

**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.]