

WAC 260-70-090 Permitted level of approved NSAIDS. Trainers using permitted medication in the care of their horses are subject to all rules governing such medications. Those using approved NSAIDS are also subject to these additional rules:

(1) PHENYL BUTAZONE or OXYPHENYLBUTAZONE shall be administered in such dosage amount that the test sample shall contain not more than 5 micrograms of phenylbutazone or 5 micrograms of oxyphenylbutazone per milliliter of blood plasma or more than 165 micrograms of the drug substance, its metabolites and analogs per milliliter of urine.

(2) NAPROXEN shall be administered in such dosage amount that the test sample shall contain not more than 5 micrograms of the drug substance, its metabolites or analogs per milliliter of blood plasma or more than 165 micrograms of the drug substance, its metabolites or analogs per milliliter of urine.

(3) FLUNIXIN shall be administered in such dosage amount that the test sample shall not contain more than 1 microgram of the drug substance, its metabolites or analogs per milliliter of blood plasma.

(4) MECLOFENAMIC ACID shall be administered in such dosage amount that the test sample shall contain not more than 1 microgram of the drug substance, its metabolites or analogs per milliliter of blood plasma.

(5) No horse on a program of permitted medication shall be permitted to race without such medication.

[Statutory Authority: RCW 67.16.020 and 67.16.040. 87-15-020 (Resolution No. 87-03), § 260-70-090, filed 7/8/87; 84-06-061 (Order 84-01), § 260-70-090, filed 3/7/84; 80-05-132 (Order 79-03), § 260-70-090, filed 5/7/80; Order 74.1, § 260-70-090, filed 5/22/74, effective 7/1/74.]

WAC 260-70-120 Sampling medications and drugs. The state veterinarian, the test barn veterinarian, any duly authorized inspector of the commission, or any member of the board of stewards may take samples of any medicine or other materials suspected of containing improper medication or drugs which would affect the racing condition of a horse in a race, which may be found in stables or elsewhere on race tracks or in the possession of such tracks or any person connected with racing on the grounds of an association and the same shall be delivered to the chief chemist of the commission for analysis under the same conditions as in this article prescribed for analysis of blood and urine.

[Statutory Authority: RCW 67.16.020 and 67.16.040. 87-15-020 (Resolution No. 87-03), § 260-70-120, filed 7/8/87; Order 74.1, § 260-70-120, filed 5/22/74, effective 7/1/74.]

WAC 260-70-170 Veterinarian report. Every veterinarian who treats a horse upon the approved grounds shall, in writing on a form prescribed by the commission, report to the commission veterinarian in a manner and at a time prescribed by him/her, the name of the horse treated, the name of the trainer of the horse, the time of treatment, and any other information requested by the commission veterinarian. Detection of any unreported medication, drug, or substance; or failure to detect any permitted medication, drug or substance by the chief chemist in a test may be grounds for disciplinary action.

A list of horses on a program of permitted medication shall be kept in the office of the commission and shall be available for public inspection.

[Statutory Authority: RCW 67.16.020 and 67.16.040. 87-15-020 (Resolution No. 87-03), § 260-70-170, filed 7/8/87; 80-05-132 (Order 79-03), § 260-70-170, filed 5/7/80. Statutory Authority: RCW 67.16.020. 78-06-001 (Order 78-1), § 260-70-170, filed 5/4/78; Order 74.1, § 296-70-170, filed 5/22/74, effective 7/1/74.]

Title 261 WAC HOSPITAL COMMISSION

Chapters

261-06	Public records.
261-40	Review and approval of annual budget submittals, rates, rate schedules, other charges and changes.
261-50	Rules for reporting hospital patient discharge information.

Chapter 261-06 WAC PUBLIC RECORDS

WAC

261-06-070	Inspection and copying.
261-06-080	Exemptions.
261-06-090	Review of denials of public records requests.
261-06-110	Records index.

WAC 261-06-070 Inspection and copying. (1) No fee shall be charged for the inspection of public records. The commission shall charge a fee of ten cents per page of copy, plus postage, if any, for providing copies of public records and for use of the commission's copy equipment. This charge is the amount necessary to reimburse the commission for its actual costs incident to such copying.

(2) The charge for manuals and manual revisions shall be the cost to the commission for printing and mailing.

(3) The charge for computer-generated reports, tapes, or other media shall be the cost to the commission for producing and mailing.

[Statutory Authority: RCW 42.17.250 through 42.17.340 and chapter 70.39 RCW. 87-22-005 (Order 87-03, Resolution No. 87-03), § 261-06-070, filed 10/23/87. Statutory Authority: Chapter 70.39 RCW. 83-06-036 (Order 83-02, Resolution No. 83-02), § 261-06-070, filed 2/28/83; Order 73-01, § 261-06-070, filed 1/11/74.]

WAC 261-06-080 Exemptions. (1) The commission reserves the right to determine that a public record requested in accordance with the procedures outlined in WAC 261-02-060 is exempt under the provisions of RCW 42.17.310 and 70.39.110.

(2) In addition, pursuant to RCW 42.17.260, the commission reserves the right to delete identifying details when it makes available or publishes any public record, in any cases when there is reason to believe that disclosure of such details would be an invasion of personal privacy protected by chapter 42.17 RCW. The

public records officer will fully justify such deletion in writing.

(3) All denials of requests for public records must be accompanied by a written statement specifying the reason for withholding the record and a brief explanation of how the exemption applies to the record withheld.

