

Chapter 182-550 WAC

HOSPITAL SERVICES

WAC

182-550-1000	Applicability.	182-550-3450	Payment method for calculating medicaid DRG conversion factor rates.
182-550-1050	Hospital services definitions.	182-550-3460	Payment method—Per diem rate.
182-550-1100	Hospital care—General.	182-550-3470	Payment method—Bariatric surgery—Per case rate.
182-550-1200	Restrictions on hospital coverage.	182-550-3500	Hospital annual inflation adjustment determinations.
182-550-1300	Revenue code categories and subcategories.	182-550-3600	Diagnosis-related group (DRG) payment—Hospital transfers.
182-550-1350	Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals.	182-550-3700	DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers.
182-550-1400	Covered and noncovered revenue codes categories and subcategories for inpatient hospital services.	182-550-3800	Rebasing and recalibration.
182-550-1500	Covered and noncovered revenue code categories and subcategories for outpatient hospital services.	182-550-3900	Payment method—Bordering city hospitals and critical border hospitals.
182-550-1600	Specific items/services not covered.	182-550-4000	Payment method—Out-of-state hospitals.
182-550-1650	Adverse events, hospital-acquired conditions, and present on admission indicators.	182-550-4100	Payment method—New hospitals.
182-550-1700	Authorization and utilization review (UR) of inpatient and outpatient hospital services.	182-550-4200	Change in hospital ownership.
182-550-1800	Hospital specialty services not requiring prior authorization.	182-550-4300	Hospitals and units exempt from the DRG payment method.
182-550-1900	Transplant coverage.	182-550-4400	Services—Exempt from DRG payment.
182-550-2100	Requirements—Transplant hospitals.	182-550-4500	Payment method—Ratio of costs-to-charges (RCC).
182-550-2200	Transplant requirements—COE.	182-550-4550	Administrative day rate and swing bed day rate.
182-550-2301	Hospital and medical criteria requirements for bariatric surgery.	182-550-4600	Hospital selective contracting program.
182-550-2400	Inpatient chronic pain management services.	182-550-4650	"Full cost" public hospital certified public expenditure (CPE) payment program.
182-550-2431	Hospice services—Inpatient payments.	182-550-4670	CPE payment program—"Hold harmless" provision.
182-550-2500	Inpatient hospice services.	182-550-4690	Authorization requirements and utilization review for hospitals eligible for CPE payments.
182-550-2501	Acute physical medicine and rehabilitation (acute PM&R) program—General.	182-550-4700	Payment—Non-SCA participating hospitals.
182-550-2511	Acute PM&R definitions.	182-550-4800	Hospital payment methods—State administered programs.
182-550-2521	Client eligibility requirements for acute PM&R services.	182-550-4900	Disproportionate share hospital (DSH) payments—General provisions.
182-550-2531	Requirements for becoming an acute PM&R provider.	182-550-4925	Eligibility for DSH programs—New hospital providers.
182-550-2541	Quality of care—Department-approved acute PM&R hospital.	182-550-4935	DSH eligibility—Change in hospital ownership.
182-550-2551	How a client qualifies for acute PM&R services.	182-550-5000	Payment method—Low income disproportionate share hospital (LIDSH).
182-550-2561	The department's prior authorization requirements for acute PM&R services.	182-550-5125	Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).
182-550-2565	The long-term acute care (LTAC) program—General.	182-550-5130	Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH) and institution for mental diseases (IMD) state grants.
182-550-2570	LTAC program definitions.	182-550-5150	Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH).
182-550-2575	Client eligibility requirements for LTAC services.	182-550-5200	Payment method—Small rural disproportionate share hospital (SRDSH).
182-550-2580	Requirements for becoming an LTAC hospital.	182-550-5210	Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH).
182-550-2585	LTAC hospitals—Quality of care.	182-550-5220	Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH).
182-550-2590	Department prior authorization requirements for Level 1 and Level 2 LTAC services.	182-550-5400	Payment method—Public hospital disproportionate share hospital (PHDSH).
182-550-2595	Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate.	182-550-5410	CPE medicaid cost report and settlements.
182-550-2596	Services and equipment covered by the department but not included in the LTAC fixed per diem rate.	182-550-5425	Upper payment limit (UPL) payments for inpatient hospital services.
182-550-2598	Critical access hospitals (CAHs).	182-550-5450	Supplemental distributions to approved trauma service centers.
182-550-2600	Inpatient psychiatric services.	182-550-5500	Payment—Hospital-based RHCs.
182-550-2650	Base community psychiatric hospitalization payment method for medicaid and SCHIP clients and non-medicaid and non-SCHIP clients.	182-550-5550	Public notice for changes in medicaid payment rates for hospital services.
182-550-2750	Hospital discharge planning services.	182-550-5600	Dispute resolution process for hospital rate reimbursement.
182-550-2800	Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients.	182-550-5700	Hospital reports and audits.
182-550-2900	Payment limits—Inpatient hospital services.	182-550-5800	Outpatient and emergency hospital services.
182-550-3000	Payment method—DRG.	182-550-6000	Outpatient hospital services—Conditions of payment and payment methods.
182-550-3010	Payment method—Per diem payment.	182-550-6100	Outpatient hospital physical therapy.
182-550-3020	Payment method—Bariatric surgery—Per case payment.	182-550-6150	Outpatient hospital occupational therapy.
182-550-3100	Calculating DRG relative weights.	182-550-6200	Outpatient hospital speech therapy services.
182-550-3150	Base period costs and claims data.	182-550-6250	Pregnancy—Enhanced outpatient benefits.
182-550-3200	Medicaid cost proxies.	182-550-6300	Outpatient nutritional counseling.
182-550-3250	Indirect medical education costs—Conversion factors, per diem rates, and per case rates.	182-550-6350	Outpatient sleep apnea/sleep study programs.
182-550-3300	Hospital peer groups and cost caps.	182-550-6400	Outpatient hospital diabetes education.
182-550-3350	Outlier costs.	182-550-6450	Outpatient hospital weight loss program.
182-550-3381	Payment methodology for acute PM&R services and administrative day services.	182-550-6500	Blood and blood components.
182-550-3400	Case-mix index.	182-550-6600	Hospital-based physician services.

182-550-6700	Hospital services provided out-of-state.
182-550-7000	Outpatient prospective payment system (OPPS)—General.
182-550-7050	OPPS—Definitions.
182-550-7100	OPPS—Exempt hospitals.
182-550-7200	OPPS—Billing requirements and payment method.
182-550-7300	OPPS—Payment limitations.
182-550-7400	OPPS APC relative weights.
182-550-7450	OPPS budget target adjustor.
182-550-7500	OPPS rate.
182-550-7600	OPPS payment calculation.

WAC 182-550-1000 Applicability. The department 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, WAC 388-500-0005 or 388-550-1050;

(2) The services are medically necessary as defined under WAC 388-500-0005; and

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

[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, 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, 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 WAC 388-500-0005, Medical definitions, and definitions and abbreviations found in other sections of this chapter, apply to this chapter.

"Accommodation costs" means 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.

"Acquisition cost (AC)" means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice.

"Acute" means a medical condition of severe intensity with sudden onset. See WAC 388-550-2511 for the definition of "acute" for the acute physical medicine and rehabilitation (Acute PM&R) program.

"Acute care" means 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 in order to maintain their health status (see WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at a department-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.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance

abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Administrative day rate" means the statewide Medicaid average daily nursing facility rate as determined by the department.

"Admitting diagnosis" means the medical condition before study, which is initially responsible for the client's admission to the hospital, as defined by the international classification of diseases, 9th revision, clinical modification (ICD-9-CM) diagnostic code, or with the current published ICD-CM coding guidelines used by the department.

"Advance directive" means a document, recognized under state law, such as a living will, executed by a client, that tells the client's health care providers and others about the client's decisions regarding his or her health care in the event the client should become incapacitated. (See WAC 388-501-0125.)

"Aggregate capital cost" means the total cost or the sum of all capital costs.

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

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

"Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)" means the law and the state-administered program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient DRG grouper (AP-DRG)" means a computer software program that determines the medical and surgical diagnosis related group (DRG) assignments.

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

"Allowed charges" means the maximum amount for any procedure or service that the department allows as the basis for payment computation.

"Allowed covered charges" means the maximum amount of charges on a hospital claim recognized by the department as charges for "hospital covered service" and payment computation, after exclusion of any "nonallowed service or charge," and before final adjustments, deductions, and add-ons.

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

"Ancillary hospital costs" means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

"Ancillary services" means additional or supporting services provided by a hospital to a patient during the patient'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" means the level of care required to best manage a client's illness or injury based on the severity of illness presentation and the intensity of services received.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means 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 department through medicaid, SCHIP, or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying 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), submitted to the department for the purpose of establishing program rates for payment to hospital providers.

"Audit claims sample" means a selection of claims reviewed under a defined audit process.

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

"Average hospital rate" means an average of hospital rates for any particular type of rate that the department uses.

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

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Billed charge" means the charge submitted to the department by the provider.

"Blended rate" means a mathematically weighted average rate.

"Bordering city hospital" means a hospital located outside Washington state and located in one of the bordering cities listed in WAC 388-501-0175.

"BR" - See **"by report."**

"Budget neutrality" is a concept that means that hospital payments resulting from payment methodology changes and rate changes should be equal to what payments would have been if the payment methodology changes and rate changes were not implemented. (See also "budget neutrality factor.")

"Budget neutrality factor" is a factor used by the department to adjust conversion factors, per diem rates, and per case rates in order that modifications to the payment methodology and rates are budget neutral. (See also "budget neutrality.")

"Bundled services" means interventions that are integral to the major procedure and are not paid separately.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B medicare.

"By report (BR)" means a method of payment in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping hospital staff members on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services which are usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" or **"capital costs"** means the component of operating costs related to capital assets, including, but not limited to:

- (1) Net adjusted depreciation expenses;
- (2) Lease and rentals for the use of depreciable assets;
- (3) The costs for betterment and improvements;
- (4) The cost of minor equipment;
- (5) Insurance expenses on depreciable assets;
- (6) Interest expense; and
- (7) Capital-related costs of related organizations that provide services to the hospital.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

"CARF" is the official name for commission on accreditation of rehabilitation facilities. CARF is an international, independent, nonprofit accreditor of human service providers and networks in the areas of aging services, behavioral health, child and youth services, employment and community services, and medical rehabilitation.

"Case mix" means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index (CMI)" means the arithmetical index that measures the average relative weight of all cases treated in a hospital during a defined period.

"Charity care" see chapter 70.170 RCW.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Client" means a person who receives or is eligible to receive services through department of social and health services (DSHS) programs.

"CMS" means Centers for Medicare and Medicaid Services.

"CMS PPS input price index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, measured by Global Insight's Data Resources, Inc. (DRI).

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

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

"Contract hospital-selective contracting" means for dates of admission before July 1, 2007, a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's hospital selective contracting program. The department's hospital selective contracting program no longer exists for admissions on and after July 1, 2007.

"Contract hospital" means a hospital contracted by the department to provide specific services.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has medicaid claim charges for the services, but does not report costs in corresponding centers in its medicare cost report.

"Cost report" see "medicare cost report."

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

"Cost-based conversion factor (CBCF)" means for dates of admission before August 1, 2007, a hospital-specific dollar amount that reflects a hospital's average cost of treating medicaid and SCHIP clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating medicaid and SCHIP clients during a base period by the number of medicaid and SCHIP discharges during that same period and adjusting for the hospital's case mix. See also **"hospital conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered charges" means billed charges submitted to the department on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" see "hospital covered service" and WAC 388-501-0060.

"Critical border hospital" means, on and after August 1, 2007, an acute care hospital located in a bordering city that the department has, through analysis of admissions and hos-

pital days, designated as critical to provide elective health-care for the department's medical assistance clients.

"Current procedural terminology (CPT)" means 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).

"Customary charge payment limit" means the limit placed by the department on aggregate DRG payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means an inpatient case with a date of admission before August 1, 2007, that requires the department to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."** The department's day outlier policy no longer exists for dates of admission on and after August 1, 2007.

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for inpatient claims with dates of admission before August 1, 2007, for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means for inpatient claims with dates of admission before August 1, 2007, the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Department" means the state department of social and health services (DSHS). As used in this chapter, department also means MAA, HRSA, or a successor administration that administers the state's medicaid, SCHIP, and other medical assistance programs.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetes education program" means a comprehensive, multidisciplinary program of instruction offered by a department of health (DOH)-approved diabetes education provider to diabetic clients on dealing with 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" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of

Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

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

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

"Disproportionate share hospital (DSH) payment" means a supplemental payment(s) made by the department to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share hospital (DSH) program" is a program through which the department gives consideration to hospitals that serve a disproportionate number of low-income patients with special needs by making payment adjustment to eligible hospitals in accordance with legislative direction and established payment methods. See 1902 (a)(13) (A)(iv) of the Social Security Act. See also WAC 388-550-4900 through 388-550-5400.

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

"Distinct unit" means a medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a department-designated unit in a children's hospital.

"Division of alcohol and substance abuse (DASA)" is the division within DSHS responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction.

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

"DRG average length-of-stay" means for dates of admission on and after July 1, 2007, the department's average length-of-stay for a DRG classification established during a department DRG rebasing and recalibration project.

"DRG-exempt services" means services which are paid through other methodologies than those using inpatient medicaid conversion factors, inpatient state-administered program conversion factors, cost-based conversion factors (CBCF) or negotiated conversion factors (NCF). Some examples are services paid using a per diem rate, a per case rate, or a ratio of costs-to-charges (RCC) rate.

"DRG payment" means the payment made by the department for a client's inpatient hospital stay. This DRG payment allowed amount is calculated by multiplying the conversion factor by the DRG relative weight assigned by the department to provider's inpatient claim before any outlier payment calculation.

"DRG relative weight" means the average cost or charge of a certain DRG classification divided by the average cost or charge, respectively, for all cases in the entire data base for all DRG classifications.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual

therapy, group therapy and related activities to detoxified addicts and their families.

"DSHS" means the department of social and health services.

"Elective procedure or surgery" means a nonemergency procedure or surgery that can be scheduled at the client's and provider's convenience.

"Emergency medical condition" see WAC 388-500-0005.

"Emergency medical expense requirement (EMER)" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the psychiatric indigent inpatient (PII) program.

"Emergency room" or **"emergency facility"** or **"emergency department"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care.

"Emergency services" means healthcare services required by and provided to a patient 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 patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For department payment to a hospital, inpatient maternity services are treated as emergency services.

"Equivalency factor (EF)" means a factor that may be used by the department in conjunction with other factors to determine the level of a state-administered program payment. See WAC 388-550-4800.

"Exempt hospital—DRG payment method" means a hospital that for a certain patient category is reimbursed for services to medical assistance clients through methodologies other than those using DRG conversion factors.

"Exempt hospital—Hospital selective contracting program" means a hospital that is either not located in a selective contracting area or is exempted by the department from the selective contracting program. The department's hospital selective contracting program no longer exists for admissions on and after July 1, 2007.

"Expedited prior authorization (EPA)" means the department-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which department-acceptable indications, conditions, diagnoses, and/or department-defined criteria are applicable to a particular request for service.

"Expedited prior authorization (EPA) number" means an authorization number created by the provider that certifies that the department-published criteria for the medical/dental procedure or supply or services have been met.

"Experimental" means a procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 388-531-0050. 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 FDA or other requisite government body if such approval is required.

"Fee-for-service" means the general payment process the department uses to pay a hospital provider's claim for covered medical services provided to medical assistance clients when the payment for these services is through direct payment to the hospital provider, and is not the responsibility of one of the department's managed care organization (MCO) plans, or a mental health division designee.

"Fiscal intermediary" means medicare's designated fiscal intermediary for a region and/or category of service.

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

"Global surgery days" means 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" means 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)."**

"Health and recovery services administration (HRSA)" means the successor administration to the medical assistance administration within the department, authorized by the department secretary to administer the acute care portion of Title XIX medicaid, Title XXI SCHIP, and other medical assistance programs, with the exception of certain non-medical services for persons with chronic disabilities.

"Health care team" means a group of health care providers involved in the care of a client.

"High-cost outlier" means, for dates of admission before August 1, 2007, a claim paid under the DRG payment method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a high-cost outlier, the billed charges, minus the noncovered charges reported on the claim, must exceed three times the applicable DRG payment and exceed thirty-three thousand dollars. The department's high-cost outliers are not applicable for dates of admission on and after July 1, 2007.

"High outlier claim—Medicaid/SCHIP DRG" means, for dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—Medicaid/SCHIP per diem" means, for dates of admission on and after August 1, 2007, a claim that is classified by the department as being allowed a high outlier payment that is paid under the per diem payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—State-administered program DRG" means, for dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has

extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—State-administered program per diem" means, for dates of admission on or after August 1, 2007, a claim that is classified by the department as being allowed as a high outlier payment, that is paid under the per diem payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"Hospice" means 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" means 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 or a "psychiatric hospital" as defined in this section.

"Hospital base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Hospital base period costs" means costs incurred in, or associated with, a specified base period.

"Hospital conversion factor" means a hospital-specific dollar amount that reflects the average cost for a DRG paid case of treating medicaid and SCHIP clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).

"Hospital covered service" means a service that is provided by a hospital, covered under a medical assistance program and is within the scope of an eligible client's medical assistance program.

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

"Hospital dispute resolution conference" means an informal meeting for deliberation during a provider administrative appeal. For provider audit appeals, see chapter 388-502A WAC. For provider rate appeals, see WAC 388-501-0220.

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services measured by Global Insight's Data Resources, Inc. (DRI) and identified as the CMS PPS input price index.

"Hospital peer group" means the peer group categories established by the department for classification of hospitals:

(1) Peer Group A - Hospitals identified by the department as rural hospitals (excludes all rural hospitals paid by the certified public expenditure (CPE) payment method and critical access hospital (CAH) payment method);

(2) Peer Group B - Hospitals identified by the department as urban hospitals without medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);

(3) Peer Group C - Hospitals identified by the department as urban hospitals with medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);

(4) Peer Group D - Hospitals identified by the department as specialty hospitals and/or hospitals not easily assignable to the other five peer groups;

(5) Peer Group E - Hospitals identified by the department as public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) payment program; and

(6) Peer Group F - Hospitals identified by the department of health (DOH) as CAHs, and paid by the department using the CAH payment method.

"Hospital selective contracting program" or "selective contracting" means for dates of admission before July 1, 2007, a negotiated bidding program for hospitals within specified geographic areas to provide inpatient hospital services to medical assistance clients. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

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

"Inflation adjustment" means, for cost inflation, the hospital inflation adjustment. This adjustment is determined by using the inflation factor method supported by the legislature. For charge inflation, it means 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) standard reports three and four.

