

(a) Title XIX fee-for-service claims;

(b) Medicaid managed care organization (MCO) plan claims;

(c) Uninsured patients. The cost report schedules for uninsured patients must not include services that medicaid would not have covered had the patients been medicaid eligible (see WAC 182-550-1400 and 182-550-1500); and

(d) State-administered program patients. State-administered program patients are reported separately and are not to be included on the uninsured patient cost report schedule. The agency will provide provider statistics and reimbursements (PS&R) reports for the state-administered program claims.

(2) A CPE hospital must:

(a) Use the information on individualized PS&R reports provided by the agency when completing the medicaid cost report schedules. The agency provides the hospital with the PS&R reports at least thirty calendar days before the appropriate deadline.

(i) For state fiscal year (SFY) 2006, the deadline for all CPE hospitals to submit the federally required medicaid cost report schedules is June 30, 2007.

(ii) For hospitals with a December 31 year end, partial year medicaid cost report schedules for the period July 1, 2005 through December 31, 2005 must be submitted to the agency by August 31, 2007.

(iii) For SFY 2007 and thereafter, each CPE hospital must submit the medicaid cost report schedules to the agency within thirty calendar days after the medicare cost report is due to its medicare fiscal intermediary or medicare administrative contractor, whichever applies.

(b) Complete the cost report schedules for uninsured patients and medicaid clients enrolled in an MCO plan using the hospital provider's records.

(c) Comply with the agency's instructions regarding how to complete the required medicaid cost report schedules.

(3) The medicaid cost report schedules must be completed using the medicare cost report for the same reporting year.

(a) The ratios of costs-to-charges and per diem costs from the "as filed" medicare cost report are used to allocate the medicaid and uninsured costs on the "as filed" medicaid cost report schedules, unless expressly allowed for medicaid.

(b) After the medicare cost report is finalized by the medicare fiscal intermediary or medicare administrative contractor (whichever applies), final medicaid cost report schedules must be submitted to the agency incorporating the adjustments to the medicare cost report, unless expressly allowed for medicaid. CPE hospitals must submit finalized medicare cost reports with the notice of amount of program reimbursement (NPR) within thirty calendar days of receipt. The agency will then provide the hospitals with updated PS&R reports for medicaid and state program claims processed by the agency for the medicaid cost report period. The hospitals will update the data for uninsured patients and medicaid clients enrolled in an MCO plan.

(4) The medicaid cost report schedules and supporting documentation are subject to audit by the agency or its designee to verify that claimed costs qualify under federal and state rules governing the CPE payment program. The documentation required includes, but is not limited to:

(a) The revenue codes assigned to specific cost centers on the medicaid cost report schedules.

(b) The inpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(c) The outpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(d) All payments received for the inpatient and outpatient charges in (b) and (c) of this subsection including, but not limited to, payments for third party liability, uninsured patients, and medicaid clients enrolled in an MCO plan.

(5) The agency:

(a) Performs cost settlements for both the "as filed" and "final" medicaid cost report schedules for all CPE hospitals;

(b) Reports to CMS as an adjustment any difference between the payments of federal funds made to the CPE hospitals and the federal share of the certified public expenditures; and

(c) Recoups from the CPE hospitals the federal payments that exceed the hospitals' costs, unless the hold harmless provision in WAC 182-550-4670 applies.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5410, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5410, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 08-20-032, § 388-550-5410, filed 9/22/08, effective 10/23/08; WSR 07-14-090, § 388-550-5410, filed 6/29/07, effective 8/1/07.]

WAC 182-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. The upper payment limit (UPL) program is terminated effective July 1, 2007. The medicaid agency will not make UPL payments after June 30, 2007.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5425, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5425, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5425, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5425, filed 3/30/06, effective 4/30/06.]

WAC 182-550-5450 Supplemental distributions to approved trauma service centers. (1) The trauma care fund (TCF) is an amount appropriated to the medicaid agency each state fiscal year (SFY), at the legislature's sole discretion, for the purpose of supplementing the agency's payments to eligible trauma service centers for providing qualified trauma services to medicaid clients.