[Statutory Authority: RCW 42.17.250 through 42.17.340 and chapter 70.39 RCW. 87-22-005 (Order 87-03, Resolution No. 87-03), § 261-06-080, filed 10/23/87. Statutory Authority: Chapter 70.39 RCW. 83-06-036 (Order 83-02, Resolution No. 83-02), § 261-06-080, filed 2/28/83; Order 73-01, § 261-06-080, filed 1/11/74.]

WAC 261-06-090 Review of denials of public records requests. (1) Any person who objects to the denial of a request for a public record may petition for prompt review of such decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public records officer or other staff member which constituted or accompanied the denial.

(2) Immediately after receiving a written request for review of a decision denying a public record, the public records officer or other staff member denying the request shall refer it to the executive director of the commission. The executive director may request that a special meeting of the commission be called as soon as legally possible to review the denial. In any case, the request shall be returned with a final decision, within two business days following the receipt of the petition for review.

(3) Administrative remedies shall not be considered exhausted until the commission has returned the petition with a decision or until the close of the second business day following receipt of the petition for review, whichever occurs first.

[Statutory Authority: RCW 42.17.250 through 42.17.340 and chapter 70.39 RCW. 87-22-005 (Order 87-03, Resolution No. 87-03), § 261-06-090, filed 10/23/87. Statutory Authority: Chapter 70.39 RCW. 83-06-036 (Order 83-02, Resolution No. 83-02), § 261-06-090, filed 2/28/83; Order 73-01, § 261-06-090, filed 1/11/74.]

WAC 261-06-110 Records index. (1) As a result of the commission's responsibility to regulate the rates of Washington hospitals, the commission has generated and continues to generate an extremely high volume of records. These records include many categories of budget-related documents for each of the approximately one hundred hospitals subject to the commission's regulatory authority; massive data bases for various aspects of hospital rate regulation; and many other related documents necessarily generated by the commission's performance of its statutory functions. Due to the high volume of such records as well as their technical and diverse nature, the commission finds that it would be unduly burdensome and would interfere with commission operations to maintain an index of records as specified in RCW 42.17.260 (2)(a) through (f). The maintenance of such an index would substantially reduce the commission staff's availability to assist the commission in the discharge of its substantive regulatory duties.

(2) The commission has promulgated a general index of commission records. This index shall be available to

all persons under the same rules and on the same conditions as are applied to public records available for inspection.

[Statutory Authority: RCW 42.17.250 through 42.17.340 and chapter 70.39 RCW. 87-22-005 (Order 87-03, Resolution No. 87-03), § 261-06-110, filed 10/23/87; Order 73-01, § 261-06-110, filed 1/11/74.]

Chapter 261-40 WAC

REVIEW AND APPROVAL OF ANNUAL BUDGET SUBMITTALS, RATES, RATE SCHEDULES, OTHER CHARGES AND CHANGES

WAC

PART 0 GENERAL PROVISIONS

261-40-020 Applicability of this chapter.

PART I ANNUAL BUDGET SUBMITTAL REVIEW PROCESS

261-40-150 Methodology and criteria for approval, modification, or disapproval of annual budget submittal and rates, rate schedules, other charges, and changes therein.

261-40-190 Penalties for violation.

PART 0 GENERAL PROVISIONS

WAC 261-40-020 Applicability of this chapter. (1) Required commission approval of rate changes: No rate described in any hospital's annual budget submittal as approved by the commission may be changed by such hospital without applying to the commission for the approval of a rate change in accordance with the procedures set forth in this chapter. Rate changes for volume variance under WAC 261-40-150 are not considered rate changes under this section.

(2) Effective date of change in approved rates: Hospitals shall utilize only those rates that have been approved by the commission. Every request for a change in rates shall provide for a proposed effective date for that change which shall be no sooner than thirty days after the commission receives the request. If the request does not include a proposed effective date, that date shall be deemed to be thirty days after the receipt of the request.

The new rates may be utilized by the hospital after the proposed effective date unless the commission has suspended the date pursuant to WAC 261-40-030.

(3) Publication of a schedule of rates and proposed changes in rates: Each hospital shall issue and make available to the public a schedule of rates as approved by the commission. Any proposed changes in rates shall be plainly indicated on the schedule effective at that time and shall be open to public inspection for at least thirty days prior to the proposed effective date.

(4) Hospitals located within fifteen miles of one or more hospitals located in an out-of-state jurisdiction not subject to the authority of this commission and which nonjurisdictional hospitals have existing capacities to absorb twenty-five percent or more of the patients served by the hospital which would normally be subject to the jurisdiction of this commission shall not be subject to the commission's rate review and approval provisions

as set forth in RCW 70.39.140. Those hospitals found to be exempt under this provision will still have the responsibility to make on a timely basis all filings required by the commission and shall provide on a timely basis other pertinent data that may from time to time be requested by the commission.

[Statutory Authority: Chapter 70.39 RCW. 88-13-044 (Order 88-04, Resolution No. 88-04), § 261-40-020, filed 6/9/88; 84-20-066 (Order 84-05, Resolution No. 84-05), § 261-40-020, filed 10/1/84; 83-06-036 (Order 83-02, Resolution No. 83-02), § 261-40-020, filed 2/28/83; 79-07-030 (Order 79-02, Resolution No. 79-03), § 261-40-020, filed 6/19/79; Order 75-05, § 261-40-020, filed 11/10/75.]

PART I ANNUAL BUDGET SUBMITTAL REVIEW PROCESS

WAC 261-40-150 Methodology and criteria for approval, modification, or disapproval of annual budget submittal and rates, rate schedules, other charges, and changes therein. The following methodology and criteria shall be utilized by the commission in reviewing and acting on annual budget submittals. The relative importance of each criterion, and the extent to which justification for variance from the methodology and criteria is accepted, is a matter of commission discretion:

The following is effective for hospital fiscal years beginning on or after January 1, 1988.