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- (1) Disclosed and discussed the patient's diagnosis;
- (2) Offered the patient an opportunity to ask questions about the procedure and to request information in writing;
- (3) Given the patient a copy of the consent form;
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and
- (5) Given the patient oral information about all of the following:
 - (a) The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
 - (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
 - (c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient hospital admission" means an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's health record.

"Inpatient medicaid conversion factor" means a dollar amount that represents selected hospitals' average costs of treating medicaid and SCHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay medicaid and SCHIP claims under the DRG payment

method. See WAC 388-550-3450 for how this conversion factor is calculated.

"Inpatient services" means healthcare services provided directly or indirectly to a client subsequent to the client's inpatient hospital admission and prior to discharge.

"[I]npatient state-administered program conversion factor" means a dollar amount used as a rate reduced from the inpatient medicaid 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, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding).

"Length of stay (LOS)" means 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.

"Length of stay extension request" means a request from a hospital provider for the department, or in the case of psychiatric admission, the appropriate mental health division designee, to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Long term acute care (LTAC) services" means inpatient intensive long-term care services provided in department-approved LTAC hospitals to eligible medical assistance clients who meet criteria for level 1 or level 2 services. See WAC 388-550-2565 through 388-550-2596.

"Low-cost outlier" means a case having a date of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than the greater of ten percent of the applicable DRG payment or four hundred and fifty dollars. The department's low-cost outliers are not applicable for dates of admission on and after August 1, 2007.

"Low income utilization rate (LIUR)" means a rate determined by a formula represented as $(A/B)+(C/D)$ in the same period in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies);

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and dis-

counts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services.

"Major diagnostic category (MDC)" means one of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG classification system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"MDC" - See **"major diagnostic category."**

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate (MIPUR)" means a ratio expressed by the following formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical assistance administration (MAA)" means the health and recovery services administration (HRSA), or a successor administration, within the department authorized by the department's secretary to administer the acute care portion of the Title XIX medicaid, Title XXI state children's health insurance program (SCHIP), and other medical assistance programs, with the exception of certain nonmedical services for persons with chronic disabilities.

"Medical assistance program" means any healthcare program administered through HRSA.

"Medical care services" means the state-administered limited scope of care provided to general assistance-unemployable (GAU) recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

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

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists.

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration.

"Medicare cost report" means the medicare cost report (Form 2552-96), or successor document, completed and submitted annually by a hospital provider:

(1) To medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

(2) To medicaid to establish appropriate DRG and other rates for payment of services rendered.

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

"Medicare fee schedule (MFS)" means the official CMS publication of medicare policies and relative value units for the resource based relative value scale (RBRVS) payment program.

"Medicare Part A" see WAC 388-500-0005.

"Medicare Part B" see WAC 388-500-0005.

"Medicare buy-in premium" - See **"buy-in premium."**

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

"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). See WAC 388-550-2600.

"Mentally incompetent" means a person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two to four patient beds.

"National drug code (NDC)" means 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 Federal Drug Administration (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.

"Negotiated conversion factor (NCF)" means, for dates of admission before July 1, 2007, a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."** The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

"Newborn" or "neonate" or "neonatal" means a person younger than twenty-nine days old. However, a person who has been admitted to an acute care hospital setting as a newborn and is transferred to another acute care hospital setting is still considered a newborn for payment purposes.

"Nonallowed service or charge" means a service or charge that is not recognized for payment by the department, and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

"Noncontract hospital" means, for dates of admission before July 1, 2007 a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the hospital selective contracting program. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

"Noncovered charges" means billed charges submitted to the department by a provider on a claim that are indicated by the provider on the claim as noncovered.

"Noncovered service or charge" means a service or charge that is not considered or paid by the department as a "hospital covered service," and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

"Nonemergency hospital admission" means any inpatient hospitalization of a patient who does not have an emergent medical condition, as defined in WAC 388-500-0005.

"Nonparticipating hospital" means a noncontract hospital. See **"noncontract hospital."**

"Observation services" means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"OPPS" - See **"outpatient prospective payment system."**

"OPPS adjustment" means the legislative mandated reduction in the outpatient adjustment factor made to account for the delay of OPPS implementation.

"OPPS outpatient adjustment factor" means the outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate.

"Orthotic device" or **"orthotic"** means 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" means any hospital located outside the state of Washington and outside the designated bordering cities in Oregon and Idaho (see WAC 388-501-0175). For medical assistance clients requiring psychiatric services, "out-of-state hospital" means any hospital located outside the state of Washington.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases. The department's outlier set-aside factor is not applicable for dates of admission on and after August 1, 2007.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year. The department's outlier set-aside pool is not applicable for dates of admission on and after August 1, 2007.

"Outliers" means cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a patient who is receiving healthcare services in other than an inpatient hospital setting.

"Outpatient care" means healthcare provided other than inpatient services in a hospital setting.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient hospital services" means those healthcare 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)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient short stay" - See **"observation services"** and **"outpatient hospital services."**

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

"Pain treatment facility" means a department-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts department clients.

"PAS length of stay (LOS)" means, for dates of admission before August 1, 2007, the average length of an inpatient hospital stay for patients based on diagnosis and age, as determined by the commission of professional and hospital activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)."**

"Patient consent" means the informed consent of the patient and/or the patient's legal guardian, as evidenced by the patient's or guardian's signature on a consent form, for the procedure(s) to be performed upon or for the treatment to be provided to the patient.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means, for dates of admission before August 1, 2007, the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem rate" means a daily rate used to calculate payment for services provided as a "hospital covered service."

"Personal comfort items" means items and services which primarily serve the comfort or convenience of a client and do not contribute meaningfully to the treatment of an illness or injury.

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

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"PPS" see "prospective payment system."

"Primary care case management (PCCM)" means the coordination of healthcare services under the department's Indian health center or tribal clinic managed care program. See WAC 388-538-068.

"Principal diagnosis" means the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Prior authorization" means a process by which clients or providers must request and receive department or a department designee's approval for certain healthcare services, equipment, or supplies, based on medical necessity,

before the services are provided to clients, as a precondition for payment to the provider. Expedited prior authorization and limitation extension are forms of prior authorization.

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

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the commission of professional and hospital activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a payment that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prospective payment system (PPS)" means a system that sets payment rates for a predetermined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the predetermined period.

"Prosthetic device" or "prosthetic" means 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" means 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.

"Psychiatric indigent inpatient (PII) program" means a state-administered program established by the department specifically for mental health clients identified in need of voluntary emergency inpatient psychiatric care by a mental health division designee. See WAC 388-865-0217.

"Psychiatric indigent person" means a person certified by the department as eligible for the psychiatric indigent inpatient (PII) program.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Ratable" means a factor used to calculate a reduction factor used to reduce medicaid level rates to determine state administered program claim payment to hospitals.

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

"RCC" - See "ratio of costs-to-charges."

"Rebasing" means the process of recalculating the conversion factors, per diems, per case rates, or RCC rates using historical data.

"Recalibration" means the process of recalculating DRG relative weights using historical data.

"Regional support network (RSN)" means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC, to manage the provision of mental health services to medical assistance clients.

"Rehabilitation accreditation commission, The" - See "CARF."

"Rehabilitation units" means specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet department and/or medicare criteria for distinct rehabilitation units.

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

"Remote hospitals" means, for claims with dates of admission before July 1, 2007, hospitals that meet the following criteria during the hospital selective contracting (HSC) waiver application period:

- (1) Are located within Washington state;
- (2) Are more than ten miles from the nearest hospital in the HSC competitive area; and
- (3) Have fewer than seventy-five beds; and
- (4) Have fewer than five hundred medicaid and SCHIP admissions within the previous waiver period.

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

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

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

"Room and board" means the services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" means a clinic that is located in areas designed by the bureau of census as rural and by the Secretary of the Department of Health and Human Services (DHHS), as medically underserved.

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

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means, for dates of admission before July 1, 2007, an area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by medicaid and SCHIP clients. This definition is

not applicable for dates of admission on and after July 1, 2007.

"Semi-private room rate" means 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."**

"Seven-day readmission" means the 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 within seven days.

"Special care unit" means a department of health (DOH) or medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

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

"Spendedown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department. See chapter 388-519 WAC.

"Stat laboratory charges" means the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State children's health insurance program (SCHIP)" means the federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen.

"State plan" means the plan filed by the department with the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS), outlining how the state will administer medicaid and SCHIP services, including the hospital program.

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

"Surgery" means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed day" means a day in which a client is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the Centers for Medicare and Medicaid Services (CMS) for both acute care and skilled nursing services.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a procedure and service payment that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

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

"Transfer" means to move a client from one acute care facility or distinct unit to another.

"Transferring hospital" means the hospital or distinct unit that transfers a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC.

"Trauma care service" - See department of health's WAC 246-976-935.

"UB-04" is the uniform billing document required for use nationally, beginning on May 23, 2007, by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing third party payers for services provided to patients. This includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and/or modified by the Washington state payer group or the department.

"UB-92" is the uniform billing document discontinued for billing claims submitted on and after May 23, 2007.

"Unbundled services" means interventions that are not integral to the major procedure and that are paid separately.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by medicare.

"Uninsured patient" means an individual who is not covered by insurance for provided inpatient and/or outpatient hospital services.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a health-care procedure or service, or the rate charged other contractors for the service if the general public is not served.

"Vendor rate increase" means an inflation 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.

[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, 07-14-052, § 388-550-1050, filed 6/28/07, effective 8/1/07; 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. 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. 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. 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

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

(a) Pays for the admission of an eligible medical assistance client to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered according to WAC 388-501-0050, 388-501-0060 and 388-501-0065;

(ii) Are medically necessary as defined in WAC 388-500-0005;

(iii) Are determined according to WAC 388-501-0165 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 388-502-0020.

(3) The department:

(a) Pays for a hospital covered service provided to an eligible medical assistance client enrolled in a department managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the department and meets prior authorization requirements. (See WAC 388-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to a medical assistance client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 388-550-4600 and 388-550-4700 apply. The department's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

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

See WAC 388-533-0701 through 388-533-0730.

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

(a) In a detoxification unit in a hospital that has a detoxification provider agreement with the department to perform these services and the services are approved by the division of alcohol and substance abuse (DASA); or

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

(i) The hospital does not have a detoxification specific provider agreement with DASA;

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

(iii) Nonhospital based detoxification 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 a regional support network (RSN) or a mental health division (MHD) 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 department's chemical-using pregnant (CUP) women program; and

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

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

(a) Are provided in accordance with chapter 388-535 WAC; and

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

(7) The department 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 in accordance with chapter 388-535 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 medical assistance 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 department.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 388-550-2600.

[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, 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. 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 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. 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 client eligible under a medical assistance program that is paid by the department's fee-for-services payment system must be within the scope of the client's medical assistance program. Coverage restriction includes, but is not limited to the following:

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

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

(3) For emergency care exemptions for clients described in subsections (1) and (2) of this section, see WAC 388-538-100.

(4) Coverage for psychiatric indigent inpatient (PII) clients is limited to voluntary inpatient psychiatric hospital services, subject to the conditions and limitations of WAC 388-865-0217 and this chapter:

(a) Out-of-state healthcare is not covered for clients under the PII program; and

(b) Bordering city hospitals and critical border hospitals are not considered instate hospitals for PII program claims.

(5) Healthcare services provided by a hospital located out-of-state are:

(a) Not covered for clients eligible under the medical care services (MCS) program. However, clients 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 SCHIP clients without prior authorization, based on the medical necessity and utilization review standards and limits established by the department.

(ii) Nonemergency out-of-state care for medicaid and SCHIP clients when prior authorized by the department 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 388-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and SCHIP clients based on authorization by a mental health division (MHD) designee.

(6) See WAC 388-550-1100 for hospital services for chemical-using pregnant (CUP) women.

(7) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a MHD designee. See WAC 388-550-2600.

(8) For clients eligible for both medicare and medicaid (dual eligibles), the department pays deductibles and coinsurance, unless the client has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the department pays for hospitalization for such clients subject to department rules. See also chapter 388-502 WAC.

(9) The department does not pay for covered inpatient hospital services for a medical assistance client:

(a) Who is discharged from a hospital by a physician because the client 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.

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

(a) Inform the client in a written notice that the department is not responsible for payment (42 CFR 456);

(b) Comply with the requirements in WAC 388-502-0160 in order to bill the client for the service(s); and

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

(11) Other coverage restrictions, as determined by the department.

[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, 07-14-018, § 388-550-1200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 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 and/or UB-04 National Uniform Billing Data Element Specifications Manual.

(6/30/11)

(2) The department requires a hospital provider to report and bill all hospital services provided to medical assistance clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

[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, 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. 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. 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 department requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or healthcare 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 department.

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

[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. 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. 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 department 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," "angiocardiology," "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 "hyper baric 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 department pays for an inpatient hospital covered service in the following revenue code subcategories only when the hospital provider is approved by the department 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," "detoxification," "rehabilitation," and "other";

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

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

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

(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 department 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 department's published billing instructions.

(4) The department 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," "detoxification," "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," "detoxification," "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 - chemical dependency," "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.

[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, 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, 03-19-045, § 388-550-1400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 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, 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 department 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," "angiocardiology," "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 "hyper baric 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 department pays for an outpatient hospital covered service in the following revenue code subcategories only when the outpatient hospital provider is approved by the department to provide the specific service(s):

(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 department 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)";

(6/30/11)

(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.

[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. 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. 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. 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1600 Specific items/services not covered. The department 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."

[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. 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. 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.

(1) The rules in this section apply to:

- (a) Inpatient hospital claims with dates of admission on and after January 1, 2010;
- (b) Payment or denial of payment for any inpatient hospital claims identified in (a) of this subsection, including

medicaid supplemental or enhanced payments and medicaid disproportionate share hospital (DSH) payments or denial of payment;

(c) Adverse events, hospital-acquired conditions (HACs), and present on admission (POA) indicators (defined in subsection (2) of this section);

(d) Hospital requirements to report adverse events and HACs to the department (see subsection (4)(a) of this section);

(e) Hospital requests for retrospective utilization reviews and the related requirements to provide root cause analysis of events to the department (see subsection (4)(d) through (f) of this section); and

(f) Hospital requirements to use POA indicator codes on claims (see subsection (5)(a) of this section).

(2) The following definitions apply to this section:

(a) **"Adverse events"** (also known as "adverse health events" or "never events") are the events that must be reported to the department of health (DOH) under WAC 246-320-146. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the healthcare organization.

(b) **"Hospital-acquired condition (HAC)"** is a condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission. For medicaid payment purposes, the department considers a HAC to be a condition that:

(i) Is high cost or high volume, or both;

(ii) Results in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis;

(iii) Could reasonably have been prevented through the application of evidence-based guidelines; and

(iv) Does not conflict with medicare's hospital-acquired conditions policy (http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage).

(c) **"Serious disability"** means a physical or mental impairment that substantially limits the major life activities of a patient.

(d) **"Present on admission (POA) indicator"** is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)

(e) **"Root cause analysis"** is a class of problem-solving methods aimed at identifying the root causes of events instead of addressing the immediate, obvious symptoms.

(3) **Medicare crossover inpatient hospital claims.** The department applies the following rules for these claims:

(a) If medicare denies payment for a claim at a higher rate for the increased costs of care under its HAC and/or POA indicator policies:

(i) The department limits payment to the maximum allowed by medicare;

(ii) The department does not pay for care considered nonallowable by medicare; and

(iii) The client cannot be held liable for payment.

(b) If medicare denies payment for a claim under its National Coverage Determination authority from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(i) The department does not pay the claim, any medicare deductible, and/or any co-insurance related to the inpatient hospital services; and

(ii) The client cannot be held liable for payment.

(4) **Inpatient hospital claims related to adverse events (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section).** The department applies the following rules for these claims:

(a) When the department requests information from a hospital regarding adverse events identified by DOH, the hospital must provide the information requested for any affected medical assistance client (this includes both fee-for-service clients and clients enrolled in a managed care organization (MCO) contracted with the department). If no medical assistance client was affected by an adverse event, the hospital must provide a written response to the department with an assurance that no medical assistance clients were affected.

(b) The department does not pay for adverse events identified by DOH and/or identified through the department's retrospective utilization review process. Some HACs can become an adverse event if the:

(i) Patient dies or is seriously disabled; or

(ii) Level of severity is great, such as the patient develops level three or level four pressure ulcers.

(c) The client cannot be held liable for payment.

(d) A hospital may request a retrospective utilization review by the department, as described in WAC 388-550-1700 (6)(a) and (b)(iii), from the department or its designee to determine if the hospital is eligible for a partial payment for the adverse event.

(e) A hospital that requests a department retrospective utilization review of an adverse event must provide the department with the hospital's root cause analysis, as described in WAC 246-320-146 (3) and (4), of the adverse event claim.

(f) The healthcare information that is part of the retrospective utilization review, including the root cause analysis of the adverse event claim, is exempt from public disclosure under RCW 42.56.360 (1)(c).

(5) **Inpatient hospital claims related to hospital-acquired conditions that do not qualify as an adverse event (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section).** The department applies the following rules for these claims:

(a) The department reviews POA indicator codes on inpatient hospital claims in order to determine if a condition was present or incubating at the time the order for inpatient admission occurred, if a condition occurred during, or as a result of, hospital care, or if a condition developed during an outpatient encounter.

(i) All hospitals that have signed a core provider agreement with the department must provide information to the department by using POA indicator codes on each claim (refer to the table in this subsection).

(ii) These POA indicator codes must designate which procedures or complications were present on admission, and which occurred during, or as a result of, hospital care.

(iii) POA indicator codes are to be assigned to principal and secondary diagnosis (as defined in Section II of the Official Guidelines for Coding and Reporting), and the external cause of injury codes.

POA Indicator Codes	
Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission.

(b) The department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U." Specifically, for hospitals paid under the:

(i) Diagnostic related group (DRG) payment method, the department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

(ii) Per diem payment method, the department does not pay for days beyond the average length-of-stay (LOS) (defined in WAC 388-550-1050).

(iii) Departmental weighted costs-to-charges (DWCC) payment method, the department does not pay for services attributable to the HAC.

(iv) DRG and per diem outlier payment methods, the department does not pay for services attributable to the HAC.

(v) Ratio of costs-to-charges (RCC) payment method, the department does not pay for services attributable to the HAC.

(vi) Per case payment method, the department does not pay for services attributable to the HAC.

(6) The department denies payment for any HAC that results in death or serious disability.

(7) A hospital that disagrees with a department decision to deny payment or partial payment of an adverse event or hospital-acquired condition may follow the administrative appeal process in WAC 388-502-0220.

[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). 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 department's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to medical assistance clients receiving services through the fee-for-service program. For clients eligible under other medical assistance programs, see chapter 388-538 WAC for managed care organizations, chapters 388-800

(6/30/11)

and 388-810 WAC for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), and chapter 388-865 WAC for mental health treatment programs coordinated through the mental health division or its designee). See chapter 388-546 WAC for transportation services.

