

WAC 182-550-2900 Payment limits—Inpatient hospital services.

(1) **Eligibility for payment.** 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) **Exclusions.** 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 14 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 14-day readmissions.

(g) Inpatient claims for 14-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 39 weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

(3) **Interim billed inpatient hospital claims.** 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 60-calendar-day intervals, unless the client is discharged before the next 60-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.
- (i) When the agency is the primary payer, each billed psychiatric claim may be submitted in 60-calendar-day intervals unless the client is discharged before the next 60-calendar-day interval.
 - (ii) If a claim is submitted under (c) (i) of this subsection, the claim must document the current dates 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.
- (d) When the agency is not the primary payer, the agency pays a billed psychiatric claim when:
- (i) The criteria in (c) (i) of this subsection are met; and
 - (ii) Either of the following occur:
 - (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.
- (4) **Admission period for claims.** The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of 60 calendar days or less upon the client's formal release from the hospital or distinct unit.
- (5) **Billing for hospital claims.** 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) **Multiple hospital rates.** 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) **Administrative day rate.** 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) **Payment for observation services.** The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) **Required adjustments.** 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) **Clients under state-administered programs.** The agency pays hospitals less for services provided to clients eligible under state-administered programs, as provided in WAC 182-550-4800.

(11) **Final charges.** 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 23-20-048, § 182-550-2900, filed 9/28/23, effective 10/29/23; 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.]