(1) Whether the hospital's annual budget submittal and the rates, rate schedules, other charges, and changes therein:

(a) Are such that the commission can assure all purchasers of that hospital's health care services that the total costs of the hospital are reasonably related to the total services offered by that hospital;

(b) Are such that the hospital's costs do not exceed those that are necessary for a prudently and reasonably managed hospital;

(c) Are such that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs; and

(d) Are such that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.

(2) Whether the commission action will permit the hospital to render necessary, effective and efficient service in the public interest.

(3) Whether the commission action will assure access to necessary, effective, economically viable and efficient hospital health care capability throughout the state, rather than the solvency or profitability of any individual hospital except where the insolvency of a hospital would seriously threaten the access of the rural public to basic health care services.

(a) Rural includes all areas of the state with the following exceptions:

(i) The entire counties of Snohomish (including Camano Island), King, Kitsap, Pierce, Thurston, Clark, and Spokane;

(ii) Areas within a twenty-mile radius of an urban area exceeding thirty thousand population; and

(iii) Those cities or city-clusters located in rural counties but which for all practical purposes are urban. These areas are Bellingham, Aberdeen-Hoquiam, Longview-Kelso, Wenatchee, Yakima, Sunnyside, Richland-Kennewick-Pasco, and Walla Walla.

(b) The commission may, at its discretion, determine that individual hospitals located in areas meeting the aforementioned criteria should not be considered rural for purposes of conducting comparative budget reviews between hospitals. In such cases, the affected hospitals will be compared against those hospitals classified as either Peer Group B or Peer Group D for comparative purposes.

(4) Whether the appropriate area-wide and state comprehensive health planning agencies have recommended approval, modification, or disapproval of the annual budget submittal, or the rates, rate schedules, other charges, or changes therein.

(5) Whether the proposed budget and the projected revenues and expenses would result in the rate structure most reasonable under the circumstances. The following shall be considered by the commission in making that determination:

(a) For purposes of conducting comparative budget review, the commission shall assign each hospital to a peer group, as follows:

(i) Peer Group A - those hospitals designated as rural in accordance with WAC 261-40-150 (3)(a);

(ii) Peer Group B - those hospitals not designated within Peer Groups A, C, or D;

(iii) Peer Group C - those hospitals with accredited graduate medical education programs, except those that are classified within Peer Group D; and

(iv) Peer Group D - those hospitals which the commission has determined exhibit unique characteristics that make comparative analysis inappropriate.

(b) The commission shall determine whether the hospital's requested utilization statistics are reasonably attainable, based upon:

(i) The adjusted case mix value units for each hospital which were used to develop the individual hospital's operating expense component of the target dollar amount of total state-wide hospital revenue; and

(ii) Maintaining a reasonable relationship between the volumes of each hospital department with the adjusted case mix value units which were used to develop the individual hospital's operating expense component of the target dollar amount of total state-wide hospital revenue.

(A) Deviations from the volume levels determined through these procedures will be taken into account in the computation of year-end conformance, as described in WAC 261-40-150(6).

(c) The commission shall utilize a principal screen to compare the hospital's requested net patient services revenue (total rate setting revenue less deductions from revenue) per adjusted case mix value unit to the hospital's baseline net patient services revenue per adjusted case mix value unit as calculated in item (i) below and applied by items (ii), (iii), and (iv) below:

(i) Each hospital's baseline net patient services revenue per adjusted case mix value unit shall be calculated as follows:

(A) Baseline adjusted case mix value units shall be equal to the current year approved level;

(B) Baseline net patient services revenue shall be determined as an allocated amount of the net patient services revenue component of the target dollar amount of total state-wide hospital revenue.

(ii) If, after volume adjusting the revised baseline and the budget request to reasonably attainable levels of adjusted case mix value units, the requested net patient services revenue does not exceed the revised baseline, the operating expense and capital allowance sections of the hospital's annual budget submittal will not be subject to further review provided that the resulting rates meet the criteria of subsections (5)(g), (6), and (7) of this section.

(iii) If, after volume adjusting the revised baseline and the budget request to reasonably attainable levels of adjusted case mix value units, the requested net patient services revenue exceeds the revised baseline, further review of the components of operating expense and capital allowance will be conducted.

(iv) Peer Group A hospitals with requested net patient services revenue per adjusted case mix value unit which are at or below the 70th percentile for their peer group, and which are increasing from the current year approved level at a percentage change which is at or below the 70th percentile rate of change for the peer group, shall be exempted from the principal screen review and the review of operating expenses and capital allowance, so long as the budgeted adjusted case mix value units appear to be reasonably attainable.

(d) The commission shall determine whether the hospital's requested operating expenses are such that the commission can assure all purchasers of that hospital's health care services that the total costs of the services are reasonably related to the total services offered by that hospital and are such that the hospital's costs do not exceed those that are necessary for a reasonably and prudently managed hospital, based upon:

(i) Adjusting the requested level of operating expenses to reflect the adjusted case mix value units as determined according to (5)(b) of this section, utilizing the variable cost factors described in subsection (6) of this section;

(ii) Applying national hospital market basket inflation forecasts to operating expenses by natural classification. National inflation forecasts will be modified to reflect regional or state-wide economic conditions, as appropriate; and

(iii) Such other information as the commission may determine is appropriate as a basis for deviating from the standard variable cost ratios specified in subsection (6) of this section or inflation forecasts. This information shall include but not be limited to:

(A) Revisions necessary to comply with the commission's *Accounting and Reporting Manual for Hospitals* pursuant to WAC 261-20-030;