(2) All hospital services paid for by the department 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 department will deny, recover, or adjust hospital payments if the department 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 department may perform one or more types of UR described in subsection (6) of this section.

(6) The department'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 department 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 department or its designee prior to the provision of healthcare services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"—An evaluation performed by the department or its designee following the provision of healthcare services that includes both a post-payment retrospective UR (performed after healthcare services are provided and paid), and a prepayment retrospective UR (performed after healthcare services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the department 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.

[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, 07-14-018, § 388-550-1700, filed 6/22/07, effective 8/1/07; 04-20-058, § 388-550-1700, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090, 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, 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 department pays for certain specialty services without requiring prior authorization when such services are provided consistent with department

medical necessity and utilization review standards. These services include, but are not limited to, the following:

- (1) All transplant procedures specified in WAC 388-550-1900(2) under the conditions established in WAC 388-550-1900;
- (2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;
- (3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;
- (4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and
- (5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[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. 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. 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-1900 Transplant coverage. (1) The department pays for medically necessary transplant procedures only for eligible medical assistance 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 department covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the department 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 department pays facility charges only to those hospitals that meet the standards and conditions:

- (a) Established by the department; and
- (b) Specified in WAC 388-550-2100 and 388-550-2200.

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

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

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

(7) The department does not pay for experimental transplant procedures. In addition, the department 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 department 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 department pays for bone marrow, PSC, skin grafts and corneal transplants when medically necessary.

(10) The department may conduct a post-payment retrospective utilization review as described in WAC 388-550-1700, and may adjust the payment if the department determines the criteria in this section are not met.

[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. 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. 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 department approved transplants described in WAC 388-550-1900(2).

(1) The department requires instate transplant hospitals to meet the following requirements in order to be paid for transplant services provided to medical assistance clients. A hospital must have:

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

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

(2) The department 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 department approved centers of excellence (COE) in bordering city and critical border hospitals, must be prior authorized.

(3) The department considers a hospital for approval as a transplant center of excellence when the hospital submits to the department 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 department considers this requirement met when the hospital submits to the department 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 388-550-2200(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 program(s) with the network.

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

(a) A PSC transplant hospital must be a department 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 PCS [PSC] transplant hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

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

[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. 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. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2200 Transplant requirements—COE. (1) The department measures the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department applies these criteria to a hospital during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall 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 department for conditional approval as a transplant COE. The department 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 department as a transplant COE must meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department must automatically revoke such conditional approval for any hospital which fails to meet the department'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 prior to the expiration date; and

(b) Such request is granted by the department.

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

(6) A transplant COE must submit to the department 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 department, 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 department annual updates to the documents listed in subsection (a) of this section, or whenever the hospital makes a change to the criteria and/or protocols.

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

(8) The department evaluates compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by a transplant COE in accordance with subsection (7) of this section. The department 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 department:

(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 388-502-0030;

(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 such breach of compliance exists.

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

(11) The department pays a department-approved COE for covered transplant procedures using methods identified in chapter 388-550 WAC.

[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, 07-14-018, § 388-550-

2200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 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, 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 department 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 qualifies for bariatric surgery by successfully completing all requirements under WAC 388-531-1600;

(b) The client continues to meet the criteria to qualify for bariatric surgery under WAC 388-531-1600 up to the actual surgery date;

(c) The hospital providing the bariatric surgery and bariatric surgery-related services meets the requirements in this section and other applicable WAC; and

(d) The hospital receives prior authorization from the department prior to performing a bariatric surgery for a medical assistance client.

(2) A hospital must meet the following requirements in order to be paid for bariatric surgery and bariatric surgery-related services provided to an eligible medical assistance client. The hospital must:

(a) Be approved by the department to provide bariatric surgery and bariatric surgery-related services and;

(i) For dates of admission on or after July 1, 2007, be located in Washington state or approved bordering cities (see WAC 388-501-0175).

(ii) For dates of admission on or after July 1, 2007, be located in Washington state, or be a department-designated critical border hospital.

(b) Have an established bariatric surgery program in operation under which at least one hundred bariatric surgery procedures have been performed. The program must have been in operation for at least five years and be under the direction of an experienced board-certified surgeon. In addition, department requires the bariatric surgery program to:

(i) Have a mortality rate of two percent or less;

(ii) Have a morbidity rate of fifteen percent or less;

(iii) Document patient follow-up for at least five years postsurgery;

(iv) Have an average loss of at least fifty percent of excess body weight achieved by patients at five years postsurgery; and

(v) Have a reoperation or revision rate of five percent or less.

(c) Submit documents to the department's division of healthcare services that verify the performance requirements listed in this section.

(3) The department waives the program requirements listed in subsection (2)(b) of this section if the hospital participates in a statewide bariatric surgery quality assurance program such as the surgical Clinical Outcomes Assessment Program (COAP).

(4) See WAC 388-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(5) 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 meets the criteria in this section and other applicable WAC to perform bariatric surgery and/or to provide bariatric surgery-related services.

[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. 07-14-018, § 388-550-2301, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 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 department pays a hospital that is specifically approved by the department to provide inpatient chronic pain management services, an all-inclusive per diem facility fee. The department pays professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(2) A client qualifies for inpatient chronic pain management services when all of 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 in relation to the pain problem; and

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

(3) The department:

(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 department

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

[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. 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. 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2431 Hospice services—Inpatient payments. See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[11-14-075, recodified as § 182-550-2431, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

WAC 182-550-2500 Inpatient hospice services. (1) The department pays hospice agencies participating in the

(6/30/11)

medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

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

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

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

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

[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. 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. 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 department requires prior authorization for acute PM&R services. (See WAC 388-550-2561 for prior authorization requirements.)

(1) An interdisciplinary team coordinates individualized acute PM&R services at a department-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 department 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 department'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 department programs such as:

(a) Home health services;

(b) Nursing facilities;

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

(d) Neurodevelopmental centers.

[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. 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. 03-06-047, § 388-550-2501, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2511 Acute PM&R definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the acute PM&R program. If conflicts occur, this section prevails for this subchapter.

"Accredit" (or "Accreditation") means a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

"Acute" means an intense medical episode, not longer than three months.

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with acute PM&R program requirements.

[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. 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. 03-06-047, § 388-550-2511, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, 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 following programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC 388-550-2501, 388-550-2511, 388-550-2531, 388-550-2541, 388-550-2551, 388-550-2561, 388-550-3381, and other rules:

- (a) Categorically needy program (CNP);
- (b) State children's health insurance program (SCHIP);
- (c) Limited casualty program - Medically needy program (LCP-MNP);
- (d) Alien emergency medical (AEM)(CNP);
- (e) Alien emergency medical (AEM)(LCP-MNP);
- (f) General assistance unemployable (GA-U - No out-of-state care); or
- (g) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).

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

[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. 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. 03-06-047, § 388-550-2521, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 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 department-approved acute PM&R hospital. On and after August 1, 2007 an in-state, bordering city, or critical border hospital may apply to become a department-approved acute PM&R hospital. To apply, the department requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Division of Healthcare Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia, WA 98504-5506

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

- (a) A medicare-certified hospital;
- (b) Accredited by the joint commission on accreditation of healthcare 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 department's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the department; and

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

(i) WAC 246-976-830, Level I trauma rehabilitation designation; or

(ii) WAC 246-976-840, 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 department if the facility:

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

(ii) Is actively operating under CARF standards.

(b) Is required to obtain full CARF accreditation within twelve months of the department's conditional approval date. If this requirement is not met, the department sends a letter of notification to revoke the conditional approval.

(4) A hospital qualifies as a department-approved acute PM&R hospital when:

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

(b) The department's clinical staff has conducted a facility site visit; and

(c) The department provides written notification that the hospital qualifies to be paid for providing acute PM&R services to eligible medical assistance clients.

(5) The department-approved acute PM&R hospitals must meet the general requirements in chapter 388-502 WAC, Administration of medical programs—Providers.

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

WAC 182-550-2541 Quality of care—Department-approved acute PM&R hospital. (1) To ensure quality of care, the department may conduct reviews (e.g., post-pay, on-site) of any department-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 healthcare organizations (JCAHO);
- (c) CARF;
- (d) The department; or
- (e) Other agencies with review authority for the department's programs.

[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. 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. 03-06-047, § 388-550-2541, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2551 How a client qualifies for acute PM&R services. (1) To qualify for acute PM&R services, a client must meet one of the conditions in subsection (2) of this section and have:

(a) Extensive or complex medical needs, nursing needs, and therapy needs; and

(b) A recent or new onset of a condition that causes an 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.

(2) To qualify for acute PM&R services, a client must meet the conditions in subsection (1) of this section and have a new or recent onset of one of the following conditions:

- (a) Brain injury caused by trauma or disease.
- (b) Spinal cord injury resulting in:
 - (i) Quadriplegia; or
 - (ii) Paraplegia.
- (c) Extensive burns.
- (d) Bilateral limb loss.
- (e) Stroke or aneurysm with resulting hemiplegia or cognitive deficits, including speech and swallowing deficits.
- (f) Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits.

(g) Severe pressure ulcers after skin flap surgery for a client who:

- (i) Requires close observation by a surgeon; and
- (ii) Is ready to mobilize or be upright in a chair.

[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. 03-06-047, § 388-550-2551, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

WAC 182-550-2561 The department's prior authorization requirements for acute PM&R services. (1) The department 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

(6/30/11)

(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 388-550-2521, subject to the restrictions and limitations listed in that section;

(ii) Require acute PM&R services as determined in WAC 388-550-2551;

(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 department's clinical consultation team by fax, electronic mail, or telephone as published in the department'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 and/or independence;

(B) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive acute PM&R services be provided in a department-approved acute PM&R facility; and

(C) The client suffers from severe disabilities including, but not limited to, neurological and/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 department clinical consultation team by fax, electronic mail, or telephone as published in the department'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 department denies the request for an extension of stay, the client must be transferred to an appropriate lower level of care as described in WAC 388-550-2501(3).

(5) The department'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 department notifies the client and the acute PM&R provider of a decision.

(a) If the department approves the request for authorization, the notification letter includes:

- (i) The number of days requested;
- (ii) The allowed dates of service;
- (iii) A department-assigned authorization number;
- (iv) Applicable limitations to the authorized services; and

(v) The department's process to request additional services.

(b) If the department 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 a department-approved acute PM&R hospital, and/or a department-approved acute PM&R hospital requesting an extension of stay for a client, must:

(a) Discuss the department's authorization decision with the client and/or the client's legal representative; and

(b) Document in the client's medical record that the department's decision was discussed with the client and/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 388-02 WAC. After receiving a request for a fair hearing, the department may request additional information from the client and the facility, or both. After the department reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

(8) The department may authorize administrative day(s) 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 department 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(s); 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.

[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. 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. 03-06-047, § 388-550-2561, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 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 department-approved LTAC hospital during the acute phase of a client's care. The department requires prior authorization for LTAC stays. See WAC 388-550-2590 for prior authorization requirements.

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

(2) The department 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 388-550-2590.

(3) When the department-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.

[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. 07-11-129, § 388-550-2565, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2565, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2570 LTAC program definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the long-term acute care (LTAC) program.

"Level 1 services" means long-term acute care (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).

"Level 2 services" means long-term acute care (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 decanulation; and

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

"Long-term acute care" means inpatient intensive long-term care services provided in department-approved LTAC hospitals to eligible medical assistance clients who require Level 1 or Level 2 services.

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

[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. 08-21-039, § 388-550-2570, filed 10/8/08, effective 11/8/08; 07-11-129, § 388-550-2570, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2570, 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 388-550-2565,

388-550-2570, 388-550-2580, 388-550-2585, 388-550-2590, 388-550-2595, 388-550-2596, 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).

[11-14-075, recodified as § 182-550-2575, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 07-11-129, § 388-550-2575, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 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 department-approved long-term acute care (LTAC) hospital, the department requires a hospital to:

- (a) Submit a letter of request to:

LTAC Program Manager
Division of Healthcare 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 healthcare 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 department as a medicaid participating provider.

(2) A hospital qualifies as a department-approved LTAC hospital when:

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

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

- (c) The department provides written notification to the hospital that it qualifies for payment when providing LTAC services to eligible medical assistance clients.

(3) Department-approved LTAC hospitals must meet the general requirements in chapter 388-502 WAC.

(4) The department 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 department agreeing to the payment rates established for LTAC services in accordance with WAC 388-550-2595.

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

[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, 08-21-039, § 388-550-2580, filed 10/8/08, effective 11/8/08; 07-11-129, § 388-550-2580, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 02-14-162, § 388-550-2580, filed 7/3/02, effective 8/3/02.]

(6/30/11)

WAC 182-550-2585 LTAC hospitals—Quality of care. (1) To ensure quality of care, the department may conduct post-pay or on-site reviews of any department-approved LTAC hospital. See WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for additional information on audits conducted by department 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 healthcare organizations (JCAHO);
- (c) The department; or
- (d) Other agencies with review authority for the department's programs.

[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, 07-11-129, § 388-550-2585, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 02-14-162, § 388-550-2585, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2590 Department prior authorization requirements for Level 1 and Level 2 LTAC services. (1)

The department requires prior authorization for Level 1 and Level 2 long term acute care (LTAC) inpatient stays. The prior authorization process includes all of the following:

- (a) For an initial thirty-day stay:

- (i) The client must:

(A) Be eligible under one of the programs listed in WAC 388-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC 388-550-2570.

- (ii) The LTAC provider of services must:

(A) Before admitting the client to the LTAC hospital, submit a request for prior authorization to the department by fax, electronic mail, or telephone, as published in the department's LTAC billing instructions;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Obtain prior authorization from the department's medical director or designee, when accepting the client from the transferring hospital; and

(D) Meet all the requirements in WAC 388-550-2580.

(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 department with sufficient medical justification.

(2) The department 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 388-02 WAC. After receiving a request for a fair hearing, the department may request additional information from the client and the facility, or both. After the department reviews the available information, the result may be:

- (a) A reversal of the initial department decision;

- (b) Resolution of the client's issue(s); or
- (c) A fair hearing conducted per chapter 388-02 WAC.
- (4) The department may authorize an administrative day rate payment 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.

[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. 08-21-039, § 388-550-2590, filed 10/8/08, effective 11/8/08; 07-11-129, § 388-550-2590, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 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 department'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/or epogen/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 department 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 healthcare 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 department may make annual rate increases to the LTAC fixed per diem rate by using a vendor rate increase. The department may rebase the LTAC fixed per diem rate periodically.

(4) When the department 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 department.

[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. 07-11-129, § 388-550-2595, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 03-02-056, § 388-550-2595, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2595, filed 7/3/02, effective 8/3/02.]

WAC 182-550-2596 Services and equipment covered by the department but not included in the LTAC fixed per diem rate. (1) The department 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/or epogen/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 department 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 department but not included in the LTAC fixed per diem rate. The provider must bill the department directly and the department 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 388-546 WAC; and

(d) Must be billed directly to the:

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

(ii) Department's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 388-546 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 department evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.

(5) When the department 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 department.

[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, 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. 06-24-036, § 388-550-2596, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 03-02-056, § 388-550-2596, filed 12/26/02, effective 1/26/03; 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 WAC 388-500-0005 and 388-550-1050 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) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (5) of this section for how the department calculates a DWCC rate.

(e) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."

(f) "HFY" see "Hospital fiscal year."

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

(h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate DWCC rate, as determined by the department.

(i) "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.

(2) To be paid as a CAH by the department, 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 department

upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.

(3) The department pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using departmental weighted costs-to-charges (DWCC) rates and a retrospective cost settlement process. The department 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, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care Health Options and MHD designee DWCC payment rates to be cost. Cost settlements are not performed by the department for managed care claims.

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

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

(i) Within twenty working days of receiving the request from the department, 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 department provides to the CAH from the department's CAH DWCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the department, 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 department's CAH DWCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The department:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH DWCC 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 department may use the CAH DWCC rate calculation model without considering the differences.

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

(c) The department:

(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) Medical assistance 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 department 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) Medical assistance 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 department.

(vii) Uses the claims classifications and cost center combinations as defined in the department's CAH DWCC 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 departmental-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) Departmental-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

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

(xiv) Multiplies each hospital's total departmental-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 department will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient DWCC 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 DWCC 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 DWCC 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 department uses the current statewide average DWCC rates for the initial prospective DWCC rates.

(8) For a CAH that comes under new ownership, the department uses the prior owner's DWCC 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 department, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The department has calculated new DWCC 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 DWCC rates, the department:

(a) Incorporates the DWCC rates into the calculations for the department'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 DWCC rates applicable to managed care claims. For purposes of this section, the department considers the DWCC 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 department 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 department:

(a) Compares actual department total interim CAH payments to the departmental-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, department 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 department 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 department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department 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 department 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 department programs.

(14) The department pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than DWCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the department 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 on and after August 1, 2007, the department uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The department may conduct a post pay or on-site review of any CAH.

[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, 07-14-054, § 388-550-2598, filed 6/28/07, effective 8/1/07; 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, 06-04-089, § 388-550-2598, filed 1/31/06, effective 3/3/06; 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. 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]

WAC 182-550-2600 Inpatient psychiatric services.

(1) The department, 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 medical assistance 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 388-550-0005 and 388-550-1050 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 medical assistance 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 medical assistance 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 persons 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 medical assistance client. Retrospective authorization can be prior to 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 medical assistance 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 medical assistance 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 prior to 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 388-502-0100; and

(b) The voluntary inpatient psychiatric admission must meet the following:

(i) For a client eligible for medical assistance, the admission to voluntary inpatient psychiatric care must:

(A) Be medically necessary as defined in WAC 388-500-0005;

(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 medical assistance program, the department pays secondary to medicare.

(iii) For a client eligible for both medicare and a medical assistance 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 in accordance with medicare standards.

(iv) For a client eligible for both medicare and a medical assistance program who has exhausted medicare lifetime benefits, the admission must have prior authorization by a MHD designee.

(v) When a liable third party is identified (other than medicare) for a client eligible for a medical assistance program, the hospital provider or hospital unit provider must obtain a 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 in accordance with 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 in accordance with chapter 388-865 WAC;

(ii) Must meet the applicable general conditions of payment criteria in WAC 388-502-0100; 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 medical assistance 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 medical assistance 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 ICD9-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 prior to the end of the initial authorized days of services (see subsections (11) and (12) of this section for payment methodology and payment limitations); and

(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 prior to the transfer.

(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 dis-

charge. 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 timeframes stated in this section. For a retrospective certification request prior to 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 medical assistance 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 department uses the payment methods described in WAC 388-550-2650 through 388-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to medical assistance clients, unless otherwise specified in this section.

(11) Covered days for a voluntary psychiatric admission are determined by a 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 prior to 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 department pays the administrative day rate for any authorized days that meet the administrative day definition in WAC 388-550-1050, and when all of 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 medical assistance 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 medical assistance 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 department will recover any unauthorized days paid.