(2) Encounter data, for trauma care provided to medicaid clients enrolled in an agency-contracted managed care organization, may be included when calculating supplemental distributions from the TCF, so long as the beginning dates of service for trauma care are on and after July 1, 2013.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable rules;

(c) Meet the billing requirements in this section and other applicable rules;

(d) Submit all information the agency requires to monitor the program; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) Allocated into five payment pools. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals are determined by first summing the agency's qualifying payments to each eligible hospital since the beginning of the service year. This amount is then expressed as a percentage of the agency's total payments to all eligible hospitals for qualifying services provided during the service year-to-date. For TCF purposes, service year is defined as the SFY. Each hospital's qualifying payment percentage for the service year-to-date is multiplied by the available amount for the service year-to-date, and then the agency subtracts what has been allocated to each hospital for the service year-to-date to determine the portion of the current payment pool to be paid to each qualifying hospital. Eligible hospitals and qualifying payments are described in (a)(i) through (iii) of this subsection. Qualifying payments are the agency's payments to:

(i) Level I, Level II, and Level III trauma service centers for qualified medicaid trauma cases since the beginning of the service year. The agency determines the countable payment for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The Level I, Level II, and Level III hospitals for trauma cases transferred to these facilities since the beginning of the service year. A Level I, Level II, or Level III hospital that receives a transferred trauma case from any lower level hospital is eligible for an enhanced payment, regardless of the client's injury severity score (ISS); and

(iii) Level II and Level III hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in (b) of this subsection) transferred by these hospitals since the beginning of the service year to a trauma service center with a higher designation level.

(b) Paid only for a medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of (c) of this subsection.

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) The hospital is designated or recognized by DOH as an approved Level II or Level III adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level IV or Level V trauma service center does not qualify for supple-

mental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in (b) of this subsection.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the agency to:

(i) Trauma service centers designated or recognized as Level IV or Level V;

(ii) Critical access hospitals (CAHs), except when the CAH is also a Level III trauma service center; or

(iii) Any facility for follow-up services related to the qualifying trauma incident but provided to the client after the client has been discharged from the initial hospitalization for the qualifying injury.

(5) Distributions for an SFY are paid as follows:

(a) The first supplemental distribution from the TCF is made three to six months after the SFY begins;

(b) Subsequent distributions are made approximately every two to four months after the first distribution is made, except as described in (c) of this subsection;

(c) The final distribution from the TCF for an SFY is:

(i) Made one year after the end of the SFY;

(ii) Limited to the remaining balance of the agency's TCF appropriation for that SFY; and

(iii) Distributed based on each eligible hospital's percentage share of the total payments made by the agency to all designated trauma service centers for qualified trauma services provided during the relevant SFY.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) At its discretion, and with sufficient public notice, the agency may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary program needs;

(b) The agency considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the agency within three hundred sixty-five calendar days from the date of the initial trauma service;

(c) Except as provided in (a) of this subsection, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the agency as specified in WAC 182-502-0150(3). See WAC 182-502-0150 (11) and (12) for other time limits applicable to TCF claims;

(d) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(e) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the agency in any SFY cannot exceed the amount appropriated by the legislature for that SFY. The agency has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[Statutory Authority: RCW 41.05.021 and Washington State Plan Amendment 13-15. WSR 14-10-002, § 182-550-5450, filed 4/23/14, effective 5/24/14. Statutory Authority: RCW 41.05.021. WSR 13-17-017, § 182-550-5450, filed 8/9/13, effective 9/9/13; WSR 12-14-041, § 182-550-5450, filed 6/27/12, effective 7/28/12. WSR 11-14-075, recodified as § 182-550-5450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. WSR 10-12-013, §

388-550-5450, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.160, 74.09.500, and 70.168.040. WSR 08-08-065, § 388-550-5450, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5450, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; WSR 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]

WAC 182-550-5500 Payment——Hospital-based RHCs. (1) The medicaid agency will reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the agency will not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The agency will shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The agency will shall determine the hospital-based rural health clinic's RCC from the hospital's annual medicare cost report, according to WAC 182-550-4500(1).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5500, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5550 Public notice for changes in medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe how the medicaid agency, pertaining to medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 182-550-2900 through 182-550-5500.

(d) "Justification" means an explanation of why the agency is proposing or implementing a medicaid rate change based on a change in medicaid rate setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the agency.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Website" means the agency's internet home page on the worldwide web: http://www.hca.wa.gov/ is the internet address.