(B) Reasonable operating expenses related to implementation or deletion of services or programs for which

certificate of need approval has been obtained, if requested;

(C) Reasonable operating expenses related to expansion or contraction of hospital capacity for which certificate of need approval has been obtained, if required;

(D) Volume adjustments of a magnitude which render the standard variable cost factors described in subsection (6) of this section inappropriate; and

(E) Reasonable operating expenses related to malpractice tail liability expense accruals, if requested, under the following conditions:

(I) The expense will be recognized in the year-end conformance calculations at the lesser of the approved or funded level;

(II) This expense will be subject to the statutory requirement that expenses be necessary for prudently and reasonably managed hospitals, including any determinations by the commission that risk sharing among multiple hospitals may result in lower costs to the consumers and purchasers of hospital health care services;

(III) If requested and approved in rates, this expense must be placed into a fund, restricted by the commission and reviewed annually, with interest earnings accruing to that fund;

(IV) Malpractice claims which are not otherwise covered by malpractice insurance which are in excess of the malpractice tail liability restricted fund should be included in rates in the year in which an actual award, resulting from litigation or negotiation, is made to the claimant: *Provided*, That only that portion of any such awards that exceeds the restricted funds held for this purpose will be included in commission approved total rate setting revenue;

(V) In the event that a hospital changes insurance carriers, does not obtain insurance in a subsequent year, is sold, or discontinues services as a hospital as defined in RCW 70.39.020(3), the premium for malpractice tail coverage insurance must be paid out of the restricted fund: *Provided*, That such malpractice tail coverage insurance is not otherwise made available to the hospital as a condition of previous or existing malpractice insurance policies;

(VI) Annual requests for malpractice tail liability expense accrual funding must be documented by actuarial studies or reasonable estimates, subject to verification, of the total of such liabilities and documentation of the amount of such restricted funds, with the difference between the two amounts equalling the amount that the commission will consider including in rates for that budget period: *Provided*, That if the commission determines that full funding of the malpractice liability restricted fund within any one budget period may result in unreasonable rates or excessive rates of increase in rates, the approval of rates to achieve full funding of the restricted fund may be spread over additional years;

(VII) Once a hospital has received approval from the commission to increase patient rates to include the malpractice tail liability expense accrual, the hospital must provide an annual report to the commission from a licensed actuary or reasonable estimate, subject to verification, showing the total estimate of such liabilities as of

the end of the budget year, and any excesses which may have been expensed and funded in previous years will be deducted from that year's approved total rate setting revenue;

(VIII) As a condition of approving the inclusion of malpractice tail liability expense accruals in total rate setting revenue, the commission will require that each hospital for which this expense is approved file financial statements which have been audited by an independent certified public accountant.

(F) Other consideration presented by the hospital or other concerned persons and determined to be appropriate by the commission, including the impact that the acceptance of operating expense increases above the baseline level would have on the commission's ability to achieve total state-wide revenue that are within the target dollar amount of total state-wide hospital revenue as adopted by the commission in accordance with RCW 70.39.150(6), and comparative analysis of the hospital's operating expenses with hospitals within the same peer group.

(e) The commission shall determine whether the hospital's requested capital allowance is appropriate based upon the following:

(i) Capital allowance includes a return on net property, plant and equipment (property, plant and equipment less accumulated depreciation) used in hospital operations, an allowance for working capital, and other considerations as determined to be appropriate by the commission.

(A) The value for net property, plant and equipment shall be derived from the balances at the end of the hospital's current year, as approved by the commission, and the projected balances at the end of the budget year. An average shall be calculated. The average of the net property, plant and equipment shall be the base upon which the return shall be calculated.

(I) Any capital expenditures contained in the projected balances at the end of the budget year which are subject to certificate of need approval will be excluded from the base until such time as the certificate of need has been issued by the department of social and health services.

(II) Any assets contained in net property, plant and equipment that do not relate to hospital operations, as defined in the commission's *Accounting and Reporting Manual for Hospitals*, pursuant to WAC 261-20-030, will be excluded from the base.

(B) A return on net property, plant and equipment as determined in (I), (II), and (III) below shall be presumed appropriate; however, the commission may vary from that return, higher or lower, where appropriate.

(I) The rate of return on equity financed net property, plant and equipment shall be calculated by averaging the reported interest rates on twenty-five year "A" rated tax-exempt bonds as reported in each issue of *Rate Controls* from the three months ending on August 31, of the year preceding the budget year.

(II) The rate of return on debt financed net property, plant and equipment shall be a blended average of each hospital's average interest rate on long-term debt and

the rate of return on equity financed net property, plant and equipment. The blending schedule is as follows:

(aa) For hospital fiscal years beginning in 1988: Fifty percent – each hospital's average interest rate on long-term debt, fifty percent – rate of return on equity financed net property, plant and equipment;

(bb) For hospital fiscal years beginning in 1989: Twenty-five percent – each hospital's average interest rate on long-term debt, seventy-five percent – rate of return on equity financed net property, plant and equipment;

(cc) For hospital fiscal years beginning in 1990 and each year thereafter: Zero percent – each hospital's average interest rate on long-term debt, one hundred percent – rate of return on equity financed net property, plant and equipment.

(III) After computation of the return on net property, plant and equipment, allowable interest expense on long-term debt shall be deducted from the computed return.

(C) Working capital increases, if requested, shall be added to the return on net property, plant and equipment for determination of the total capital allowance. Working capital increases up to thirteen and one-half percent of the increase in net patient services revenue from the approved budget in the current year to the approved budget as determined by the commission in the requested year shall be presumed appropriate; however, the commission may vary from that allowance, higher or lower, where appropriate.