[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, 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, 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 SCHIP clients and nonmedicaid and non-SCHIP clients. (1) Effective for dates of admission from July 1, 2005 through June 30, 2007, and in accordance with legislative directive, the department implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and SCHIP clients and one for nonmedicaid and non-SCHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and SCHIP clients and nonmedicaid and non-SCHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid or non-SCHIP client" is defined as a client eligible under the general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered program, as determined by the department.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and SCHIP 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 388-500-0005. In addition, the department 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 department does not consider detoxification 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 mental health division (MHD) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 388-550-2600.

(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 MHD designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC 388-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act patient claim information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the county involuntary treatment office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and department-covered services.

(6) The medicaid base community psychiatric hospitalization payment rate applies only to a medicaid or SCHIP client admitted to a nonstate-owned free-standing psychiatric hospital located in Washington state.

(7) The nonmedicaid base community psychiatric hospitalization payment rate applies only to a nonmedicaid or SCHIP client admitted to a hospital:

(a) Designated by the department as an ITA-certified hospital; or

(b) That has a department-certified ITA bed that was used to provide ITA services at the time of the nonmedicaid or non-SCHIP admission.

(8) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the department pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the department-specific nondiagnosis related group (DRG) payment method.

(ii) For nonmedicaid and non-SCHIP 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 department-specified non-DRG payment method if no relative weight exists for the DRG in the department'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 SCHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system.

(ii) For nonmedicaid and SCHIP 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 department-specified non-DRG payment method if no relative weight exists for the DRG in the department'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 SCHIP 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-SCHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and SCHIP 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 SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650.

(ii) For nonmedicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650 in conjunction with the non-medicaid 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 SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

(ii) For nonmedicaid [and] non-SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

[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, 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. 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.

[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. 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

WAC 182-550-2800 Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Diagnosis related group (DRG) negotiated conversion factor	Hospitals participating in the medicaid hospital selective contracting program under waiver from the federal government	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount, minus the third-party payment amount and any client responsibility amount.
DRG cost-based conversion factor	Hospitals not participating in or exempt from the medicaid hospital selective contracting program	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount, minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC)	Some services exempt from DRG payment methods	The allowable minus the third-party payment amount and any client responsibility amount.

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Ratio of costs-to-charges (RCC) subject to cost settlement	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	The payment made is the federal share of costs after deducting any third party payment amount and any client responsibility amount.
Single case rate	Hospitals eligible to provide bariatric surgery to medical assistance clients	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the single case rate allowed amount minus the third-party payment amount and any client responsibility amount.
Fixed per diem rate	Long-term acute care (LTAC) hospitals	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the per diem allowed amount minus the third-party payment amount and any client responsibility amount.
Per diem rate	Some providers/services exempt from the DRG payment methods	Per diem allowed amount, and for some services a high outlier amount, minus the third-party payment amount and any client responsibility amount.
Cost settlement	DOH-approved critical access hospitals (CAHs)	The allowed amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Medicaid base community psychiatric hospitalization rate	Nonstate-owned free-standing psychiatric hospitals located in Washington state	Paid according to applicable payment method in WAC 388-550-2650 for medicaid and SCHIP clients, minus the third-party payment amount and any client responsibility amount.

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs. The department's policy for payment on state-administered program claims that involve third-party liability (TPL) and/or client responsibility payments on claims is the same policy indicated in the table in subsection (1) of this section. However, to determine the department's payment on the claim, state-administered program rates, not medicaid or SCHIP rates, apply when comparing the lesser of either the billed amount minus the third-party payment and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount.

(2) In response to direction from the legislature, the department may change any one or more payment methodologies outlined in chapter 388-550 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 department in the Biennial Appropriations Act. In response to this legislative direction, the department 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 department and applied to existing inpatient hospital rates in order to meet targeted expenditure levels as directed by the legislature.

(b) The department will apply the inpatient adjustment factor when the department determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The department will apply any such inpatient adjustment factor to each affected rate in a proportional manner.

(3) The department's annual aggregate medicaid and SCHIP payments to each hospital for inpatient hospital services provided to medicaid and SCHIP clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR Sec. 447.271). The department recoups annual aggregate medicaid and SCHIP payments that are in excess of the usual and customary charges.

(4) The department's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the department would have paid using medicare payment principles.

(5) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(6) Hospitals participating in the department's medical assistance program must annually submit to the department:

(a) A copy of the hospital's CMS medicare cost report (form 2552-96) 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 388-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(7) Reports referred to in subsection (6) 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 department.

(8) The department requires hospitals to follow generally accepted accounting principles.

(9) Participating hospitals must permit the department to conduct periodic audits of their financial records, statistical records, and any other records as determined by the department.

(10) The department 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.

(11) For a client's hospital stay that involves both regional support network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

(12) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

[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). 09-12-063, § 388-550-2800, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500, 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. 07-06-043, § 388-550-2800, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-2800, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 74.09.500. 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. 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. 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. 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-2800, 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 department; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of such a hospital, that meets the definition in RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act; or

(c) Be an out-of-state hospital that meets the conditions in WAC 388-550-6700.

(6/30/11)

(2) The department does not pay:

(a) A hospital or distinct unit for inpatient care and/or services provided to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) A hospital or distinct unit for care and/or services 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) A hospital or distinct unit for ancillary services in addition to the:

(i) Diagnosis related group (DRG) payment, or per case rate payment on claims with dates of admission before August 1, 2007; or

(ii) DRG payment, per diem payment, or per case rate payment on claims with dates of admission on and after August 1, 2007.

(d) For additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the department or mental health division (MHD) designee (see WAC 388-550-2600), as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not requested and/or received approval for an extended length of stay (LOS) from the department or MHD designee as specified in WAC 388-550-4300(6). The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700, to evaluate an extended LOS. A MHD designee may also perform those utilization reviews to evaluate an extended LOS.

(e) For dates of admission before August 1, 2007, for elective or nonemergency inpatient services provided in a nonparticipating hospital. A nonparticipating hospital is defined in WAC 388-550-1050. See also WAC 388-550-4600.

(f) For inpatient hospital services when the department determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The department may perform a retrospective utilization review as described in WAC 388-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(g) For two separate inpatient hospitalizations if a client is readmitted to the same or different hospital or distinct unit within seven calendar days of discharge, unless the readmission is due to conditions unrelated to the previous admission. The department:

(i) May perform a retrospective utilization review as described in WAC 388-550-1700 to determine the appropriate payment for the readmission.

(ii) Determines if the combined hospital stay for the admission qualifies to be paid as an outlier. See WAC 388-550-3700 for DRG high-cost outliers and per diem high outliers for dates of admission on and after August 1, 2007.

(h) For a client's day(s) of absence from the hospital or distinct unit.

(i) For an inappropriate or nonemergency transfer of a client from one acute care hospital or distinct unit to another. The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700 to determine if the admission to the second hospital

or distinct unit qualifies for payment. See also WAC 388-550-3600 for hospital transfers.

(3) An interim billed inpatient hospital claim submitted for a client's continuous inpatient hospitalization of at least sixty calendar days, is considered for payment by the department only when the following occurs (this does not apply to interim billed hospital claims for which the department is not the primary payer (see (b) of this subsection), or to inpatient psychiatric admissions:

(a) Each interim billed hospital claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged prior to 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 department is not the primary payer, the department pays an interim billed hospital claim when the criteria in (a) of this subsection are met and:

(i) After sixty calendar days from the date the department becomes the primary payer; or

(ii) The date a client eligible for both medicare and medicaid has exhausted the medicare lifetime reserve days for inpatient hospital care.

(4) A hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less is considered for payment by the department upon the client's discharge from the hospital or distinct unit. The department considers a client discharged from the hospital or distinct unit if one of the following occurs. The client:

(a) Obtains a formal release issued by the hospital or distinct unit;

(b) Dies in the hospital or distinct unit;

(c) Transfers from the hospital or distinct unit as an acute care transfer; or

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

(5) To be eligible for payment, a hospital or distinct unit must bill an inpatient hospital claim:

(a) In accordance with the current national uniform billing data element specifications:

(i) Developed by the national uniform billing committee;

(ii) Approved and/or modified by the Washington state payer group or the department; and

(iii) In effect on the date of the client's admission.

(b) In accordance with the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) In accordance with the department's current 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 department considers and pays an initial interim billed hospital claim and/or subsequent interim billed hospital claims;

and

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (i.e., 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.

(6) The department allows the semiprivate room rate for a client's room charges, even if a hospital bills the private room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by C.F.R. §447.271.

(7) For inpatient hospital claims, the department allows hospitals an all-inclusive administrative date rate, beginning on the client's admission date, 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 an appropriate placement outside the hospital is not available.

(8) The department pays for observation services according to WAC 388-550-3000 (2)(b), 388-550-6000 (4)(c) and 388-550-7200 (2)(e) and other applicable rules.

(9) The department determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include, but are not limited to, any client responsibility, any third party liability amount, including medicare part A and part B, and any other adjustments as determined by the department.

(10) The department reduces payment rates to hospitals and distinct units for services provided to clients eligible under state-administered programs according to the hospital equivalency factor and/or ratable, or other department policy, as provided in WAC 388-550-4800.

(11) All hospital providers must present final charges to the department 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 based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[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. 07-14-055, § 388-550-2900, filed 6/28/07, effective 8/1/07; 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. 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. 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3000 Payment method—DRG. (1) The department uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. The

department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not limited to:

(a) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, 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 (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's specific DRG conversion factor. See WAC 388-550-3450. The total allowed amount also includes any high outlier amount calculated for claims.

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific DRG conversion factor rate used in calculating the DRG payment.

(6) The department's DRG payment to a hospital may be adjusted when one or more of the following occur:

(a) For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007, a claim qualifies as a DRG high outlier (see WAC 388-550-3700);

(b) A client transfers:

(i) Before July 1, 2009, from one acute care hospital or distinct unit to another acute care hospital or distinct unit; or

(ii) On and after July 1, 2009 from one acute care hospital or distinct unit to:

(A) Another acute care hospital or distinct unit;

(B) A skilled nursing facility (SNF);

(C) An intermediate care facility;

(D) Home care under the department'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 388-550-3600); or

(H) A nursing facility certified under medicaid but not medicare.

(c) A client is not eligible for a medical assistance 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 and medicare has made a payment for the Part B hospital charges; or

(f) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment. Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high-cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.

(7) For dates of admission on and after July 1, 2009, the department pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

(8) The department does not pay for a client's day(s) of absence from the hospital.

(9) The department pays an interim billed hospital claim or covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(10) The department applies to the payment for each claim all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

(11) The department pays hospitals in designated bordering cities for allowed covered services as described in WAC 388-550-3900.

(12) The department pays out-of-state hospitals for allowed covered services as described in WAC 388-550-4000.

[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). 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3010 Payment method—Per diem payment. (1) Effective for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay some covered inpatient hospital services as specified in this section and WAC 388-550-4300, 388-550-4400, and 388-550-3460.

(2) The per diem payment method is effective for dates of admission before, on, and after August 1, 2007, for the following:

(a) Long term acute care (LTAC);

(b) Hospital administrative day bed; and

(c) Hospital swing bed.

(3) The department uses the all-patient diagnosis related group (AP-DRG) grouper to assign a DRG classification to each inpatient hospital stay. The department uses the per diem payment method to pay for hospital stays that have insufficient data available to determine stable relative weights and other specialty services identified in WAC 388-550-3460.

(4) A per diem payment includes, but is not limited to:

(a) A hospital covered service(s) provided to a client during the client's inpatient hospital stay.

(b) An outpatient hospital covered service(s), including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital admission. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(5) The department establishes an average length of stay (ALOS) for each DRG classification during the rebasing process. The DRG ALOS is used as a benchmark to authorize and pay for inpatient hospital stays that are exempt from the DRG payment method. See WAC 388-550-4300(6).

(6) The department's per diem payments to a hospital may be adjusted when one or more of the following occur:

(a) A claim qualifies as a per diem high outlier claim (see WAC 388-550-3700). The outlier provision does not include a claim grouped to a DRG classification in a specialty service category. The specialty service categories include psychiatric, rehabilitation, detoxification, and CUP program services. Long term acute care (LTAC), administrative days and swing bed days do not qualify for high outlier payment.

(b) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay.

(c) A client has third party liability coverage at the time of admission to the hospital or distinct unit.

(d) A client is eligible for medicare, and medicare has made a payment for the hospital charges.

(e) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital or a different hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which, if any, inpatient hospital

stay(s) qualify for payment. An outlier payment may be made if the department determines the claim for the combined hospital stays qualifies as a high outlier. (See WAC 388-550-3700 for high outliers.)

(f) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the per diem rate payments.

(7) The department does not pay for a client's day(s) of absence from the hospital.

(8) The department 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 388-550-2900.

(9) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[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). 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. 07-14-051, § 388-550-3010, filed 6/28/07, effective 8/1/07.]

WAC 182-550-3020 Payment method—Bariatric surgery—Per case payment. (1) The department pays designated department-approved hospitals for prior authorized bariatric surgery when the criteria in WAC 388-550-2301 are met. Claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) do not qualify for outlier payments.

(2) The department pays for claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) using a per case rate. See WAC 388-550-3470.

(3) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific per case rate.

[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). 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. 07-14-051, § 388-550-3020, filed 6/28/07, effective 8/1/07.]

WAC 182-550-3100 Calculating DRG relative weights. (1) This section describes how the department calculates Washington diagnostic-related group (DRG) relative weights. The department:

(a) Classifies the Washington hospital admissions data using the all-patient diagnosis related group (AP-DRG).

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes a single set of medicaid-specific relative weights from Washington hospital admissions data. For dates of admission before August 1, 2007, the relative weights are based on claim charges. The department identifies these relative weights as stable or unstable.

(d) Tests the stability of the relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. The department accepts as stable and adopts those relative weights that pass the reasonable statistical test.

(e) For dates of admission before August 1, 2007, may compare the medicaid-specific relative weights to nonmedicaid relative weights. The department:

(i) May combine the medicaid-specific relative weights with the nonmedicaid relative weights if the nonmedicaid relative weights are statistically comparable to the medicaid-specific weights; or

(ii) Uses only the medicaid-specific relative weights if the nonmedicaid relative weights are not statistically comparable to the medicaid-specific relative weights.

(f) For dates of admission before August 1, 2007, uses the ratio of costs-to-charges (RCC) payment method to pay for hospital stays that have unstable DRG relative weights.

(2) When using ratios with a DRG relative weight as base, the department adjusts all stable relative weights so that the average weight of the case mix population equals 1.0.

(3) For dates of admission on and after August 1, 2007, the department:

(a) Bases the relative weights on the estimated wage adjusted cost of the claims in each stable DRG classification. The operating and capital component costs were used for this process. To calculate relative weights, the department divides the average cost per discharge for each stable AP-DRG classification by the average cost per discharge for all stable AP-DRG classifications combined. For purposes of these calculations, the department uses the two most current years of medicaid inpatient hospital paid claims data available at the time of relative weight calibration.

(i) The department uses a combination of medicaid fee-for-service and healthy options (HO) managed care organization (MCO) data from the two most current years of fully adjudicated paid claims data available at the time of relative weight calibration.

(ii) The department removes:

(A) Claims that represent statistical outliers from the dataset prior to calculating relative weights, based on the assumption that these claims are likely to be paid under an alternative outlier payment methodology. The department identifies statistical outliers as those claims with estimated costs that exceed three standard deviations of the mean cost of all claims in each AP-DRG classification;

(B) Claims to be paid by alternative methods, including psychiatric, rehabilitation, detoxification, CUP woman program, bariatric surgery cases, and organ transplant claims;

(C) Transfer-out claims;

(D) Same day discharges;

(E) Claims that were either ungroupable or had invalid diagnosis for AP-DRG classification purposes; and

(F) Claims related to state-administered programs where the payment calculations are based on reduced state-administered program payment rates.

(b) Uses the term "unstable" generically to describe an AP-DRG classification that has fewer than ten occurrences, or that is unstable based on the statistical stability test indicated below. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the populations's estimated standard deviation.

The formula is:

$N = (Z^2 * S^2) / R^2$, where

• The Z statistic for 90 percent confidence is 1.64;

• S = the standard deviation for the AP-DRG classification; and

• R = acceptable error range, per sampling unit.

(c) Uses:

(i) The per diem payment method to pay for hospital stays that group to an unstable DRG relative weight, some long term acute care (LTAC) services, and other specialty service and low volume services groups identified in WAC 388-550-3460.

(ii) One of the other non-DRG payment methods (e.g., RCC, per case rate, etc.) to pay for claims paid using other non-DRG payment methods (e.g., some transplants, the high outlier portion of high outlier claims, non-per diem portion of LTAC claims, bariatric surgery, etc.).

[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. 07-14-051, § 388-550-3100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.04.050. 04-13-048, § 388-550-3100, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3150 Base period costs and claims data. (1) The department sets a hospital's cost-based conversion factor for dates of admission before August 1, 2007, using base period cost data from its medicare cost report (Form CMS 2552) for its fiscal year corresponding with the base period.

(2) The department may use in rate-setting, "as filed" base period cost data, or "final settled" medicare cost report base period cost data that have been desk reviewed and/or field audited by the medicare intermediary.

(3) The department, to the extent feasible, factors out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600 before calculating the hospital's conversion factor.

(4) For dates of admission before August 1, 2007, the department uses the figures for total costs, capital costs, and direct medical education costs from a hospital's medicare cost report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize medicaid claims.

(5) For dates of admission before August 1, 2007, the department uses nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

- (a) Routine;
- (b) Intensive care;
- (c) Intensive care-psychiatric;
- (d) Coronary care;
- (e) Nursery;
- (f) Neonatal intensive care unit;
- (g) Alcohol/substance abuse;
- (h) Psychiatric; and
- (i) Oncology.

(6) For dates of admission before August 1, 2007, the department uses twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

- (a) Operating room;
- (b) Recovery room;
- (c) Delivery/labor room;
- (d) Anesthesiology;
- (e) Radiology-diagnostic;
- (f) Radiology-therapeutic;
- (g) Radioisotope;
- (h) Laboratory;
- (i) Blood storage;
- (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;
- (t) Ancillary oncology;
- (u) Cardiology;
- (v) Ambulatory surgery;
- (w) Computerized tomography scan/magnetic resonance

imaging;

- (x) Clinic;
- (y) Emergency;
- (z) Ultrasound;
- (aa) Neonatal intensive care unit transportation;
- (bb) Gastrointestinal laboratory; and
- (cc) Miscellaneous.

(7) The department shall:

(a) Extracts from the medicaid management information system all medicaid and SCHIP paid claims data for each hospital's base year;

(b) Assigns line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Uses the cost center categories to apportion medicaid and SCHIP costs.