(3) The agency will notify stakeholders of proposed and final changes in individual medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed medicaid hospital rates, the methodologies underlying the establishment of the rates, and justifications for the rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed medicaid hospital rates, the methodologies underlying the establishment of the rates, and justifications for the rates; and

(c) Publish the final medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the agency will determine the manner of publication of proposed or final medicaid hospital rates.

(b) Publication of proposed medicaid hospital rates will occur as follows:

(i) The agency will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the agency will post proposed rates on the agency's website.

(c) Publication of final medicaid hospital rates will occur as follows:

(i) The agency will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the agency will post final rates on the agency's website.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 182-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The agency, when it proposes amendments to the methodologies underlying the establishment of medicaid hospital rates as described in WAC 182-550-2900 through 182-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final medicaid hospital rates or proposed and final amendments to WAC 182-550-2900 through 182-550-5500 must notify the agency in writing. The agency will send notice of all the actions to the stakeholders postage prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to medicare rules, methods, or levels of reimbursement for clients who are eligible for both medicare and medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rule making is necessary to implement the change; or

(iii) Part of a nonmedicaid program.

(b) Although notice and publication are not required for medicaid rate changes described in subsection (7)(a) of this section, the agency will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the agency and an individual hospital negotiate or contractually agree to medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final medicaid contract rates are effective on the date contractually agreed to by the agency and the individual hospital.

(d) Before the execution of the contract, the agency will not publish negotiated contract prices that are agreed to between the agency and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the agency will publish the negotiated contract prices on its website.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the agency in proposing or implementing a change to medicaid hospital rates, the methodologies underlying the establishment of the rates, or the justification for the rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the agency; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the agency under which hospital providers may appeal their medicaid rates.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5550, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.500 and 42 U.S.C. 1396a (a)(13)(A). WSR 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

WAC 182-550-5600 Dispute resolution process for hospital rate reimbursement. The dispute resolution process for hospital rate reimbursement follows the procedures as stated in WAC 182-502-0220.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5600, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-5600, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 74.09.730. WSR 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5700 Hospital reports and audits. (1) In-state and border area hospitals will complete and submit a copy of their annual medicare cost reports (HCFA 2552) to the medicaid agency. These hospital providers will:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual medicare HCFA 2552 cost report according to the applicable medicare statutes, regulations, and instructions; and

(c) Submit a copy to the agency:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days before the due date of the report. Hospital providers will include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the agency may withhold all or part of the payments due the hospital until the agency receives the properly completed or late report.

(3) Hospitals will submit other financial information required by the agency to establish rates.

(4) The agency will periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5700, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5800 Outpatient and emergency hospital services. The medicaid agency will cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-5800, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-5800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6000 Outpatient hospital services—Conditions of payment and payment methods. (1) The medicaid agency pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 182-550-1700. All profes-

sional medical services must be billed according to chapter 182-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

(a) Have a current core provider agreement with the agency;

(b) Bill the agency according to the conditions of payment under WAC 182-502-0100;

(c) Bill the agency according to the time limits under WAC 182-502-0150; and

(d) Meet program requirements in other applicable WAC and the agency's published issuances.

(3) The agency does not pay separately for any services:

(a) Included in a hospital's room charges;

(b) Included as covered under the agency's definition of room and board (e.g., nursing services). See WAC 182-550-1050; or

(c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.

(4) The agency does not pay:

(a) A hospital for outpatient hospital services when a managed care plan is contracted with the agency to cover these services;

(b) More than the "acquisition cost" ("A.C.") for HCPCS (health care common procedure coding system) codes noted in the outpatient fee schedule; or

(c) For cast room, emergency room, labor room, observation room, treatment room, and other room charges in combination when billing periods for these charges overlap.

(5) The agency uses the outpatient weighted costs-to-charges (OWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 182-550-2598.

(6) Hospitals must provide documentation as required or requested by the agency.