(I) The commission may determine that a hospital which is found essential to assure access of the rural public to basic health care services is experiencing financial distress and may determine to vary from the allowance for working capital.

(II) The commission may determine to allow additional working capital where the hospital can demonstrate to the commission's satisfaction that its payer mix would require additional funding of accounts receivable. In the event that increased working capital is determined by the commission to be necessary, but the amount of working capital is found by the commission to cause an excessive impact on total revenues or rates, the commission may choose to allow the hospital to borrow the necessary cash and to allow interest on borrowed cash as an operating expense in the budget year.

(D) The commission may consider other elements in the determination of appropriate capital allowance for inclusion in total rate setting revenue. These considerations include, but are not limited to, the following elements:

(I) Rural hospitals that have been under-capitalized as determined by an average accounting age of property, plant and equipment which exceeds one hundred fifty percent of the state-wide average; and a total turnover rate of assets which exceeds the upper quartile of far west hospitals of the same size category as defined in the latest "Hospital Industry Financial Report" of the healthcare financial management association or a fixed asset turnover rate which exceeds the upper quartile of

far west hospitals of the same bed size category as defined in the latest "Hospital Industry Financial Report" of the healthcare financial management association, provided that:

(aa) The total level of capital allowance for under-capitalized hospitals should not exceed one hundred twenty-five percent of the baseline level; and

(bb) The requested rate per adjusted admission, as revised to reflect the hospital's case mix index, does not exceed the peer group median; and

(cc) The resulting increase in the rate per adjusted case mix value unit does not exceed one hundred twenty-five percent of the budgeted peer group median rate of increase.

(II) Whether that portion of debt principal payments which exceeds the total depreciation expense in the budget year should be allowed;

(III) Whether the capital allowance should include equity funding or accumulation of funds for a project in the future, if the hospital's net patient services revenue per adjusted case mix value unit is at or below the median of its peer group and which is increasing from the current year approved level at a percentage change which is at or below the median rate of change of its peer group, the proposed project is consistent with the hospital's long-range plan and financing plan which have been approved by the hospital's governing body, and any equity funding allowed in total rate setting revenue is maintained in a separate subaccount within board designated assets and cannot be used for any other purpose without prior approval of the commission;

(IV) If the hospital has an approved certificate of need and related financing consistent with the approved certificate of need and the impact on rates of the additional funding is determined not to be excessive by the commission; and

(V) Other considerations proposed by the hospital or other interested persons and determined to be appropriate by the commission, including the impact that any deviation from the baseline capital allowance will have on the commission's ability to achieve total state-wide hospital revenue that do not exceed the target dollar amount of total state-wide hospital revenue as adopted by the commission in accordance with RCW 70.39.150(6).

(f) Whether the budgeted deductions from revenue are appropriate:

(i) Contractual adjustments related to governmental programs, such as Titles V, XVIII, XIX of the Social Security Act, Department of Labor and Industries, self-insured workers' compensation, Veteran's Administration, and Indian Health Service are allowable as deductions from revenue for rate setting purposes when the hospital payment rates are established unilaterally by the program.

(ii) Contractual adjustments related to bank card discounts, negotiated rates and all other nongovernmental-sponsored patients are not allowable as deductions from revenue for rate setting purposes;

(iii) Contractual adjustments relating to contracts executed with the department of social and health services,

under the Medicaid selective contracting program, are allowable as deductions from revenue for rate setting purposes;

(iv) Bad debts and charity will be trended as a percentage of total rate setting revenue over time and any significant changes will require justification;

(v) Administrative adjustments exceeding one-tenth of one percent of total rate setting revenue will require justification; and

(vi) Deductions from revenue may be recomputed based on determinations in all other areas of the budget.

(g) Whether the reviews performed in accordance with (a), (b), (c), (d), (e) and (f) of this subsection result in rates, rate schedules, other charges, and changes therein which are the most reasonable under the circumstances.

(i) Net patient services revenue per adjusted case mix value unit should not exceed the 70th percentile of the peer group revenue screens as adjusted for each hospital's case mix index unless the hospital demonstrates to the commission's satisfaction that the relatively high rates are acceptable;

(ii) After allocating deductions from revenue and capital allowance to the various hospital revenue centers as a constant percentage of operating expenses, cross subsidization shall not exceed plus or minus five percent of expenses for rate setting, unless the commission concurs with a specific hospital request for larger levels of cross subsidization or the hospital is a basic service hospital as defined by the commission.

(iii) The commission may consider any other information it determines is appropriate as the basis for deviating from these criteria including the relative level of deductions from revenue experienced by the hospitals;

(iv) If the rates are not approved as requested, including the disapproval of requested cross-subsidization levels, the hospital must submit revised rates to the commission within twenty days of the date of service of the decision and order. Upon notification that the rates are in accordance with the decision and order, the approved rates are the maximum revenue that a hospital may receive for each unit of service, except for such rate changes as may be necessary to reflect differences between approved and actual volumes and deductions from revenue. Variable costs associated with changes in volumes will be determined in accordance with the variable cost ratios as described in (6)(d) below.

The following is effective for hospital fiscal years beginning on or after January 1, 1987.

(6) Whether the rates implemented and revenues collected by the hospital in the previous budget year conformed to the applicable commission determination for that year.

(a) Conformance will be determined by comparing, at the end of the budget year, actual revenues for the budget year to commission-approved revenues, on the basis of the aggregate rate per adjusted case mix value unit. The revenues may be modified, where appropriate, for volume variance between budgeted and actual levels of adjusted case mix value units.

(b) Actual allowable, rather than budgeted, deductions from revenue will be used in the conformance calculation.