(8) For dates of admission on and after August 1, 2007, the department rebased the hospital inpatient payment system and used claim and estimated cost data to estimate costs for the system development.

(a) Claim data used for rebasing process. The department uses the following claim data resources considered the most complete and available at the time the system is developed for the rebase:

(i) From the department's medicaid management information system (MMIS) data base, two years of fee-for-ser-

vice paid claim data, excluding claims related to state programs and paid at the Title XIX reduced rates;

(ii) From the comprehensive hospital abstract reporting system (CHARS) dataset that is maintained by the department of health (DOH), two years of sample claims representing healthy options (HO) services that are identified from the CHARS dataset based on the medicaid HO eligibility data files; and

(iii) From the healthcare cost report information system (HCRIS) that is maintained by the centers for medicare and medicaid (CMS), the hospital's most current medicare cost report data. If the hospital's medicare cost report from the HCRIS system is not available, the department uses the medicare cost report provided by the hospital.

(b) Claim data used to estimate costs. The department uses:

(i) The fee-for-service and HO claims for two fiscal years to calculate diagnosis related group (DRG) relative weights.

(ii) The fee-for-service and HO claims for the most current single fiscal year to calculate conversion factors, per diem rates, and per case rates.

(iii) The payments from fee-for-service only claims for a single year to model the fiscal impacts to the department and individual hospitals that result from the implementation of the payment methodology.

(c) Estimated costs of claims. The department:

(i) Identifies the operating (routine and ancillary), capital (routine and ancillary), and direct medical education (routine and ancillary) cost components from different worksheets from the hospital's medicare cost report;

(ii) Estimates costs for each separate component identified in (c)(i) of this subsection for each fee-for-service and HO claim in the dataset by:

(A) Calculating the operating, capital, and direct medical education routine costs for each fee-for-service and HO claim by multiplying 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.

(B) Calculating the operating, capital, and direct medical education ancillary costs for each fee-for-service and HO claim by multiplying the ratio of costs-to-charges (RCC) reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, clinic) by the allowed charges reported at the claim line level by type of service.

(d) Routine and ancillary cost components. For purposes of estimating costs consistently for all hospitals' claims, the department uses standard routine and ancillary cost components. The standard cost components used for estimating costs of claims are:

(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) Deliver/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.

[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. 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. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has medicaid and SCHIP charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its medicare cost report, the department establishes cost proxies to estimate costs in order to ensure recognition of medicaid related costs.

(2) For the inpatient payment system effective for dates of admission before August 1, 2007, the department develops per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) For the inpatient payment system effective for dates of admission before August 1, 2007, the department also develops ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

(4) For the inpatient payment system effective for dates of admission on and after August 1, 2007, the department:

(a) Develops per diem proxies for accommodation cost centers using the hospital's per diem cost data within the affected same type of services; and

(b) Develops ratios of costs-to-charges (RCC) proxies for ancillary cost centers based on the hospital's aggregate ancillary costs to aggregate ancillary charges.

[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. 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. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3250 Indirect medical education costs—Conversion factors, per diem rates, and per case rates.

(1) For dates of admission before August 1, 2007, for each hospital with a graduate medical education program, the department removes indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap for conversion factor rebasing.

(2) For dates of admission before August 1, 2007, to arrive at indirect medical education costs for each component, the department:

(a) Multiplies medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) Multiplies the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) For dates of admission before August 1, 2007, after the peer group's cost cap has been calculated, the department adds back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450.

(4) For dates of admission on and after August 1, 2007, the department:

(a) Uses the indirect medical costs in the calculation of the hospital DRG conversion factor, per diem rates, and per case rates.

(b) Uses the medicare's indirect medical education factor matching the same period of the hospital medicare cost report used in calculating the hospital cost to estimate the hospital aggregate operating and capital costs. The indirect medical education costs were removed from the hospital aggregate operating and capital costs in determination of statewide standardized average operating and capital cost per discharge, per day, and per case amounts.

(c) To calculate the hospital-specific DRG conversion factor, per diem rates, and per case rates during rebasing. The department:

(i) Multiplies the statewide standardized labor portion of the operating amount by the most currently available facility-specific wage index established by medicare that exists at the time of the medicaid rebasing (to determine the labor portion, the department used the factor established by medicare multiplied by the statewide operating standardized amount), then the nonlabor portion is added to the result to produce a hospital-specific operating amount; then

(ii) Multiplies the hospital-specific operating amount by 1.0 plus the most currently available operating indirect medi-

cal education factor established by medicare that exists at the time of the medicaid rebasing; then

(iii) Multiplies the statewide standardized capital amount by 1.0 plus the most currently available capital indirect medical education factor established by medicare that exists at the time of the medicaid rebasing; then

(iv) Adds this hospital-specific operating amount to the statewide standardized capital amount; then

(v) Adds the hospital-specific direct medical education portion adjusted for hospital-specific casemix index to the operating and capital amounts.

[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. 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. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3300 Hospital peer groups and cost caps. (1) For rate setting purposes, the department groups hospitals into peer groups.

(2) The six hospital peer groups are:

(a) Group A, rural hospitals;

(b) Group B, urban hospitals without medical education programs;

(c) Group C, urban hospitals with medical education program;

(d) Group D, specialty hospitals or other hospitals not easily assignable to the other five groups;

(e) Group E, public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) program; and

(f) Group F, hospitals approved by the department of health (DOH) as critical access hospitals.

(3) For dates of admission before August 1, 2007, the department uses a cost cap at the seventieth percentile for hospitals in peer groups B and C for cost based conversion rate setting. All other peer groups are exempt from the cost caps for the following reasons:

(a) Peer group A hospitals because they are paid under the ratio of costs-to-charges (RCC) methodology for medic-aid claims.

(b) Peer group D hospitals because they are specialty hospitals without a common peer group on which to base comparisons.

(c) Peer group E hospitals because they are paid under the "full cost" public hospital certified public expenditure (CPE) program RCC methodology for inpatient claims.

(d) Peer group F hospitals because they are paid under the departmental weighted costs-to-charges (DWCC) methodology for most hospital claims. See WAC 388-550-2598(14) for the payment methods for inpatient detoxification unit, distinct psychiatric unit, and distinct rehabilitation unit claims.

(4) For dates of admission before August 1, 2007, the department calculates cost caps for peer groups B and C for cost based conversion rate setting based on the hospitals' base period costs after subtracting:

(a) Indirect medical education costs, in accordance with WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5) For dates of admission before August 1, 2007, the department uses the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor. After the peer group cost cap is calculated, the department adds back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) For dates of admission before August 1, 2007, in cases where corrections or changes in an individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, the department updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will result in a five percent or greater change in the seventieth percentile of costs calculated for either its previous peer group category, its new peer group category, or both.

(7) For dates of admission on and after August 1, 2007, the department continues to use the hospital peer groups in subsection (2) of this section to determine some rate setting and payment methods.

[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. 07-14-055, § 388-550-3300, filed 6/28/07, effective 8/1/07; 06-08-046, § 388-550-3300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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. 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. 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3350 Outlier costs. (1) The information and processes described in subsections (1) through (5) of this section are applicable for claims with dates of admission before August 1, 2007.

(a) The department removes the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050.

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department adds the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:
 (i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department pays high-cost outlier claims from the outlier set-aside pool. The department calculates an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the medicaid management information system (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost diagnosis related group (DRG) outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department uses the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department funds the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements will be made to hospitals for outlier cases.

(6) For dates of admission on and after August 1, 2007, the department includes statistical outlier claims for calculation of the conversion factors, per diem rates, and per case rates, and does not establish an outlier set-aside pool. The department does not include statistical outlier claims for calibration of DRG relative weights.

[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. 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. 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3381 Payment methodology for acute PM&R services and administrative day services. The department's payment methodology for acute PM&R services provided by acute PM&R hospitals is described in this section.

(1) For dates of admission before August 1, 2007, the department pays an acute PM&R rehabilitation hospital according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500. For dates of admission on and after August 1, 2007, the department pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See WAC 388-550-3010 and 388-550-3460.

(6/30/11)

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When the department authorizes administrative day(s) for a client as described in WAC 388-550-2561(8), the department pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed in the client's use during the administrative portion of the client's stay.

(4) The department pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital according to chapter 388-546 WAC.

[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. 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. 03-06-047, § 388-550-3381, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 182-550-3400 Case-mix index. (1) The department:

(a) Adjusts hospital costs used to calculate the conversion factor and per diem rates during the rebasing process by the hospital's case-mix index; and

(b) Calculates the case-mix index (CMI) for each individual hospital to measure the relative cost for treating medicaid and SCHIP cases in a given hospital.

(2) The department calculates the CMI for each hospital using medicaid and SCHIP admissions data from the individual hospital and the hospital's base period cost report. See WAC 388-550-3150. The CMI is calculated for each hospital by summing all relative weights for all claims in the dataset, and dividing the sum of the relative weights by the number of claims. That amount represents the relative acuity of the claims. The hospital-specific CMI is calculated as follows:

(a) The department multiplies the number of medicaid and SCHIP admissions to the hospital for a specific DRG classification by the relative weight for that DRG classification. The department repeats this process for each DRG billed by the hospital.

(b) The department adds together the products in (a) of this subsection for all of the medicaid and SCHIP admissions to the hospital in the base year.

(c) The department divides the sum obtained in (b) of this subsection by the corresponding number of medicaid and SCHIP hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRG classifications. A CMI of less than 1.0 indicates a mix of patients in the less costly DRG classifications.

(3) The department recalculates each hospital's case-mix index periodically, but no less frequently than each time rebasing is done.

[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. 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. 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3450 Payment method for calculating medicaid DRG conversion factor rates. (1) For medicaid and SCHIP accommodation costs, the department:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the accommodation categories described in WAC 388-550-3150; then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total medicaid and SCHIP days to arrive at total medicaid accommodation costs per category for the three components.

(2) For ancillary costs the department:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's ancillary categories described in WAC 388-550-3150; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by medicaid and SCHIP charges per category, as tracked by the medicaid management information system (MMIS), to arrive at total medicaid and SCHIP ancillary costs per category for the three components (operating, capital, and medical education).

(3) The department:

(a) Combines medicaid and SCHIP accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of medicaid and SCHIP cases during the base year to arrive at an average medicaid and SCHIP cost per discharge; then

(c) For dates of admission before August 1, 2007, adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the medicaid and SCHIP average cost by a factor determined by the department to standardize hospital costs to the common fiscal year end. The department adjust the hospital's medicaid and SCHIP average cost by the hospital's specific case mix index.

(4) For dates of admission before August 1, 2007, the department caps the medicaid and SCHIP average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, the department removes the indirect medical education and outlier costs from the medicaid average cost per admission.

(a) For hospitals in department peer groups B or C, the department determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, the department adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350.

(5) For dates of admission before August 1, 2007, for an inflation adjustment and outlier set-aside adjustment, the department may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year;

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF.

(6) For dates of admission on and after August 1, 2007, the department establishes medicaid DRG conversion factors for calculation of the medicaid and SCHIP DRG payments.

(a) The department determines DRG conversion factors based on the estimated hospital operating, capital, and direct medical education costs from medicaid and SCHIP fee-for-services and Health Option claims data for the most current state fiscal year, or "base year claims data." The claims data is designated by the department as the "base year claims data" used for the DRG conversion factor calculation process. The "base year claims data" consists of medicaid and SCHIP fee-for-service and health options claims data for the most current state fiscal year (at the time the rebasing process takes place) from in-state acute care hospitals that are not a critical access hospital (CAH) or a long term acute care (LTAC) hospital. The detailed cost calculation is described in WAC 388-550-3150. Only base year claims grouped to a DRG classification that has a stable DRG relative weight are included in the DRG conversion factor calculation. Stable relative weight DRGs are defined in WAC 388-550-3100.

(b) The department calculates and adjusts hospital-specific operating, capital and direct medical education costs as follows:

(i) For hospital-specific operating costs (to determine the labor portion, the department used the factor established by medicare multiplied by the statewide operating standardized amount) by the most currently available hospital-specific medicare wage index established by medicare that exists at the time of the medicaid rebasing; then adds the nonlabor portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor established by medicare that exists at the time of the medicaid rebasing); then divides that result by the hospital-specific medicaid case-mix index; then

(ii) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides that result by the hospital-specific medicaid case-mix; then

(iii) For hospital-specific direct medical education costs, the department divides hospital-specific direct medical education costs by the hospital-specific medicaid case-mix; then

(iv) To make adjustments to hospital-specific costs derived in subsections (i) through (iii) of this subsection, the department uses:

(A) The medicare wage indices and indirect medical education factors in effect for the medicare inpatient prospective payment system (PPS) federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations; and

(B) The medicaid case mix indices based on the recalibrated DRG relative weights applied to the base year claims data. Medicaid case mix index is described in WAC 388-550-3400.

(c) Calculates statewide operating and capital standardized amounts to adjust hospital-specific operating and capital costs as follows. The department:

(i) Divides the statewide aggregate adjusted operating costs by the statewide aggregate number of discharges in the base year claims data (cost and discharges are described in subsection (a) and (b) of this subsection); and

(ii) Divides the statewide aggregate adjusted capital costs by the statewide aggregate number of discharges in the base year claims data (costs and discharges described in subsection (a) and (b) of this section.

(d) The department makes hospital-specific adjustments to the statewide operating and capital standardized amounts as follows:

(i) To determine the labor portion, the department used the factor established by medicare multiplied by the statewide operating standardized amount. The labor portion of the hospital-specific operating standardized amount is multiplied by the most currently available hospital-specific medicare wage index established by medicare that exists at the time of the medicaid rebasing; then the nonlabor portion is added to the result; then the result is multiplied by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor established by medicare that exists at the time of the medicaid rebasing). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(ii) Capital standardized amount is multiplied by (1.0 plus the most current available hospital-specific medicare capital indirect medical education factor that has been published at the point the rate setting calculation takes place during the rebasing process).

(e) To determine hospital-specific DRG conversion factors, the department sums for each hospital:

(i) The adjusted operating standardized amount;

(ii) The adjusted capital standardized amount; and

(iii) The direct medical education cost per discharge adjusted for hospital-specific case-mix index.

(f) The department adjusts the hospital-specific DRG conversion factors 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 rebased inpatient payment system implementation year.

(g) The department may adjust the hospital-specific DRG conversion factors by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services for the rebasing implementation year.

(h) The department may make other necessary adjustments as directed by the legislature.

(i) The hospital's specific DRG conversion factor may not be changed unless the inpatient payment system is rebased or the legislature authorized the changes.

[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. 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. 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. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3460 Payment method—Per diem rate. (1) For dates of admission before August 1, 2007 the department established per diem rates for:

(a) Inpatient chronic pain management as specified in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as specified in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as specified in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as specified in WAC 388-550-4500 as it existed before July 1, 2009 or WAC 388-550-4550 for these services effective for dates of admission on and after July 1, 2009.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diem rates for the services identified in subsection (1), except for the community psychiatric inpatient hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of community psychiatric inpatient services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates separate statewide standardized per diem rates for the following categories:

(i) Rehabilitation services—Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services—Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services—Chemically using pregnant (CUP) women program services are identified as any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the system. These claims include any statistical outliers. These statewide standardized amounts serve as the basis for calculating per diem rates for

each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs. Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department adjusts the labor portion of the hospital-specific operating costs by the most current hospital-specific medicare wage index established and published by medicare at the time of the medicaid rebasing; then adds the nonlabor portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor established by medicare that exists at the time of the medicaid rebasing); then divides that result by the hospital-specific medicaid case-mix index; then

(B) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides the result by the hospital-specific medicaid case-mix; then

(iii) The department then sums the costs and days for all included hospitals for each service, and calculates each service's statewide standardized weighted average cost per day amounts, weighted based on number of days.

(d) Once the department establishes the statewide standardized amounts, hospital-specific per diem rates for each specialty service are calculated.

(i) Starting with the statewide standardized operating amount, the department multiplies the labor portion of the amount by the most current hospital-specific medicare wage index established and published by medicare at the time of the medicaid rebasing. (To determine the labor portion, the department uses the factor established by medicare multiplied by the statewide operating standardized amount.) This adjustment is made to reflect wage differences incurred by hospitals in different regions of the state. The department then adds the nonlabor portion to the result.

(ii) The department-adjusted operating and capital amounts reflect the indirect costs associated with approved teaching programs. The department adjusts for the indirect costs by multiplying the operating and capital amounts by (1.0 plus the most currently available hospital-specific medicare indirect medical education factor in the medicare final rule for the operating and capital components). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(iii) The department then adds to the operating and capital amounts the hospital-specific direct medical education cost per day (hospital-specific direct medical education cost per day adjusted for hospital-specific case-mix index).

(iv) Finally, the department adjusts the facility-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(e) Specialty service claims are not eligible for high outlier payments. See WAC 388-550-3700.

(4) For dates of admission on and after August 1, 2007, the department establishes hospital-specific per diem rates for psychiatric services provided by in-state noncritical access hospitals that are free-standing psychiatric hospitals, acute care hospitals with psychiatric distinct part units, or other acute care hospitals.

(a) The department identifies psychiatric claims for hospitals meeting the criteria in this subsection as all claims from free-standing psychiatric hospitals, and all claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at the acute care hospitals. The department includes all claims from freestanding psychiatric hospitals, regardless of AP-DRG assignment.

(b) To determine a facility-specific payment rate per day for psychiatric services, the department uses the greater of the estimated costs per diem of the:

(i) Hospital's inpatient psychiatric claims in the base year dataset; or

(ii) Statewide average of the estimated costs of the hospital's inpatient psychiatric claims (as described in subsection (4)(a)) in the base year claims including adjustments for regional wage differences and for differences in medical education costs.

(c) The department calculates average cost per day amounts for each hospital and then makes adjustments to the average cost per day amounts to reflect changes in the indirect medical education factor and hospital-specific wage index between the base year and the implementation year.

(d) Finally, the department adjusts the hospital-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(5) For dates of admission on and after August 1, 2007, for hospitals not meeting the criteria in subsection (4), the department calculates per diem rates using the same method used for rehabilitation, detoxification and CUP women program payments described in this section, except that the department uses only the psychiatric claims from those facilities identified as qualifying for hospital-specific rates.

(6) For dates of admission on and after August 1, 2007, for freestanding rehabilitation facilities, the department uses the per diem rate established for rehabilitative services rather than a facility-specific rate.

(7) For dates of admission on and after August 1, 2007, for claims that are classified into AP-DRG classifications that

do not have enough claims volume to establish stable relative weights, and that are not specialty claims as described in this section, the department also uses a per diem rate.