(7) All hospital providers must present final charges to the agency within 365 days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond 365 days from the "statement covers period from date" shown on the claim.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-14-040, § 182-550-6000, filed 6/27/22, effective 7/28/22; WSR 22-04-051, § 182-550-6000, filed 1/27/22, effective 2/27/22; WSR 15-18-065, § 182-550-6000, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-6000, filed 6/20/07, effective 8/1/07; WSR 04-20-060, § 388-550-6000, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-044, § 388-550-6000, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 02-21-019, § 388-550-6000, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271 and 42 C.F.R. 11303. WSR 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6100 Outpatient hospital physical therapy. (1) The medicaid agency pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 182-545-200 and 182-550-6000.

(2) A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the agency's current published billing instructions. The agency does not pay outpatient hospitals a facility fee for these services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6100, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-6100, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6150 Outpatient hospital occupational therapy. (1) The medicaid agency pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 182-545-200 and 182-550-6000.

(2) The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the agency's current published billing instructions. The agency does not pay outpatient hospitals a facility fee for these services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6150, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-6150, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6200 Outpatient hospital speech therapy services. (1) The medicaid agency pays for speech therapy services provided to eligible clients as an outpatient hospital service according to this section and WAC 182-545-200 and 182-550-6000.

(2) The agency requires swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(3) The agency requires a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(4) A hospital must bill outpatient hospital speech therapy services using appropriate billing codes listed in the agency's current

published billing instructions. The agency does not pay the outpatient hospital a facility fee for these services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6200, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-6200, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits. The medicaid agency will provide outpatient substance use disorder treatment in programs qualified under WAC 182-538C-230 and certified under chapter 246-341 WAC or its successor. See RCW 71.24.385.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-18-059, § 182-550-6250, filed 8/26/21, effective 9/26/21; WSR 15-18-065, § 182-550-6250, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6300 Outpatient nutritional counseling. See chapter 182-555 WAC for medical nutrition therapy.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-22-060, § 182-550-6300, filed 10/31/18, effective 1/1/19; WSR 15-18-065, § 182-550-6300, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6400 Outpatient hospital diabetes education. (1) The medicaid agency pays for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility where the services are provided is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The agency requires the diabetes education teaching curriculum to have measurable, behaviorally stated educational objectives. The diabetes education teaching curriculum must include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the women, infants, and children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long-term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin startup.

(3) The agency pays for a maximum of six hours of individual core survival skills outpatient diabetes education per calendar year per client.

(4) The agency requires DOH-approved centers to bill the agency for diabetes education services on the UB92 billing form using the specific revenue codes designated and published by the agency.

(5) The agency reimburses for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6400, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-6400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6450 Outpatient hospital weight loss program. The medicaid agency may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the agency. The agency will deny payment for services provided by non-approved providers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6450, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6500 Blood and blood components. (1) The medicaid agency pays a hospital only for:

(a) Blood bank service charges for processing and storage of blood and blood components; and

(b) Blood administration charges.

(2) The agency does not pay for blood and blood components.

(3) The agency does not pay a hospital separately for the services identified in subsection (1) when these services are included and paid using the diagnosis-related group (DRG), per diem, or per case rate payment rates.

(4) The agency pays a hospital no more than the hospital's cost, as determined by the agency, for the services identified in subsection (1) when the hospital is paid using the ratio of costs-to-charges (RCC) or weighted costs-to-charges WCC payment method.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6500, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-6500, filed 6/20/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6600 Hospital-based physician services. See chapter 182-531 WAC regarding rules for inpatient and outpatient physician services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-6600, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-6600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6700 Hospital services provided out-of-state. (1) The agency pays:

(a) For dates of admission before August 1, 2007, for only emergency care for an eligible medicaid and CHIP client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 182-501-0175 for a list of border cities.

(b) For dates of admission on and after August 1, 2007, for both emergency and nonemergency out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, for eligible medicaid and CHIP clients based on the medical necessity and utilization review standards and limits established by the agency.

(i) Prior authorization by the agency is required for the nonemergency out-of-state hospital medical care provided to medicaid and CHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As instate hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. Agency designated critical border hospitals are paid as instate hospitals. See WAC 182-550-3900 and 182-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible medicaid and CHIP clients based on authorization by a division of behavioral health designee.

(d) Based on the agency's limitations on hospital coverage under WAC 182-550-1100 and 182-550-1200 and other applicable rules.