(c) The approved capital allowance shall be considered a fixed cost when considering year-end conformance.

(d) Only that portion of total operating costs designated as variable according to the following schedule will be adjusted for volume variance:

(i) Peer Group A and specialty hospitals having fewer than fifty beds; fixed costs – eighty percent, variable costs – twenty percent;

(ii) Peer Group B and specialty hospital having from fifty to one hundred seventy-five beds; fixed costs – sixty-five percent, variable costs – thirty-five percent; and

(iii) Peer Group C and specialty hospitals having more than one hundred seventy-five beds; fixed costs – fifty percent, variable costs – fifty percent.

(e) Alternatively, the hospital may submit suggested ratios of fixed costs to variable costs by natural classification of expense. Upon approval by the commission, such approved ratios will be used only prospectively to determine allowable operating expense variance due to volume changes.

(f) The hospital may submit any proposed justifying information to explain deviations/variances from approved revenues.

(i) Any proposed justifying information must include at least the following supporting information:

(A) The exact nature and extent of the factors contributing to excess revenue;

(B) The date at which hospital management became aware of the factors contributing to excess revenue;

(C) The date at which hospital management increased rates above the allowable level taking into account volume changes and actual deductions from revenue;

(D) An explanation of efforts to reduce other components of the budget to offset the factors contributing to the excess revenues; and

(E) An explanation of why the hospital did not seek a budget amendment.

(ii) In no event will increased operating expenses be accepted as justification if the volume adjusted allowable operating expenses equal or exceed the actual level.

(iii) In no event will proposed justifying information be accepted if the commission determines that the factors contributing to excess revenues could have been controlled by hospital management.

(iv) In no event will proposed justifying information be accepted if the commission determines that the factors contributing to excess revenues could have been anticipated by the hospital or could have been identified by the hospital in sufficient time to submit a budget amendment in accordance with WAC 261-20-045.

(v) In no event will capital allowance in excess of the approved level be accepted as justification.

(vi) Hospitals will be allowed to retain any actual capital allowance in excess of the approved level that results from cost effective practices as defined as, and

measured by, actual operating expenses that are below the volume adjusted approved operating expenses.

(g) Staff shall notify each hospital found to be out of conformance within sixty days of receiving all applicable information necessary to compute the hospital's year-end conformance calculation. If the commission determines that a hospital's revenues have not conformed to the applicable determinations for that year, a decision and order will be issued reducing the hospital's current budget and rates by the amount that actual revenues exceed allowable revenues.

(7) Whether the hospital or its medical staff either adopts or maintains admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage or who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is or is likely to be less than the anticipated charges for or costs of such services; and

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

[Statutory Authority: Chapter 70.39 RCW. 88-22-038 (Order 88-07, Resolution No. 88-07), § 261-40-150, filed 10/28/88; 88-17-054 (Order 88-06, Resolution No. 88-06), § 261-40-150, filed 8/17/88; 88-11-033 (Order 88-02, Resolution No. 88-02), § 261-40-150, filed 5/13/88; 87-24-011 (Order 87-05, Resolution No. 87-05), § 261-40-150, filed 11/20/87. Statutory Authority: RCW 70.39.180. 86-15-018 (Order 86-04, Resolution No. 86-04), § 261-40-150, filed 7/11/86; 85-22-036 (Order 86-04, Resolution No. 86-04), § 261-40-150, filed 11/1/85. Statutory Authority: Chapter 70.39 RCW. 84-20-066 (Order 84-05, Resolution No. 84-05), § 261-40-150, filed 10/1/84. Statutory Authority: RCW 70.39.160. 83-06-036 (Order 83-02, Resolution No. 83-02), § 261-40-150, filed 2/28/83; 79-07-030 (Order 79-02, Resolution No. 79-03), § 261-40-150, filed 6/19/79; Order 77-02, § 261-40-150, filed 12/23/77; Order 75-05, § 261-40-150, filed 11/10/75.]

WAC 261-40-190 Penalties for violation. RCW 70.39.200 provides that every person who shall violate or knowingly aid and abet the violation of chapter 70.39 RCW or any valid orders, rules, or regulations thereunder, or who fails to perform any act which that chapter makes it his/her duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of chapter 70.39 RCW may be enjoined from continuing such violation. Failure to file the reports required by WAC 261-40-110, 261-40-130, 261-40-150 (5)(f)(iii), and 261-40-170 shall constitute a violation, and the commission may levy a civil penalty not to exceed one hundred dollars per day for each day following official notice of the violation by the commission. The executive director of the commission may grant extensions of time to file the reports, in which cases failure to file the reports shall not constitute a violation until the extension period has expired.

[Statutory Authority: Chapter 70.39 RCW. 88-13-044 (Order 88-04, Resolution No. 88-04), § 261-40-190, filed 6/9/88.]

Chapter 261-50 WAC
RULES FOR REPORTING HOSPITAL PATIENT
DISCHARGE INFORMATION

WAC	
261-50-030	Reporting of UB-82 data set information.
261-50-035	Reporting of E-Codes.
261-50-040	Acceptable media for submission of data.
261-50-045	Repealed.
261-50-050	Time deadline for submission of data.
261-50-060	Edits to data.
261-50-075	Certification of data accuracy.
261-50-090	Penalties for violation.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS
CHAPTER

261-50-045	Magnetic diskette and tape record layout. [Statutory Authority: RCW 70.39.180. 86-14-081 (Order 86-03, Resolution No. 86-03), § 261-50-045, filed 7/1/86; 85-17-020 (Order 85-05, Resolution No. 85-05), § 261-50-045, filed 8/13/85. Statutory Authority: Chapter 70.39 RCW. 84-20-067 (Order 84-06, Resolution No. 84-06), § 261-50-045, filed 10/1/84.] Repealed by 87-04-008 (Order 87-01, Resolution No. 87-01), filed 1/23/87. Statutory Authority: Chapter 70.39 RCW.
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WAC 261-50-030 Reporting of UB-82 data set information. (1) Effective with all hospital patient discharges on or after July 1, 1984, hospitals shall collect and report the following UB-82 data set elements to the commission:

(a) Patient control number

Patient's unique alpha-numeric number assigned by the hospital to facilitate retrieval of individual patient records and posting of payments. This number should be constructed to allow prompt hospital access to the patient's discharge record for data verification.