(a) These types of claims are less homogeneous than the specialty claims described in this section, and the costs of these claims are more variable than the costs of those that are included under the DRG payment method. The department conducts significant analyses to establish per diem rates based on groupings that would distinguish between higher cost per day claims and lower cost per day claims. As part of this analysis, the department analyzes costs per day based on the following criteria for groupings, which are not mutually exclusive:

- (i) Neonatal claims, based on assignment to major diagnostic category (MDC) 15;
- (ii) Burn claims based on assignment to MDC 22;
- (iii) AP-DRG assignments that include primarily medical procedures;
- (iv) AP-DRG assignments that include primarily surgical procedures;
- (v) Cranial procedure claims, based on specific cranial procedure AP-DRG classifications, and
- (vi) MDC assignment.

(b) Based on the analyses of cost per day amounts for each grouping criteria identified in subsection (7)(a), the department identified four nonspecialty service groupings appropriate for establishing per diem payments. These are:

- (i) Neonatal claims, based on assignment to MDC 15;
- (ii) Burn claims based on assignment to MDC 22;
- (iii) AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified in this subsection; and
- (iv) AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified in this subsection.

(c) For each service group, except for burn cases, the department calculates a per diem rate for each hospital based on the aggregate statewide weighted average cost per day for the service after adjusting costs for regional wage differences and differences in graduate medical education program costs. For burn cases, per diem rates are based on the average operating and capital cost per day for Harborview Medical Center, which had the vast majority of burn cases in the state.

(d) The per diem calculations are based on the estimated costs of the claims for each service group in the base year, including both fee-for-service and healthy options claims data. After determining the statewide weighted average cost per day after these adjustments, the department calculates the per diem rate for each hospital for each service group by adjusting the statewide weighted average cost per day amount for each hospital based on its hospital-specific wage index and medical education program costs.

(e) Because of the variability of the cost of claims in unstable AP-DRG classifications, the department developed an outlier policy for these per diem payments, similar to the outlier methodology recommended for the DRG payment method.

(f) Claims that are not in the specialty service groupings indicated in subsection (3)(a) and (b), may qualify for a high outlier payment if the claim qualifies under the high outlier criteria. See WAC 388-550-3700.

(8) For dates of admission on and after August 1, 2007, for inpatient chronic pain services, the department establishes per diem rates based on allowed charges data that the department obtains from the hospital. The department determines the hospital per diem rate by identifying costs and dividing the total cost by the number of days associated with the cost.

[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). 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. 07-14-051, § 388-550-3460, filed 6/28/07, effective 8/1/07.]

WAC 182-550-3470 Payment method—Bariatric surgery—Per case rate. (1) The department:

(a) Pays for bariatric surgery provided in designated department-approved hospitals when all criteria established in WAC 388-550-2301 and 388-550-3020 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC 388-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the department determines the per case rate by using a hospital-specific medicare fee schedule rate the department used to pay for bariatric surgery.

(3) For dates of admission on and after August 1, 2007, the department determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the department's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the department:

(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 department:

(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 department:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all in-state hospitals operating standardized amount after making adjustments for the wage index and the indirect medical education. The department:

(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 department to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of in-state hospitals approved by the department to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all in-state hospitals capital standardized amount after adjusting for the indirect medical education. The department:

(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 department to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of in-state hospitals approved by the department to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the in-state 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 department 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 department 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 department to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the department sums for each hospital the in-state statewide bariatric operating payment per case, the in-state 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 in-state hospitals approved by the department to provide bariatric services.)

(e) The department 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 department may make other necessary adjustments as directed by the legislature (i.e., rate rebasing and other changes as directed by the legislature).

[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. 07-14-051, § 388-550-3470, filed 6/28/07, effective 8/1/07.]

WAC 182-550-3500 Hospital annual inflation adjustment determinations. (1) Effective each state fiscal year, except rebase implementation years, the department may adjust all cost-based conversion factors (CBCF), per diem rates, and per case rates, by an inflation factor (vendor rate increase), as determined by the state legislature and supported in the state's budget. The department does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

(2) For dates of admission on and after August 1, 2007, except for rebase implementation years, the department makes adjustments to the hospital's DRG conversion factors, per diem rates, and per case rates, by an inflation factor (vendor rate increase), as authorized and determined by the legislature and supported in the state's budget.

[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. 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. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

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:

(a) Before July 1, 2009, to another acute care hospital or distinct unit; and

(b) On or after July 1, 2009, to one of the following:

(i) Another acute care hospital or distinct unit;

- (ii) A skilled nursing facility (SNF);
- (iii) An intermediate care facility (ICF);
- (iv) Home care under the department's home health program;
- (v) A long-term acute care facility (LTAC);
- (vi) Hospice (facility-based or in the client's home);
- (vii) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3000); or
- (viii) A nursing facility certified under medicaid but not medicare.

(2) The department pays a hospital that transfers an emergency case to another acute care hospital, including an acute physical medicine and rehabilitation (acute PM&R) facility or distinct unit, an acute psychiatric facility or distinct unit, and a long-term acute care facility, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment based on a stable DRG; or

(b) A prorated DRG payment when the client's stay at the transferring hospital is less than the average length of stay (LOS) for the AP-DRG classification as determined by the department.

(3) The department pays a transferring hospital as follows:

(a) For dates of admission before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average LOS.

(b) For dates of admission on and after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average LOS (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(4) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) The department's LOS data to determine the number of medically necessary days for a client's hospital stay.

(5) When a post-acute care hospital transfer occurs to one of the locations listed in subsection (1)(b)(ii) through (viii) of this section, the department pays the transferring hospital the lesser of:

(a) The appropriate DRG payment; or

(b) For dates of admission on and after July 1, 2009, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average length of stay (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(6/30/11)

(6) The department applies the outlier payment methodology if a transfer case qualifies:

(a) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(b) For dates of admission on or after August 1, 2007, as a high-cost outlier.

(7) The department does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(8) The department pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the department's maximum payment to a discharging hospital.

(9) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(10) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (3) of this section.

(11) The transfer payment policy described in this section does not apply to claims grouped into AP-DRG classifications that are paid based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(12) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[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). 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. 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. 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. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers.

This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under the per diem payment methodology.

(1) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

- (i) A threshold of twenty-eight thousand dollars; and
- (ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

- (i) A threshold of thirty-three thousand dollars; and
- (ii) A threshold of three times the applicable DRG payment amount.

(2) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date on or after January 1.

(3) For dates of admission before August 1, 2007, the department determines payment for medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and claims from in-state children's hospitals, are paid seventy-five percent of the allowed charges above

the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Examples for DRG high-cost outlier claim qualification and payment calculation
(Admission dates are January 1, 2001, or after, and before August 1, 2007.)

Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > \$33,000?	Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
\$17,000	\$5,000	\$15,000	No	Yes	N/A	64%
*\$33,500	5,000	15,000	Yes	Yes	**\$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
*\$33,500	Allowed charges
- \$33,000	The greater amount of 3 x applicable DRG pymt (\$15,000) or \$33,000
\$500	
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/nonin-state children's) (75% x 64% = 48%)
\$240	Outlier portion
+ \$5,000	Applicable DRG payment
**\$5,240	Outlier payment

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007, the department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for a day outlier claim is the

applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.

(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection (16) of this section.

(a) The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission. Except as specified in (b) of this subsection, a claim that is grouped to a medical, surgical, or burn DRG service category qualifies as a high outlier when the claim's estimated cost is greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.

(b) For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty per-

cent of the applicable per diem base allowed amount for payment.

(c) The department may perform retrospective utilization reviews on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.

Specifically, this formula is:

$$N = (Z^2 * S^2) / R^2$$
, where

- The Z statistic for 90 percent confidence is 1.64
- S = the standard deviation for the AP-DRG classification, and
- R = acceptable error range, per sampling unit

If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classification during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.

The DRG classifications assigned to the per diem payment method, that are in one of the major service categories in subsection (16)(a) through (d) of this section, qualify for examination if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of an AP-DRG relative weight. A claim in a DRG classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:

- (a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;
- (b) Burn claims based on assignment to MDC 22;
- (c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and
- (d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.

(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the medicaid or SCHIP DRG paid and per diem paid

claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for medicaid or SCHIP DRG paid and per diem paid claims is as follows:

(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the non-covered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.

(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:

(i) For DRG paid claims grouped to nonneonatal or non-pediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For nonspecialty service category per diem paid claims grouped to nonneonatal and nonpediatric DRG classifications, and for nonspecialty service category per diem paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment allowed amount; and

(iv) For nonspecialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all nonspecialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment indicated in (b)(i) through (iv) of this subsection, respectively, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. Hospitals paid with the payment method used for out-of-state hospitals are paid using the percent of outlier adjustment factor identified in (c)(iii) of this subsection. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Used as indicated in WAC 388-550-4800 to calculate payment for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

DRG high outlier

Three examples for medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

			Department Determined Estimated Costs			
Total Submitted Charges Minus Noncovered Charges	Base DRG Pay- ment Allowed Amount ¹	175% of Base DRG Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than \$50,000? ²	Are Greater Than 175% of Base DRG Pay- ment Allowed Amount?	Total DRG High Outlier Claim Payment Allowed Amount ^{3,4}	Hospital's Indi- vidual RCC Rate
\$95,600	\$28,837	\$50,465	Yes	Yes	\$38,761	65%
\$64,500	\$28,837	\$50,465	No	Yes	\$28,837	65%
\$77,000	\$28,837	\$50,465	Yes	No	\$28,837	65%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

\$6,300 x 4.5773 = \$28,837 = Base DRG allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

\$95,600 x 65% = \$62,140 = Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria (in this example \$50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$\$62,140 - \$50,465 = \$11,675 \times 85\% = \$9,924 =$ High outlier portion allowed amount

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$\$28,837 + \$9,924 = \$38,761$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$\$6,300 \times 4.5773 = \$28,837 =$ Base DRG allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$64,500 \times 65\% = \$41,925 =$ Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$41,925 - \$50,465 = (\$8,540)) \times 85\% = (\$7,259)$, which is converted to \$0. Also, \$41,925 is not greater than \$50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$\$28,837 + \$0 = \$28,837$

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$\$6,300 \times 4.5773 = \$28,837 =$ Base DRG allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$77,000 \times 65\% = \$50,050 =$ Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = high outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$50,050 - \$50,465 = (\$415)) \times 85\% = (\$353)$, which is converted to \$0. Also, \$50,050 is greater than \$50,000, but not greater than \$50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$\$28,837 + \$0 = \$28,837$

Per Diem High Outlier

Three examples for medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Less Total Noncovered Charges	Base Per Diem Payment Allowed Amount ¹	175% of Base Per Diem Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than \$50,000? ²	Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount?	Total Per Diem High Outlier Claim's Payment Allowed Amount ^{3,4}	Hospital's Individual RCC Rate
\$100,000	\$25,000	\$43,750	Yes	Yes	\$47,313	70%
\$64,000	\$25,000	\$43,750	No	Yes	\$25,000	70%
\$75,000	\$35,000	\$61,250	Yes	No	\$35,000	70%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$\$1,000 \text{ (rate)} \times 25 \text{ (days)} = \$25,000 =$ Base per diem allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$100,000 \times 70\% = \$70,000 =$ Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$70,000 - \$43,750 = \$26,250) \times 85\% = \$22,313 =$ High outlier portion allowed amount

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$$\$25,000 + \$22,313 = \$47,313$$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$$\$1,000 \times 25 = \$25,000 = \text{Base per diem allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$64,500 \times 70\% = \$45,150 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

(\$45,150 - \$43,750 = \$1,400), but \$45,150 is not greater than \$50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$$\$25,000 + \$0 = \$25,000$$

Example three: (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$$\$1,000 \times 35 = \$35,000 = \text{Base per diem allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$75,000 \times 70\% = \$52,500 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

(\$52,500 - \$61,250 = (\$8,750)) \times 85% = (\$7,438), which is converted to \$0. Also, \$52,500 is greater than \$50,000, but not greater than \$61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$$\$35,000 + \$0 = \$35,000$$

(18) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the percentages of outlier adjustment factors described in this section.

(19) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[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). 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. 07-14-051, § 388-550-3700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 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. 01-16-142, § 388-550-3700, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303 and 447.2652. 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. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3800 Rebasing and recalibration. (1)

The department rebases most of the rates used in the medic-aid inpatient payment system once every three years. Changes to the inpatient hospital rate calculations and rate-setting methods involved in this rebasing process are implemented pursuant to the rebasing of the rate system

(a) To determine costs for that rebasing process, the department uses:

(i) Each instate hospital's medicare cost report for the hospital fiscal year that ends during the calendar year that the rebasing base year designated by the department begins; and

(ii) Inpatient medicaid and SCHIP claims data for the twelve-month period designated by the department as the rebasing base year.

(b) The rebasing process updates rates for the diagnosis related group (DRG), per diem, and per case rate payment methods.

(c) Other inpatient payment system rates (e.g., the ratio of costs-to-charges (RCC) rates, departmental weighted costs-to-charges (DWCC) rates, administrative day rate, and swing bed rate) are rebased on an annual basis.

(d) The department increases inpatient hospital rates only when mandated by the state legislature. These increases are implemented according to the base methodology in effect, unless otherwise directed by the legislature.

(2) The department periodically recalibrates diagnosis-related group (DRG) relative weights, as described in WAC 388-550-3100, but no less frequently than each time the rate rebasing process described in subsection (1) takes place. The department makes recalibrated relative weights effective on the rebasing implementation date, which can change with each rebasing process.

(3) When recalibrating DRG relative weights without rebasing, the department may apply a budget neutrality factor (BNF) to hospitals' conversion factors to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the prior payment system.

[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. 07-14-051,

(6/30/11)

§ 388-550-3800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 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. 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. 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 182-550-3900 Payment method—Bordering city hospitals and critical border hospitals. The department 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 388-550-1050.

(1) Bordering city hospitals—Inpatient hospital claim payment methods.

(a) For dates of admission before August 1, 2007, under the diagnosis related group (DRG) payment method:

(i) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(b) For dates of admission before August 1, 2007, under the ratio of costs-to-charges (RCC) payment method:

(i) The department calculates the RCC in accordance with WAC 388-550-4500.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department bases the RCC on the Washington instate average RCC.

(c) For dates of admission on and after August 1, 2007:

(i) The department calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the instate inpatient hospital rates without graduate medical education (GME) (excluding DWCC rates that are paid to instate critical access hospitals) for the DRG conversion factor, the per diem, per case, and RCC payment methods; and

(ii) The department pays the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(2) Bordering city hospitals—Outpatient hospital claim payment methods for allowed covered charges related to medically necessary services.

(a) For bordering city hospitals paid according to the outpatient prospective payment system (OPPS), refer to WAC 388-550-7000 through 388-550-7600. The department uses the following types of payment methods used in OPPS:

(i) Ambulatory payment classification (APC) method (the primary payment method for OPPS) (WAC 388-55-7200):

(A) Before August 1, 2007, the department determines the OPPS conversion factor using the methods described in WAC 388-550-7500.

(B) On and after August 1, 2007, the department pays using the lowest instate OPPS conversion factor.

(ii) OPPS maximum allowable fee schedule (WAC 388-550-7200).

(iii) Hospital outpatient RCC rate (WAC 388-550-4500).

(A) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(B) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(b) For bordering city hospitals exempt from OPPS, the department uses the following payment methods:

(i) Outpatient maximum allowable fee schedule (WAC 388-550-6000); and

(ii) Hospital outpatient RCC rate (WAC 388-550-4500).

(c) When the RCC payment method described in WAC 388-550-4500 is used to pay for outpatient services provided:

(i) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(ii) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(d) When the maximum allowable fee schedule method is used to pay for outpatient services provided, the department pays the lesser of the:

(i) Billed charges; or

(ii) Calculated payment amount.

(3) Designated critical border hospitals.

(a) Beginning August 1, 2007, the department designated 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 388-550-1050; and

(ii) Have submitted at least ten percent of the total non-emergency inpatient hospital claims that have been paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington state medicaid and state-administered programs. Nonemergency inpatient hospital claims are defined as those that do not include emergency room charges (revenue code 045X series).

(b) The department 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 department pays inpatient critical border hospital claims with dates of services on and after August 1, 2007, 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 department pays inpatient critical border hospital claims using the same payment methods and rates as for instate 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 instate 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 not listed in (A) and (B) of this subsection for inpatient hospital claims cannot exceed the highest corresponding in-state inpatient payment rate for in-state hospitals that are not designated as:

- (A) Critical access hospitals (CAHs);
- (B) University hospitals; or
- (C) Level 1 trauma centers.

(5) Critical border hospitals—Outpatient hospital claim payment methods. The department pays outpatient critical border hospital claims with dates of services on and after August 1, 2007, using the same payment methods as for in-state outpatient hospital claims, including the APC method using the hospital's OPPS conversion factor, maximum allowable fee schedule method, and the hospital outpatient RCC rate method (refer to WAC 388-550-7000 through 388-550-7600 and WAC 388-550-4500), 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.

(c) Outpatient rates used to pay the critical border hospitals not listed in (i) and (ii) of this subsection for outpatient claims cannot exceed the highest corresponding rate for in-state hospitals that are not designated as:

- (i) Critical access hospitals (CAH);
- (ii) University hospitals; or
- (iii) 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 department 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).

[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). 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. 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. 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. 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 department uses to pay hospitals located out-of-state for providing services to eligible Washington state medical assistance clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 388-501-0175. Payment methods that apply to bordering city

hospitals, including critical border hospitals, are described in WAC 388-550-3900.

(1) Emergency hospital services before August 1, 2007.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals with dates of admission before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) Weighted average of ratio of costs-to-charges (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals with the first date of service before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) Weighted average of hospital outpatient RCC rates for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(2) Emergency hospital services on and after August 1, 2007.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals with dates of admission on and after August 1, 2007, the department:

(i) Pays using the same methods used to pay in-state hospitals:

(A) Diagnosis related group (DRG) (WAC 388-550-3000);

(B) Per diem (WAC 388-550-3010);

(C) DRG and per diem outliers (WAC 388-550-3700); and

(D) Ratio of costs-to-charges (RCC) (WAC 388-550-4500).

(ii) Pays using the lowest in-state inpatient hospital rate corresponding to the payment method used in (a)(i) of this subsection.

(iii) Limits payment to out-of-state hospitals to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals with dates of service on or after August 1, 2007, the department pays an out-of-state hospital using one or both of the following methods:

(i) The maximum allowable fee schedule method described in WAC 388-550-6000, and limits payment when the maximum allowable fee schedule method is used to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(ii) The hospital outpatient RCC method described in WAC 388-550-4500. When using the RCC payment method, the department pays the lowest in-state hospital outpatient RCC rate, excluding departmental weighted costs-to-charges (DWCC) rates that are paid to in-state critical access hospitals.

(c) Out-of-state hospitals are not eligible to receive payment for graduate medical education (GME).

(3) The department makes:

(a) Claim payment adjustments, including but not limited to client responsibility, third party liability, and medicare; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

(4) Nonemergency services. The department does not pay for nonemergency hospital services provided to a medical assistance client in a hospital located out-of-state unless the hospital is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

(a) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

(b) Authorized services are paid according to subsections (1), (2), and (3) of this section.

