

WSR 21-18-059

PERMANENT RULES

HEALTH CARE AUTHORITY

[Filed August 26, 2021, 10:12 a.m., effective September 26, 2021]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority is adopting these rules to update outdated references, terminology, and language to align with behavioral health integration.

Citation of Rules Affected by this Order: Amending WAC 182-550-1700, 182-550-2900, and 182-550-6250.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 21-15-038 on July 14, 2021.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: August 26, 2021.

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Rules Coordinator

OTS-3152.2

AMENDATORY SECTION (Amending WSR 14-16-019, filed 7/24/14, effective 8/24/14)

**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 ((WAH)) medicaid clients receiving services through the fee-for-service program. For clients ((eligible under other WAH programs)) enrolled in an agency-contracted managed care organization (MCO), see chapters 182-538 and 182-538D WAC ((for managed care organizations, and chapter 388-865 WAC for mental health treatment programs coordinated through the department of social and health services' division of behavioral health and recovery or its designee)). 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, 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.]

AMENDATORY SECTION (Amending WSR 19-18-026, filed 8/28/19, effective 9/28/19)

**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 (~~mental health~~) 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 (~~mental health~~) 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. (~~A mental health~~) 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 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.]

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

**WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits.** The medicaid agency will provide outpatient ((~~chemical dependency~~)) substance use disorder treatment in programs qualified under ((~~chapter 388-810~~)) WAC 182-538C-230 and certified under chapter ((~~388-805 WAC or its successor~~)) 246-341 WAC or its successor. See RCW 71.24.385.

[Statutory Authority: RCW 41.05.021 and 41.05.160. 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.]