(b) Type of bill

This three-digit code requires 1 digit each, in the following sequence form: Type of facility, bill classification, frequency.

Digit #1 must be "1" to indicate a hospital.

Digit #2 must be a "1," a "2" or an "8" to indicate an inpatient.

Digit #3 must be one of the following:

1 - Admit through discharge claim

(c) Medicare provider number

This is the number assigned to the provider by Medicare.

(d) Patient identifier

The patient identifier shall be composed of the first two letters of the patient's last name, the first two letters of the patient's first name, or one or two initials if no first name is available, and the patient's birthdate.

(e) Zipcode

Patient's five or nine digit zipcode. In the case of a foreign country, enter the first nine characters of the name.

(f) Birthdate

The patient's date of birth in MMDDYY format. Note: If the patient is over 100 years old at the date of admission, then "17" must be the value in the "condition code #1" field.

(g) Sex

Patient's sex in M/F format.

(h) Admission date

Admission date in MMDDYY format.

(i) Type of admission

This field is filled with one of the following codes:

- 1 Emergency
- 2 Urgent
- 3 Elective
- 4 Newborn
- 5 Other

(j) Source of admission

This field is completed with one of the following codes:

- 1 Physician referral
- 2 Clinic referral
- 3 HMO referral
- 4 Transfer from another hospital
- 5 Transfer from a SNF
- 6 Transfer from another HCF
- 7 Emergency room
- 8 Court/law enforcement
- 9 Other

When type of admission is a "4 newborn," enter one of the following for source of admission:

- 1 Normal delivery
- 2 Premature delivery
- 3 Sick baby
- 4 Extramural birth
- 5 Multiple birth

(k) Patient status

Patient discharge disposition in one of the following codes:

- 01 Discharged home
- 02 Discharged to another short-term general hospital
- 03 Discharged to SNF
- 04 Discharged to an ICF
- 05 Discharged to another type institution
- 06 Discharged to home under care of HHA
- 07 Left against medical advice
- 20 Expired

(l) Statement covers period

This is the beginning and ending dates for which the UB-82 covers.

Chapter 261-50 WAC

(m) Condition code #1

If a patient is equal to or over 100 years old at the time of admission, the value "17" must be the value of this field.

(n) Revenue code

The Medicare required revenue code (as defined in the *UB-82 Procedures Manual*), which identifies a specific accommodation, ancillary service or billing calculation. Effective January 1, 1987.

(o) Units of service

The Medicare required units of service (as defined in the *UB-82 Procedures Manual*) which provide a quantitative measure of services rendered by revenue category to or for the patient. Where no units of service are required by Medicare, the units of service may be those used by the hospital. Effective January 1, 1987.

(p) Total charges by revenue code category

Total charges pertaining to the related revenue code. Effective January 1, 1987.

(q) Payer identification #1

Enter the three-digit code that identifies the primary payer. The required code options include:

- 001 for Medicare
- 002 for Medicaid
- 004 for health maintenance organizations
- 006 for commercial insurance
- 008 for labor and industries
- 009 for self pay
- 610 for health care service contractors, e.g., Blue Cross, county medical bureaus, Washington Physicians Service
- 625 for other sponsored patients, e.g., CHAMPUS, Indian health
- 630 charity care, as defined in WAC 261-14-020(5)

(r) Payer identification #2

Same requirements as in payer identification #1. This field should only be completed when a secondary payer has been identified.

(s) Principal diagnosis code

ICD9-CM code describing the principal diagnosis (the condition established after study to be chiefly responsible or causing the hospitalization) that exists at time of admission.

(t) Diagnosis #2 code

ICD9-CM code of secondary diagnosis corresponding to additional diagnosis that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

(u) Diagnosis #3 code

ICD9-CM code of secondary diagnosis corresponding to additional diagnosis that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

(v) Diagnosis #4 code

ICD9-CM code of secondary diagnosis corresponding to additional diagnosis that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

(w) Diagnosis #5 code

ICD9-CM code of secondary diagnosis corresponding to additional diagnosis that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

(x) Principal procedure code

The ICD9-CM code that identifies the principal procedure performed during the patient admission.

(y) Procedure #2 code

Secondary procedure code identifying procedures, other than the principal procedure, performed during the admission.

(z) Procedure #3 code

Secondary procedure code identifying procedures, other than the principal procedure, performed during the admission.

(aa) Attending physician ID

The Medicaid assigned number of the licensed physician who would normally be expected to certify and recertify

the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment. For physicians who do not have a Medicaid number assigned, the state license number should be used. Effective July 1, 1987.

(bb) Other physician ID

The Medicaid assigned number of the licensed physician who performed the principal procedure. For physicians who do not have a Medicaid number, the state license number should be used. If no principal procedure was performed, this field should be left blank. Effective July 1, 1987.