(c) Bariatric surgery performed in a designated department-approved hospital is paid a per case rate and must be prior authorized by the department (see WAC 388-550-3020).

[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). 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. 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. 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 department considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs) conversion factors, RCC rates, per diem rates, per case rates, etc.; or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) The department determines a new hospital's:

(a) CBCF as the average of the CBCF of all hospitals within the same department peer group for dates of admission before August 1, 2007.

(b) 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, for dates of admission on and after August 1, 2007, adjusted by the geographically appropriate hospital specific medicare wage index.

(3) The department determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) The department considers that a change in hospital ownership does not constitute a new hospital.

[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. 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. 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. 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 department in writing ninety days prior to 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 department 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) below.

(4) The department 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 388-550-4500. Partial year cost reports will not be used for this purpose.

(5) The department recaptures depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

[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. 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. 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 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) For dates of admission before August 1, 2007, subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from

the DRG payment method for inpatient services provided to medicaid-eligible clients:

(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are paid through the DRG payment method (see WAC 388-550-4400):

- (i) General assistance programs; and
- (ii) Other state administered programs.

(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.

(c) Peer group F hospitals (critical access hospitals).

(d) Rehabilitation units when the services are provided in department-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

The department uses the same criteria as the medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Inpatient rehabilitation services provided to clients eligible under the following programs are covered and paid through the DRG payment method (see WAC 388-550-4400 for exceptions):

- (i) General assistance programs; and
- (ii) Other state-only administered programs.

(e) Out-of-state hospitals excluding hospitals located in designated bordering cities as described in WAC 388-501-0175. Inpatient services provided in out-of-state hospitals to clients eligible under the following programs are not covered or paid by the department:

- (i) General assistance programs; and
- (ii) Other state administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

- (i) A negotiated per diem rate; or
- (ii) DRG.

(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with medicare certified distinct psychiatric units. The department uses the same criteria as the medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are paid through the DRG payment method:

- (A) General assistance programs; and
- (B) Other state administered programs.

(ii) Mental health division (MHD) designees that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through a MHD are paid through the department's payment system.

(3) The department limits inpatient hospital stays for dates of admission before August 1, 2007 that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, *"Length of Stay by Diagnosis and Operation, Western Region,"* unless the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

(5) For dates of admission on and after August 1, 2007, the department exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to medicaid-eligible clients:

(a) Peer group E hospitals as described in WAC 388-550-3300(2), i.e., hospitals participating in the department's certified public expenditure (CPE) payment program. See WAC 388-550-4650.

(b) Peer group F hospitals, i.e., critical access hospitals. See WAC 388-550-2598.

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. Inpatient psychiatric services, Involuntary Treatment Act services, and detoxification services provided in out-of-state hospitals are not covered or paid by the department or a MHD designee. The department 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:

- (i) General assistance programs; and
- (ii) Other state-administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. The department, 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.

(g) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. A MHD designee that arranges to pay a hospital and/or a designated distinct psychiatric unit of a hospital directly, may use the department's payment methods or contract with the hospitals to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(6) For dates of admission on and after August 1, 2007, the department has established an average length of stay (ALOS) for each DRG classification. The DRG ALOS is based on the claims data used during the rebasing period. For DRGs with an exceptionally low volume of claims, the department uses a proxy DRG ALOS. The DRG ALOS is used as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the department'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 MHD or the MHD designee who prior authorized the admission. See WAC 388-550-2600;

(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 department unit that prior authorized the admission. See WAC 388-550-2561 and 388-550-2590;

(c) For an inpatient hospital stay for detoxification for a chemical dependent pregnant CUP client, see WAC 388-550-1100;

(d) For other medical inpatient stays for detoxification, see WAC 388-550-1100 and subsection (7) of this section;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC 388-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the department may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

(7) If subsection (6)(d) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

[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. 07-14-051, § 388-550-4300, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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. 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. 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4400 Services—Exempt from DRG payment. (1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500,

(6/30/11)

the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) Subject to the restrictions and limitations in this section, for dates of admission before August 1, 2007, the department exempts the following services for medicaid clients from the DRG payment method:

(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.

(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.

(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. These are medicaid program services and are not funded by the department for the general assistance programs or any other state administered program.

(e) Acute physical medicine and rehabilitation services provided in department-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. See WAC 388-550-4300 (2)(d). Rehabilitation services provided to clients under the general assistance programs and any other state-only administered program are also reimbursed through the RCC payment method.

(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals. Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii) Other state administered programs.

(g) Chronic pain management treatment provided in department-approved pain treatment facilities.

(h) Administrative day services. The department pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.

(i) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid

through the general assistance programs and any other state administered program.

(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, pancreas, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.

(k) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3470.

(3) Inpatient services provided through a managed care plan contract are paid by the managed care plan.

(4) Subject to the restrictions and limitations in this section, for dates of admission on and after August 1, 2007, the department exempts the following services for medicaid and SCHIP clients from the DRG payment method. This policy also applies to covered services paid through the general assistance programs and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services.

(b) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically-using pregnant (CUP) women program by a certified hospital. These are medicaid program services and are not covered or funded by the department through the general assistance programs or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. A mental health division (MHD) designee that arranges to pay a hospital directly for psychiatric services, may use the department's payment methods or contract with the hospital to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(e) Chronic pain management treatment provided in a hospital approved by the department to provide that service.

(f) Administrative day services. The department pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. A hospital must request an administrative day designation on a case-by-case basis. The department may designate part of a client's stay to be paid an administrative day rate upon review of the claim and/or client's medical record.

(g) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG (AP DRG) relative weight. Claims grouped to DRG 469 or DRG 470 will be denied payment.

(h) Organ transplants that involve heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The department pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method.

(i) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3020 and 388-550-3470.

(j) Services provided by a critical access hospital (CAH).

(k) Services provided by a hospital participating in the certified public expenditure (CPE) payment program. The CPE "hold harmless" provision allows a reconciliation that is described in WAC 388-550-4670.

(l) Services provided by a long term acute care (LTAC) hospital.

[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. 07-14-051, § 388-550-4400, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 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. 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. 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) Ratio of costs-to-charges (RCC) is defined in WAC 388-550-1050. The department uses:

(a) The RCC payment method to pay hospitals for hospital services that are exempt from the diagnosis related group (DRG), per diem, ambulatory payment classification (APC), maximum allowable fee schedule, and per case payment methods.

(b) The term "ratio of costs-to-charges" to refer to the factor (rate) applied to a hospital's allowed covered charges to determine estimated costs for medically necessary services.

(2) The department:

(a) Determines the payment due a hospital under the RCC payment method for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC rate by the allowed covered charges for medically necessary services.

(ii) Outpatient claims by multiplying the hospital's outpatient RCC rate by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection any:

(i) Client responsibility amount;

(ii) Third-party liability (TPL) amount; and

(iii) Other applicable payment program adjustment.

(c) Limits the RCC payment to the hospital's allowable usual and customary charges.

(3) For inpatient hospital dates of admission before August 1, 2007, the department uses the RCC payment method to pay for inpatient hospital services that are:

(a) Provided in a hospital located in the state of Washington (see WAC 388-550-4000 for out-of-state hospital payment methods and WAC 388-550-3900 for payment methods to designated bordering city and critical border hospitals);

(b) Provided in a diagnosis related group (DRG)-exempt hospital identified in WAC 388-550-4300; and

(c) Identified in WAC 388-550-4400 as DRG-exempt services (see WAC 388-550-4400 (2)(g), (h), and (k) for exceptions).

(4) For inpatient hospital dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay for:

(a) Organ transplant services identified in WAC 388-550-4400 (4)(h);

(b) High outlier qualifying claims (see WAC 388-550-3700 (14) and (15));

(c) Hospital services not covered under the LTAC per diem rate (see WAC 388-550-2596);

(d) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments (see WAC 388-550-4650(5)); and

(e) Any other hospital service identified and published by the department as being paid by the RCC payment method.

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection (4) of this section, except as provided in subsection (6) of this section.

(6) For hospitals paid under the certified public expenditure (CPE) payment method, the inpatient adjustment factor referred to in subsection (5) of this section does not apply, except to payments for repriced claims adjusted according to WAC 388-550-4670 (2)(a)(ii).

(7) The department calculates each inpatient and critical border hospital's RCC rate as follows. The department:

(a) Divides each hospital's allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) Excludes, prior to calculating the RCC rate, department nonallowed costs and nonallowed revenue, such as costs and revenues attributable to a change in ownership.

(c) Bases the RCC rate calculation on data from the hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital. The "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC rate annually after the hospital sends its "as filed" hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the department. In the case where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the RCC rate based on a department-determined method.

(e) Limits a noncritical access hospital's RCC payment to one hundred percent of its allowed covered charges.

(f) Determines an RCC rate, when a hospital is formed as a result of a merger (refer to WAC 388-550-4200), by combining the previous hospital's medicare cost reports and following the process in (a) of this subsection. The department does not use partial year cost reports for this purpose.

(g) Determines a new inpatient hospital's RCC rate by calculating and using the average RCC rate for all current noncritical access hospitals located in Washington state. The department annually calculates a weighted average inpatient RCC rate by identifying all inpatient hospitals with specific

RCC rates and dividing the department-determined total patient-related revenues associated with those costs.

(8) The department calculates each hospital's outpatient RCC rate annually.

(a) The department calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor (OAF).

(b) The department determines the weighted average inpatient hospital outpatient RCC rate by multiplying the inpatient weighted average inpatient RCC rate by the outpatient adjustment factor.

(9) The outpatient adjustment factor:

(a) Is the ratio between the outpatient and inpatient RCC payments, established in 1998 through negotiation with hospital providers;

(b) Is updated annually to adjust for cost and charge inflation;

(c) Must not exceed 1.0; and

(d) Is differentiated from the OPPTS outpatient adjustment factor (defined in WAC 388-550-1050), and applies to hospitals exempt from OPPTS.

[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). 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. 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. 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. 01-16-142, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 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.

The department allows hospitals an all-inclusive 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 an appropriate placement outside the hospital is not available.

(a) The department uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1 of each year.

(b) The department does not pay for ancillary services provided during administrative days.

(c) The department identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(2) **Swing bed day rate.** The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The department 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 department-approved nursing service level of care in a swing bed.

(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

[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). 09-12-062, § 388-550-4550, filed 5/28/09, effective 7/1/09.]

WAC 182-550-4600 Hospital selective contracting program. This section applies only for dates of admission before July 1, 2007. The hospital selective contracting program ends on June 30, 2007.

(1) The department designates selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to medicaid clients. Selective contracting areas are based on historical patterns of hospital use by medicaid clients.

(2) The department requires medicaid clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department exempts from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department designates hospitals as remote when they meet the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities;

(e) Out-of-state hospitals located in nonbordering cities, and out-of-state hospitals in bordering cities not designated as selective contracting areas;

(f) Peer group E hospitals; and

(g) Peer group F hospitals (critical access hospitals).

(4) The department:

(a) Negotiates with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services provided to medicaid clients.

(b) Calculates its maximum financial obligation for a medicaid client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) Applies NCFs to medicaid clients only. (The department uses CBCFs in calculating payments for medical care services clients.)

[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. 07-12-040, § 388-550-4600, filed 5/30/07, effective 7/1/07; 06-08-046, § 388-550-4600, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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. 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4650 "Full cost" public hospital certified public expenditure (CPE) payment program. (1) The department's "full cost" public hospital certified public expenditure (CPE) payment program provides payments to participating 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 department's payments to participating hospitals equal the federal matching amount for allowable costs. The department uses the ratio of costs-to-charges method described in WAC 388-550-4500 to determine "full cost."

(2) Only the following facilities are reimbursed through the "full cost" public hospital CPE payment program:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; and

(ii) Not certified by the department of health (DOH) as a critical access hospital;

(b) Harborview Medical Center; and

(c) University Medical Center.

(3) Payments made under the 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 department determines the actual payment for inpatient hospital services under the CPE payment program by:

(a) Multiplying the hospital's medicaid RCC rate 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 matching assistance percentage (FMAP) by the amount derived in (b) of this subsection.

[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. 06-08-046, § 388-550-4650, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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 department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure (CPE)

payment program. Under the provision and subject to legislative directives and appropriations, hospitals eligible for payments under the CPE payment program 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 the CPE payment program, including but not limited to cost report schedules, are subject to audit at any time by the department or its designee.

(1) The department:

(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 department 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 department 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 department determines total state and federal payments made under the program, including:

(a) Inpatient claim payments;

(b) Disproportionate share hospital (DSH) payments; and

(c) Supplemental upper payment limit payments, as applicable.

(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 department 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.

[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. 10-11-032, § 388-550-4670, filed 5/11/10, effective 6/1/10. Statutory Authority: RCW 74.08.090 and 74.09.500. 08-20-032, § 388-550-4670, filed 9/22/08, effective 10/23/08; 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). 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 388-550-2600.

(1) CPE inpatient hospital claims submitted to the department must meet all authorization and program requirements in WAC and current department-published issuances.

(2) The department performs utilization reviews of inpatient hospital:

(a) Admissions in accordance with the requirements of 42 CFR 456, subparts A through C; and

(b) Claims for compliance with medical necessity, appropriate level of care and the department's (or a department designee's) established length of stay (LOS) standards.

(3) For CPE inpatient admissions prior to August 1, 2007, the department performs utilization reviews:

(a) Using the professional activity study (PAS) length of stay (LOS) standard in WAC 388-550-4300 on claims that qualified for ratio of costs-to-charges (RCC) payment prior to July 1, 2005.

(b) On seven-day readmissions according to the diagnosis related group (DRG) payment method described in WAC 388-550-3000 (5)(f) for claims that qualified for DRG payment prior to July 1, 2005.

(4) For claims identified in this subsection, the department may request a copy of the client's hospital medical records and itemized billing statements. The department sends written notification to the hospital detailing the department's findings. Any day of a client's hospital stay that exceeds the LOS standard:

(a) Is paid under a nonDRG payment method if the department determines it to be medically necessary for the client at the acute level of care;

(b) Is paid as an administrative day (see WAC 388-550-1050 and 388-550-4500(8)) if the department determines it to be medically necessary for the client at the subacute level of care; and

(c) Is not eligible for payment if the department determines it was not medically necessary.

(5) For CPE inpatient admissions on and after August 1, 2007, CPE hospital claims are subject to the same utilization review rules as nonCPE hospital claims.

(a) LOS reviews may be performed under WAC 388-550-4300.

(b) All claims are subject to the department's medical necessity review under WAC 388-550-1700(2).

(c) For inpatient hospital claims that involve a client's seven-day readmission, see WAC 388-550-3000 (5)(f).

[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. 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). 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), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department 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:

<u>County</u>	<u>Community Travel Distance Standard</u>
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
Lewis	15 miles
Lincoln	31 miles

<u>County</u>	<u>Community Travel Distance Standard</u>
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/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemergent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA 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 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[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. 07-12-040, § 388-550-4700, filed 5/30/07, effective 7/1/07. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-4800 Hospital payment methods—State administered programs. Subsections (1) through (11) of this section apply to hospital payment methods for state administered programs for dates of admission before August 1, 2007. Subsections (12) through (19) of this section apply to hospital payment methods for state administered programs for dates of admission on and after August 1, 2007.

(1) Except as provided in subsection (2) of this section, the department uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to pay hospitals at reduced rates for covered services provided to a client who is not eligible under a medicaid program, the SCHIP program, or alien emergency medical (AEM) program and:

(a) Who qualifies for the general assistance unemployment (GAU) program; or

(b) Is involuntarily detained under the Involuntary Treatment Act (ITA).

(2) The department exempts the following services from the state-administered programs' payment methods and/or reduced rates:

(a) Detoxification services when the services are provided under a department-assigned provider number starting with "thirty-six." (The department pays these services using the Title XIX medicaid RCC payment method.)

(b) Program services provided by department-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (The department pays these services through cost settlement as described in WAC 388-550-2598.)

(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (The department pays these services through the "full cost" public hospital certified public expenditure (CPE) payment program (see WAC 388-550-4650).)

(3) The department determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) The department determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate = current Title XIX medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:

State-administered programs' DRG CF = current Title XIX medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) The department determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative weight (see subsection (6) of this section for how the department determines payment for state-administered program claims that qualify as DRG high-cost outliers).

(6) For state-administered program claims that qualify as DRG high-cost outliers, the department determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

High-cost Outlier Calculations for Qualifying Claims State-administered Programs (for admission dates January 1, 2001 and after)														
In-state Children's Hospitals Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	85%	(=)	Outlier Add-on Amount	(+)	*DRG Allowed Amount
Psychiatric DRGs 424-432 Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	100%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
All other qualifying claims Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	60%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount														

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8) The department determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9) To calculate a hospital's ratable that is applied to both the Title XIX medicaid RCC rate and the Title XIX medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, the department:

(a) Adds the hospital's medicaid revenue (medicaid revenue as reported by department of health (DOH) includes all medicaid revenue and all other medical assistance revenue) and medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 medicare cost report received by the department at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital-medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an instate-average ratable and an instate-average ratable factor used for new hospitals with no prior year history.

(10) The department updates each hospital's ratable annually on August 1.

(11) The department:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

$$EF = \frac{\text{State-administered programs' prior DRG CF}}{\text{divided by current Title XIX medicaid DRG CBCF} \times (\text{one minus the prior ratable})}$$

(12) For dates of admission on and after August 1, 2007, the department pays for services provided to a client eligible for a state administered program based on state-administered program rates. The state administered program rates are established independently from the process used in setting the medicaid payment rates. The state administered program rates may not be changed unless the legislature authorizes the changes. The department uses the ratable factor and equivalency factor to keep the state administered program payment rates at the same level they were at before the state medicaid rates are rebased.

(13) The table in this subsection shows a comparison of the payment policy for the department's inpatient payment system for dates of admission before August 1, 2007, and the inpatient payment system effective for dates of admission on and after August 1, 2007. Under this inpatient payment system effective August 1, 2007, the per diem rates are used to pay for many services previously paid using the RCC payment method.

The following table indicates differences in policy for the two inpatient payment systems:

	Inpatient payment system for dates of admission before August 1, 2007	Inpatient payment system for dates of admission on and after August 1, 2007
Stable DRGs	DRG Grouper v 14.1	DRG grouper v 23.0
Unstable/Medical DRGs	RCC	Per diem
Unstable Surgical DRGs	RCC	Per diem
Unstable Neonate DRGs	RCC	Per diem
Psych	RCC	Per diem
Rehab	RCC	Per diem
Detox	RCC	Per diem
Transplant	RCC	RCC
Military hospitals	RCC	RCC
HIV	RCC	Not separately defined
Chronic pain management	Per diem	Per diem
Bariatric surgery	Per case rate	Per case rate
CUP	Not separately defined	Per diem
Burns	Not separately defined	Per diem

See specific sections in the chapter 388-550 WAC to determine how the department pays hospitals participating in the critical access hospital (CAH) program, the long term acute care (LTAC) program, and the certified public expenditure (CPE) payment program.