(2) The agency authorizes and pays for comparable hospital services for a medicaid and CHIP client who is temporarily outside the state to the same extent that such services are furnished to an eligible medicaid client in the state, subject to the exceptions and limitations in this section. See WAC 182-550-3900 and 182-550-4000.

(3) The agency limits out-of-state hospital coverage for persons eligible under state-administered programs as follows:

(a) For a person who receives services under the Involuntary Treatment Act (ITA), the agency does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(b) For a person eligible under an agency's general assistance program, the agency pays only for hospital services covered under the person's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The agency does not pay for hospital services provided to persons eligible under a general assistance program in other hospitals located outside the state of Washington. The agency or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC 182-550-1200.

(4) The agency covers hospital care provided to medicaid or CHIP clients in areas of Canada as described in WAC 182-501-0180, and based on the limitations described in the state plan.

(5) The agency may review all cases involving out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, to determine whether the services are within the scope of the person's WAH program.

(6) If the person can claim deductible or coinsurance portions of medicare, the provider must submit the claim to the intermediary or carrier in the provider's own state on the appropriate medicare billing form. If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For payment for out-of-state inpatient hospital services, see WAC 182-550-3900 and 182-550-4000.

(8) Out-of-state providers, including bordering city hospitals and critical border hospitals, must present final charges to the agency within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment of charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-6700, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-6700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-6700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-6700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-7000 Outpatient prospective payment system (OPPS)—General. (1) The medicaid agency pays for outpatient services using an outpatient prospective payment system (OPPS) for all hospitals that do not qualify as in-state critical access hospitals per WAC 182-550-2598.

(2) The agency uses the enhanced ambulatory payment group (EAPG) software provided by 3M™ Health Information Systems to group OPPS claims based on services performed and resource intensity.

(3) The agency uses the group established in subsection (2) of this section to determine payment for OPPS claims.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7000, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7000, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7000, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7200 OPPS——Billing requirements and payment method. This section describes hospital provider billing requirements and the payment methods the medicaid agency uses to pay for covered outpatient hospital services provided by hospitals included in the outpatient prospective payment system (OPPS).

(1) Providers must bill according to national correct coding initiative (NCCI) standards maintained by the Centers for Medicare and Medicaid Services (CMS).

ENHANCED AMBULATORY PATIENT GROUP (EAPG) METHOD

(2) The agency uses the enhanced ambulatory patient group (EAPG) method as the primary payment method for OPPS. Examples of services paid by the EAPG method include:

(a) Surgeries;

(b) Significant procedures;

(c) Observation services;

(d) Medical visits;

(e) Dental procedures; and

(f) Ancillary services.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(3) The agency pays using the outpatient fee schedule for:

(a) Covered services exempted from the EAPG payment method due to agency policy;

(b) Covered services for which there are no established relative weights, such as:

(i) Durable medical equipment procedures grouped to EAPG type 7; and

(ii) Physical therapy procedures grouped to EAPG type 21;

(c) Corneal tissue acquisition; and

(d) Other services as identified by the agency and posted on the agency's website.

HOSPITAL OUTPATIENT RATIO OF COSTS-TO-CHARGES (RCC)

(4) The agency uses the hospital outpatient ratio of costs-to-charges (RCC) in WAC 182-550-3900 and 182-550-4500 to pay for the services listed in subsection (3) of this section for which the agency has not established a maximum allowable fee.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7200, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7200, filed 6/30/11, effective

7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. WSR 10-08-023, § 388-550-7200, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7200, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7300 OPPS—Payment limitations. (1) The medicaid agency limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule published on the agency's website, subject to the following limitations:

(a) To receive payment for services, providers must bill claims according to national correct coding initiative (NCCI) standards. When a unit limit for services is not stated in the outpatient fee schedule, the agency pays for services according to the program's unit limits stated in applicable WAC and published provider guides.

(b) The average resource, including units of service, are factored into the enhanced ambulatory patient group (EAPG) weight determination, and the allowable units of service for EAPGs is equal to one.

(2) The following service categories are included in the EAPG payment for significant procedure(s) on the claim and do not receive separate payments under EAPG:

(a) Services classified as the same or clinically related to the main significant procedure;

(b) Routine ancillary services;

(c) Chemotherapy services grouped as class I, class II, or minor; and

(d) Pharmacotherapy services grouped as class I, class II, or minor.