(2) It shall be the responsibility of each hospital to ensure that data reported pursuant to WAC 261-50-030(1) is provided for all patient discharges. Each patient discharge must carry a separate, unique patient control number on a separate UB-82 record. For example, a mother and her newborn require separate UB-82s, each with a separate, unique patient control number.

[Statutory Authority: Chapter 70.39 RCW. 87-08-037 (Order 87-02, Resolution No. 87-02), § 261-50-030, filed 3/30/87; 87-04-008 (Order 87-01, Resolution No. 87-01), § 261-50-030, filed 1/23/87. Statutory Authority: RCW 70.39.180. 86-14-081 (Order 86-03, Resolution No. 86-03), § 261-50-030, filed 7/1/86; 85-17-020 (Order 85-05, Resolution No. 85-05), § 261-50-030, filed 8/13/85. Statutory Authority: Chapter 70.39 RCW. 84-20-067 (Order 84-06, Resolution No. 84-06), § 261-50-030, filed 10/1/84.]

WAC 261-50-035 Reporting of E-Codes. Effective with hospital patient discharges occurring on or after January 1, 1989, hospitals shall collect and report up to two ICD-9-CM codes identifying the external cause of injury and poisoning (E-Codes), when applicable.

[Statutory Authority: Chapter 70.39 RCW. 88-16-043 (Order 88-05, Resolution No. 88-05), § 261-50-035, filed 7/29/88.]

WAC 261-50-040 Acceptable media for submission of data. For purposes of the data collected and reported pursuant to WAC 261-50-030 and 261-50-035, hospitals shall submit such data in such form as prescribed by the commission in the *Procedure Manual for Submitting Discharge Data*.

[Statutory Authority: Chapter 70.39 RCW. 88-16-043 (Order 88-05, Resolution No. 88-05), § 261-50-040, filed 7/29/88; 87-04-008 (Order 87-01, Resolution No. 87-01), § 261-50-040, filed 1/23/87. Statutory Authority: RCW 70.39.180. 86-14-081 (Order 86-03, Resolution No. 86-03), § 261-50-040, filed 7/1/86; 85-17-020 (Order 85-05, Resolution No. 85-05), § 261-50-040, filed 8/13/85. Statutory Authority: Chapter 70.39 RCW. 84-20-067 (Order 84-06, Resolution No. 84-06), § 261-50-040, filed 10/1/84.]

WAC 261-50-045 Repealed. See Disposition Table at beginning of this chapter.

WAC 261-50-050 Time deadline for submission of data. Data collected by hospitals pursuant to WAC 261-50-030 and 261-50-035 shall be submitted to the commission or its designee within forty-five days following the end of each calendar month.

[Statutory Authority: Chapter 70.39 RCW. 88-16-043 (Order 88-05, Resolution No. 88-05), § 261-50-050, filed 7/29/88; 87-04-008 (Order 87-01, Resolution No. 87-01), § 261-50-050, filed 1/23/87; 84-20-067 (Order 84-06, Resolution No. 84-06), § 261-50-050, filed 10/1/84.]

WAC 261-50-060 Edits to data. The commission or its designee shall subject the data submitted to the commission pursuant to WAC 261-50-030 and 261-50-035 to the following set of edits:

- (1) Record layout compatibility edits on data submitted in accordance with WAC 261-50-040; and
- (2) Verification of the data set elements set forth in WAC 261-50-030 and 261-50-035.

[Statutory Authority: Chapter 70.39 RCW. 88-16-043 (Order 88-05, Resolution No. 88-05), § 261-50-060, filed 7/29/88; 87-04-008 (Order 87-01, Resolution No. 87-01), § 261-50-060, filed 1/23/87; 84-20-067 (Order 84-06, Resolution No. 84-06), § 261-50-060, filed 10/1/84.]

WAC 261-50-075 Certification of data accuracy. Following the end of each calendar quarter, the commission shall furnish each hospital a report of its discharge data for that quarter contained in the commission's discharge system. The chief executive officer of the hospital shall, within fourteen calendar days of receipt of the report, certify that the information contained in the commission's discharge system is complete and accurate to within ninety-five percent of the total discharges and total charges experienced at the hospital during that quarter, or submit the necessary corrections to the data to permit such certification.

[Statutory Authority: Chapter 70.39 RCW. 87-08-037 (Order 87-02, Resolution No. 87-02), § 261-50-075, filed 3/30/87.]

WAC 261-50-090 Penalties for violation. RCW 70.39.200 provides that every person who shall violate or knowingly aid and abet the violation of chapter 70.39 RCW or any valid orders, rules, or regulations thereunder, or who fails to perform any act which that chapter makes it his/her duty to perform shall be guilty of misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of chapter 70.39 RCW may be enjoined from continuing such violation. Failure to file the information required by WAC 261-50-030, 261-50-035, 261-50-040, 261-50-065 and 261-50-075 shall constitute a violation, and the commission may levy a civil penalty not to exceed one hundred dollars per day for each day following official notice of violation by the commission. The executive director of the commission may grant extensions of time to file the information, in which cases failure to file the information shall not constitute a violation until the extension period has expired.

[Statutory Authority: Chapter 70.39 RCW. 88-16-043 (Order 88-05, Resolution No. 88-05), § 261-50-090, filed 7/29/88; 87-08-037 (Order 87-02, Resolution No. 87-02), § 261-50-090, filed 3/30/87; 87-04-008 (Order 87-01, Resolution No. 87-01), § 261-50-090, filed 1/23/87. Statutory Authority: RCW 70.39.180. 86-14-081 (Order 86-03, Resolution No. 86-03), § 261-50-090, filed 7/1/86; 85-17-020 (Order 85-05, Resolution No. 85-05), § 261-50-090, filed 8/13/85.]