(3) The agency reduces the EAPG payment by fifty percent based on the default EAPG grouper settings for services subject to one or more of the following discounts:

(a) Multiple procedures;

(b) Repeat ancillary services; or

(c) A terminated procedure.

(4) The agency limits outpatient services billing to one claim per episode of care. If any line of the claim is denied, or a service that was provided was not stated on the initial submitted claim, the agency requires the entire claim to be adjusted.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-09-022, § 182-550-7300, filed 4/11/18, effective 5/12/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7300, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. WSR 10-08-023, § 388-550-7300, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7300, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7400 OPPS EAPG relative weights. (1) The medicaid agency uses national relative weights established by 3M™ as part of its enhanced ambulatory patient group (EAPG) payment system.

(2) The agency may update the relative weights used for calculating OPPS payments on July 1st of each year, beginning on July 1, 2015.

(3) The agency may update relative weights more frequently for newly added EAPGs in order to maintain current EAPG grouper system functionality.

(4) The agency will post all relative weights used on the agency's website.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7400, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7400, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7400, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7450 OPPS budget target adjustor. The medicaid agency may apply an outpatient prospective payment system (OPPS) budget target adjustor to the enhanced ambulatory patient group (EAPG) payment. The agency calculates the OPPS budget target adjustor based on legislative direction to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7450, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7450, filed 5/28/09, effective 7/1/09.]

WAC 182-550-7500 OPPS rate. (1) The medicaid agency calculates hospital-specific outpatient prospective payment system (OPPS) rates using all of the following:

(a) A base conversion factor established by the agency;

(b) An adjustment for direct graduate medical education (DGME); and

(c) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) when the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(2) Base conversion factors. The agency calculates the base enhanced ambulatory patient group (EAPG) conversion factor during a hospital payment system rebasing. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter, to maintain aggregate payments across the system. The agency will publish base conversion factors on its website.

(3) Wage index adjustments reflect labor costs in the CBSA where a hospital is located.

(a) The agency determines the labor portion of the base rate by multiplying the base rate by the labor factor established by medicare; then

(b) Multiplying the amount in (a) of this subsection is multiplied by the most recent wage index information published by CMS when the rates are set; then

(c) The agency adds the nonlabor portion of the base rate to the amount in (b) of this subsection to produce a hospital-specific wage adjusted factor.

(4) DGME. The agency obtains the DGME information from the hospital's most recently filed medicare cost report as available in the CMS health care cost report information system (HCRIS) dataset.

(a) The hospital's medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(b) If a hospital's medicare cost report is not available on HCRIS, the agency may use the CMS Form 2552-10 to calculate DGME.

(c) In the case where a hospital has not submitted a CMS medicare cost report in more than eighteen months from the end of the hospital's cost reporting period, the agency may remove the hospital's DGME adjustment.

(d) The agency calculates the hospital-specific DGME by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report.

(5) The formula for calculating the hospital's final specific conversion factor is:

EAPG base rate × (.6(wage index) + .4)/(1-DGME)

(6) The agency considers an in-state hospital a sole community hospital if all the following conditions apply. The hospital must:

(a) Be certified by CMS as a sole community hospital as of January 1, 2013.

(b) Have a level III adult trauma service designation from the department of health as of January 1, 2014.

(c) Have less than one hundred fifty acute care licensed beds in fiscal year 2011.

(d) Be owned and operated by the state or a political subdivision.

(e) Accept single bed certification patients as of July 1, 2021, according to RCW 71.05.745.

(7) If the hospital meets the agency's sole community hospital (SCH) criteria listed in subsection (6) of this section, effective:

(a) January 1, 2015, through June 30, 2018, the agency multiplies the hospital's specific conversion factor by 1.25;

(b) July 1, 2018, through June 30, 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.50;

(c) July 1, 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.25.

(8) The formula for calculating a sole community hospital's final conversion factor is:

(EAPG base rate × (.6(wage index) + .4)/(1-DGME)) x SCH Factor

[Statutory Authority: RCW 41.05.021, 41.05.160 and 2021 c 334 §§ 211(46) and 215(66). WSR 22-03-008, § 182-550-7500, filed 1/6/22, effective 2/6/22. Statutory Authority: RCW 41.05.021, 41.05.160, and

2019 c 415 § 211(14). WSR 20-01-075, § 182-550-7500, filed 12/11/19, effective 1/11/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2018 c 299 § 213 (1)(fff). WSR 18-16-059, § 182-550-7500, filed 7/26/18, effective 8/26/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 14-22-003, § 182-550-7500, filed 10/22/14, effective 11/22/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7500, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 182-550-7550 OPPS payment enhancements. (1) Pediatric adjustment.

(a) The medicaid agency establishes a policy adjustor to be applied to all enhanced ambulatory patient group (EAPG) services for clients under age eighteen years.

(b) Effective July 1, 2014, this adjustor equals one point thirty-five (1.35).

(2) Chemotherapy and combined chemotherapy/pharmacotherapy adjustment.

(a) The agency establishes a policy adjustor to be applied to services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs.

(b) Effective July 1, 2014, this adjustor equals one point one (1.1).

(3) Sole community hospitals (SCH).

(a) To qualify as an SCH, a hospital must meet all of the following criteria. The hospital must:

(i) Be certified as an SCH by the Centers for Medicare and Medicaid Services (CMS) as of January 1, 2013;

(ii) Have a level III adult trauma service designation by the department of health as of January 1, 2014;

(iii) Have less than one hundred fifty acute-care-licensed beds in state fiscal year 2011; and

(iv) Be owned and operated by the state or one of its political subdivisions.

(b) Effective January 1, 2015, the agency will apply an adjustor of one point twenty-five (1.25) to the EAPG conversion factor for any hospital that meets the conditions in (a) of this subsection.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7550, filed 6/25/14, effective 7/26/14.]

WAC 182-550-7600 OPPS payment calculation. (1) The medicaid agency calculates the enhanced ambulatory patient group (EAPG) payment as follows:

EAPG payment =
EAPG relative weight x
Hospital-specific conversion factor x

Discount factor (if applicable) x
Policy adjustor (if applicable)

(2) The total OPPS claim payment is the sum of the EAPG payments plus the sum of the allowed amounts for each nonEAPG service.

(3) If a client's third-party liability insurance has made a payment on a service, the agency subtracts any such payments made from the medicaid allowed amount.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7600, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7600, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]

WAC 182-550-8000 Hospital safety net assessment (HSNA) program—Purpose. Chapter 74.60 RCW establishes the hospital safety net assessment (HSNA) program. The HSNA program imposes an assessment on certain Washington state hospitals that is used solely to increase funding from all other sources and support additional payments to hospitals for authorized medicaid services. The medicaid agency has authority to issue rules associated with the HSNA program under RCW 41.05.021 (1)(m)(iv) and 74.60.050(1).

[Statutory Authority: RCW 41.05.021, 41.05.160, and 74.60.050. WSR 20-14-054, § 182-550-8000, filed 6/26/20, effective 7/27/20.]

WAC 182-550-8100 Assessment notices—Process and timelines. (1) **Notification.** The medicaid agency sends hospital safety net assessment (HSNA) notices on or about thirty calendar days prior to the end of each quarter as required by RCW 74.60.030 (1)(a).

(2) **Payment due date.** Each hospital must pay its assessment in full by the due date listed in the HSNA notice.

(3) **First past-due notification.** If a hospital does not pay its HSNA assessment in full by the due date, the agency sends the hospital a past-due notice. The past-due notice informs the hospital of the actions the agency may take if the hospital's assessment becomes ninety calendar days past due.

(4) **Final past-due notification.** If a hospital does not pay its assessment in full within ninety calendar days of its due date stated in the HSNA notice, the agency sends the hospital a final past-due notice.

(a) The final past-due notice informs the hospital of the actions the agency takes, as required by RCW 74.60.050(2), to offset funds from the agency's scheduled payments to the hospital.

(b) The agency does not offset funds from managed care capitation payments, as described in RCW 74.60.130.

(5) **Appeal.** A hospital may appeal the actions the agency takes to offset funds by following the process outlined in WAC 182-502-0050.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 74.60.050. WSR 20-14-054, § 182-550-8100, filed 6/26/20, effective 7/27/20.]