(14) Due to changes in payment methodologies established for the inpatient payment system effective August 1,

2007, the department has established the following state administered program rates used for dates of admission on and after August 1, 2007:

(a) State administered program DRG conversion factor for claims grouped under stable DRG classifications services.

(b) State administered program per diem rates for claims grouped under the following specialty service categories:

- (i) CUP;
- (ii) Detoxification; and
- (iii) Physical medicine and rehabilitation.

(c) State administered program per diem rates for the claims grouped to unstable DRG classifications under the following nonspecialty service categories:

- (i) Surgical;
- (ii) Medical;
- (iii) Burns; and
- (iv) Neonate and pediatric.

(d) State administered program per diem rates for claims grouped under psychiatric services.

(e) State administered program per case rate for claims grouped under bariatric services.

(f) State administered program RCC rates for claims grouped under transplant services.

(15) This subsection describes the state administered program (DRG) conversion factor and payment calculation processes used by the department to pay claims paid using the DRG payment method. The department pays for services grouped to a stable DRG classification that are provided to clients eligible for a state administered program based on use of a DRG conversion factor and a DRG relative weight. This process is similar to the payment method used to pay for medicaid and SCHIP services that are grouped to a stable DRG classification.

(a) The department's state administered program DRG conversion factor calculation process is as follows:

(i) For instate and critical border hospitals, the hospital's specific DRG conversion factor that is used to calculate payment for a state administered program claim, is based on the medicaid conversion factor adjusted by the most available ratable factor and the applicable equivalency factor. Mathematically the calculation is:

State administered program DRG CF =

((Medicaid DRG CF x applicable Equivalency Factor) x most available ratable factor)

(ii) For instate and critical border hospitals that do not have a current state administered program DRG conversion factor, the state administered program conversion factor is the hospital's specific proposed medicaid conversion factor multiplied by the average applicable equivalent factor and average applicable ratable.

(iii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program DRG conversion factor is the lowest instate medicaid DRG conversion factor multiplied by the average ratable and equivalency factor.

(b) The department's state administered program DRG equivalency factor calculation process is as follows:

(i) The equivalency factor is a factor used to hold the hospital's specific state administered program DRG conversion factor or rates at the same level before and after the medicaid DRG rate is rebased. Mathematically the calculation is:

Equivalency factor = (State administered program DRG CF / (medicaid DRG CF x ratable))

(ii) The department may make an adjustment to the equivalency factor to address the differences in the relative weight values of the two DRG grouper versions due to the recalibration of the weights.

(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.

(c) The department's DRG payment calculation process for DRG classifications grouped to stable DRG relative weights is as follows:

(i) The department determines the allowed amount for the inlier portion of the state-administered program DRG payment calculation. Mathematically the calculation is:

State administered program DRG inlier portion allowed amount of the payment = (State administered program DRG CF x DRG relative weight)

(ii) The department determines the high outlier claim calculation for the state administered program DRG payment. See WAC 388-550-3700 for more information about high outlier qualification and calculation processes. Mathematically the calculation is:

State-administered program DRG inlier and outlier portion allowed amount of the payment = (State-administered program DRG CF x DRG relative weight) + outlier adjustment

(iii) The outlier payment adjustment calculation for a state administered program claim is different than the outlier payment calculation for a medicaid claim. The outlier adjustment for a state administered program claim is adjusted by the ratable factor.

(iv) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to nonneonatal DRGs and nonpediatric DRGs, equals one hundred seventy-five percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment in hospitals other than Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center.

(v) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to neonatal DRGs, pediatric DRGs, equals one hundred fifty percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment when the claim is from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

(vi) The outlier transfer provision is applied for the calculation of services paid under the state administered program DRG payments.

(vii) Refer to the medicaid percent of outlier adjustment factor described in WAC 388-550-3700 and (d) of this subsection for how the percent of outlier adjustment factor is reduced by a ratable to determine the outlier portion allowed amount for the claim.

(d) The department determines the outlier portion allowed amount calculation for the state-administered program high outlier claim DRG payment as follows. Mathematically the calculation is:

State administered program outlier portion allowed amount of claim = ((Covered charges x RCC) - outlier threshold) x (Percent of outlier adjustment factor x ratable factor)

(i) A claim is an outlier claim when the claim cost (covered charges x RCC) is greater than both the fixed loss amount of fifty thousand dollars and one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric

DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(ii) The outlier threshold used in calculation of the outlier payment adjustment will always be one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.

(16) This subsection describes the state-administered program per diem rate and payment calculation for the following specialty service categories and unstable DRG non-specialty service categories.

(a) The per diem rate is separately established for each of the following services:

- (i) CUP;
- (ii) Detoxification;
- (iii) Physical medicine and rehabilitation;
- (iv) Surgical;
- (v) Medical;
- (vi) Burns; and
- (v) Neonate and pediatric.

(b) The per diem rate calculation process for CUP, detoxification, physical medicine and rehabilitation, surgical, medical, burns, and neonate and pediatric services is, for in-state and critical border hospitals, the hospital's specific state administered program per diem rate is based on the Title XIX medicaid rates multiplied by the most available ratable factor and the equivalency factor. Mathematically the calculation is:

State administered program per diem rate =
((Hospital's specific medicaid per diem x ratable factor)
x Equivalency factor)

(c) The per diem equivalency factor calculation process is as follows:

(i) The per diem equivalency factor is a factor used to hold the aggregate payment for all nonmedicaid claims grouped under per diem payment method at the same level before and after the per diem medicaid rate is rebased. The equivalency factor is calculated based on the estimate nonmedicaid per diem, the medicaid per diem, and the hospital's specific ratable factor. Mathematically the calculation is:

Equivalency factor =
(Estimated state administered program per diem rate/
(medicaid per diem rate x ratable))

(ii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program per diem rate is the lowest in-state medicaid per diem rate multiplied by the average ratable and equivalency factor.

(iii) The state administered program per diem rate is an estimate based on the actual payment per day. The actual payment per day equals the aggregate payment amount (inflated from the base year to the implementation year) divided by the number of days associated with the aggregate costs.

(iv) For a hospital with more than twenty state administered program claims that grouped in the base year data to DRG classifications that are paid using the per diem payment

method, a hospital's specific equivalency factor is established based on the hospital's data.

(v) For a hospital with less than twenty state administered program claims that grouped in the base year data to DRG classifications are paid using the per diem payment method, an average equivalency factor is established based on the hospital data base of all hospitals.

(d) The state administered program per diem allowed amount of payment calculation process for CUP, detoxification, and physical medicine and rehabilitation services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

The high outlier and transfer policy is not applied to payment calculations for CUP, detoxification, and physical medicine and rehabilitation services.

(e) The state administered program per diem allowed amount of payment calculation process for surgical, medical, burns, and neonate services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

(i) The outlier policy is applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services (see WAC 388-550-3700). Refer to the state administered program outlier DRG adjustment payment calculation for the outlier calculation.

(ii) The transfer policy is not applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services.

(17) The state administered program per diem rate and payment calculation for psychiatric services is as follows:

(a) The department uses a payment method similar to the method used to pay for medicaid psychiatric services, for state administered program psychiatric services provided to clients eligible for those services. Psychiatric services provided to state administered program clients are paid using a psychiatric per diem rate. The per diem rate calculation process for state administered program psychiatric services is as follows:

(i) For in-state hospitals, the hospital's specific state administered program psychiatric per diem rate used to calculate the allowed amount for payment is based on the Title XIX medicaid rate adjusted by a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem. Mathematically the calculation is:

State administered program psychiatric per diem rate =

Medicaid psychiatric per diem x a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem.

(ii) For hospitals located outside the state of Washington, including bordering city hospitals, critical border hospitals, and other out-of-state hospitals, psychiatric services and Involuntary Treatment Act (ITA) services are not covered or paid by the department.

(b) The per diem payment calculation process for state-administered program psychiatric services is as follows. Mathematically the calculation is:

Psychiatric payment =

State administered program hospital's specific per diem rate x patient stay LOS recognized by the department's MHD designee for payment

(i) Outlier payment and transfer policies are not applied to state administered program psychiatric claims.

(ii) The ratable factor was provided to the department by the legislature.

(18) This subsection describes the state administered program per case rate and payment processes for bariatric surgery services.

(a) The department limits provision of bariatric surgery services to medical assistance clients to hospitals that are approved by the department to provide those services. Bariatric surgery services provided to a medical assistance client by an approved hospital must also be prior authorized by the department for the hospital to receive payment from the department for those services. Effective August 1, 2007, the department approved bariatric surgery services programs at the Sacred Heart Medical Center, the University of Washington Medical Center, and the Oregon Health Science University. The department may approve other programs based on department discretion.

(b) The department calculates the state administered program per case rate for bariatric surgery services by multiplying the hospital's specific medicaid per case rate for bariatric surgery services by the hospital's specific ratable factor and DRG-equivalency factor. Mathematically the calculation is:

State administered program per case rate =

Medicaid per case rate x hospital's specific ratable factor x DRG equivalency factor

The per case payment rate for bariatric surgery services is an all-inclusive rate. No outlier provision is applied to the per case rate.

(19) This subsection describes the state administered program RCC rates and payment calculation processes for transplant services and other RCC paid services. Transplant services provided to a client eligible for those services through a state administered program are paid using the RCC payment method. There are some other services that may be paid using the RCC payment method, e.g., services provided by military hospitals when no other payment method is agreed upon by the department and the hospital. The state administered program RCC rate is calculated by multiplying the medicaid RCC rate by the ratable factor. Mathematically the calculation is:

State administered program RCC rate = Medicaid RCC x ratable factor

(20) The department may pay for authorized psychiatric indigent inpatient claims submitted by an instate community hospital designated as an institution for mental diseases (IMD) using state funds when such funds are provided by the state legislature specifically for this purpose.

(21) The department's policy for payment on state-administered program claims that involve third party liability (TPL) and/or client responsibility payments is the same policy indicated in the table in WAC 388-550-2800, except that when the department determines the payment on the claim, it

applies state-administered program rates, not medicaid or SCHIP rates, when comparing the lesser of billed charges or the allowed amount on the claim.

[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. 07-14-051, § 388-550-4800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-4800, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 74.09.500. 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. 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. 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. 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 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. 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 USC 1396 (a)(13)(A)) and RCW 74.09.730, the department 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 USC 1396r-4;

(b) It satisfies all the requirements of department 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 department which the department 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 department during a SFY. If a hospital does not qualify for DSH, the department 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 cli-

ents eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the TAKE CHARGE program.

(g) "Low income utilization rate (LIUR)" the sum of two percentages:

(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)" is calculated as a fraction (expressed as a percentage), 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 388-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (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 department 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" is 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 388-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (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" is 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 department considers only services that would have been covered and paid through the department'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 requirement.

(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 department receives the hospital's DSH application by the deadline posted on the department's website.

(b) 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 department 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 department finds that a hospital's application is incomplete or contains incorrect information, the department will notify the hospital. The hospital must resubmit a new, corrected application. The department must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the department'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 department must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the department's website.

(c) Official DSH application.

(i) The department 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 department 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 388-550-5000.

(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 greater than one percent; 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 department 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 department uses paid medicaid days from MMIS.

(7) The department administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH);

(c) General assistance-unemployable disproportionate share hospital (GAUDSH);

(d) Small rural disproportionate share hospital (SRDSH);

(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(g) Public hospital disproportionate share hospital (PHDSH); and

(h) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) Except for IMDDSH, the department 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. See WAC 388-550-5130 regarding IMDDSH. 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 department calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The department does not use base year data for GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The department'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 department determines a hospital's DSH cap as follows. The department:

(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 department:

(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 department's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the department's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the department will adjust DSH payments to each hospital to account for the amount overpaid. The department makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) NRIADSH;

(e) GAUDSH;

(f) PIIDSH;

(g) IMDDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the department 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 WACs for description of how amounts to be recouped are determined.

(15) The total amount the department may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed amounts. 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 department will recoup from hospitals

to make additional payments to other 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 department 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 department 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.

(17) All information related to a hospital's DSH application is subject to audit by the department or its designee. The department determines the extent and timing of the audits. For example, the department or its designee may choose to do a desk review 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 department will recoup the overpayment amount, in accordance with the provisions of RCW 74.09.220 and 43.20B.695.

(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.

[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. 10-11-032, § 388-550-4900, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-4900, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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. 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. 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. 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. 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 department in calculating DSH payments for the state fiscal year (SFY) for which the hospital provider is applying. See WAC 388-550-4900(9).

[Ch. 182-550 WAC—p. 76]

[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. 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 388-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the department 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 388-550-4900(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 department, and if therefore the utilization data reported to the department do not agree, the department 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 388-550-4900 (6)(b).

[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. 07-14-090, § 388-550-4935, filed 6/29/07, effective 8/1/07.]

WAC 182-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) The department 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 388-550-5400);

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (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 388-550-4900 (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 388-550-4900 (3)(g) that exceeds twenty-five percent.

(3) The department pays hospitals qualifying for LIDSH payments from a legislatively appropriated pool. The maximum amount of LIDSH payments in any state fiscal year

(6/30/11)

(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 department determines LIDSH payments to each LIDSH eligible hospital using the following factors from the specific hospital's base year as defined in WAC 388-550-4900 (3)(a):

(a) The hospital's medicaid inpatient utilization rate (MIPUR) (see WAC 388-550-4900 for how the department calculates the MIPUR).

(b) The hospital's medicaid case mix index (CMI). The department 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 department uses for LIDSH calculations is not the same as the CMI the department uses in other hospital rate calculations.

(c) The number of the hospital's Title XIX medicaid discharges. The department includes in this number only the discharges pertaining to Washington state medicaid clients.

(5) The department calculates the LIDSH payment to an eligible hospital as follows.

(a) The department:

(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 greater than the hospital-specific DSH cap, the payment to the hospital is limited to the hospital-specific DSH cap, and the department:

(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 in accordance with the factors in (a) of this subsection.

(6) A hospital receiving LIDSH payments must comply with a department 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 department will not make changes in the LIDSH payment distribution after the applicable SFY has ended. The department 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 identified, and if the department considers the recalculation necessary and appropriate under its regulations.

(8) Consistent with the provisions of subsection (7) of this section, the department applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs in accordance with the provisions of WAC 388-550-4900 (13) through (16).

(6/30/11)

dance with the provisions of WAC 388-550-4900 (13) through (16).

[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). 10-17-095, § 388-550-5000, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5000, filed 6/29/07, effective 8/1/07; 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. 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. 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. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5125 Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH). (1) Effective for dates of admission on and after July 1, 2003, a hospital is eligible for the psychiatric indigent inpatient disproportionate share hospital (PIIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900(5);

(b) Is not designated an institution for mental diseases (IMD);

(c) Provides services to clients eligible under the psychiatric indigent inpatient (PII) program. See WAC 388-865-0217 for more information regarding the PII program; and

(d) Is located within the state of Washington. A hospital located out-of-state, including a hospital located in a designated bordering city, is not eligible to receive PIIDSH payments.

(2) PIIDSH is available only for emergency, voluntary inpatient psychiatric care. PIIDSH is not available for charges for nonhospital services associated with the inpatient psychiatric care.

(3) The department makes PIIDSH payments to an eligible hospital on a claim-specific basis.

[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, 07-14-090, § 388-550-5125, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5125, filed 3/30/06, effective 4/30/06.]

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 persons 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 persons. 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 department. See WAC 388-550-4800 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 department 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 department as an IMD is eligible to receive a state grant amount from the department 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 USC 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.

[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. 07-14-090, § 388-550-5130, filed 6/29/07, effective 8/1/07.]

WAC 182-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH). (1) A hospital is eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900;

(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 department determines the GAUDSH payment for each eligible hospital in accordance with:

(a) WAC 388-550-4800 for inpatient hospital claims submitted for general assistance unemployable (GAU) clients; and

(b) WAC 388-550-7000 through 388-550-7600 and other sections in chapter 388-550 WAC that pertain to outpatient hospital claims submitted for GAU clients.

(3) The department makes GAUDSH payments to a hospital on a claim-specific basis.

[Ch. 182-550 WAC—p. 78]

[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. 10-11-032, § 388-550-5150, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5150, filed 6/29/07, effective 8/1/07; 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. 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. 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. 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 department 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 388-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (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 department pays hospitals qualifying for SRDSH payments from a legislatively appropriated pool. The department 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 department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department 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 department:

(i) Identifies the medicaid payment amounts made by the department 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 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

(6/30/11)

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 department'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 department reallocates dollars as defined in the state plan.

[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). 10-17-095, § 388-550-5200, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5200, filed 6/29/07, effective 8/1/07; 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. 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. 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. 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. 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 department 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 388-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (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 department pays hospitals qualifying for SRIADSH payments from a legislatively appropriated pool. The department 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 department calculates each hospital's profitability margin

(6/30/11)

based on the hospital's base year data and audited financial statements.

(b) The department 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 department:

(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 department'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 department reallocates dollars as defined in the state plan.

[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). 10-17-095, § 388-550-5210, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5210, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5210, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 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. 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 department 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 388-550-4650;

(b) Not be designated as an "institution of mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (4) and (5);

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC 388-550-4900 (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 department considers as nonrural any hospital located in a designated bordering city.

(3) The department pays hospitals qualifying for NRIADSH payments from a legislatively appropriated pool. The department 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 department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department 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 department:

(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 department'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 department reallocates dollars as defined in the state plan.

[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). 10-17-095, § 388-550-5220, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5220, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5220, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 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. 04-12-044, § 388-550-5220, filed 5/28/04, effective 7/1/04.]

WAC 182-550-5400 Payment method—Public hospital disproportionate share hospital (PHDSH). (1) The department's public hospital disproportionate share hospital (PHDSH) program is a public hospital program for:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by a public hospital district; and

(ii) Not certified by the department of health (DOH) as a critical access hospital;

(b) Harborview Medical Center; and

(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 388-550-4900(10). The hospital receives only the federal matching 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 department federally required medicaid cost report schedules apportioning inpatient and outpatient costs, beginning with the services provided during state fiscal year 2006. See WAC 388-550-5410.

(5) PHDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the department 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 388-550-4900 (13) and (14), and WAC 388-550-4670.

[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, 07-14-090, § 388-550-5400, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5400, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 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, 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, 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, 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 on or after July 1, 2005, a certified public expenditure (CPE) hospital must annually submit to the department 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 388-550-1400 and 388-550-1500); 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 department 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 department when completing the medicaid cost report schedules. The department provides the hospital with the PS&R reports at least thirty calendar days prior to 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 department by August 31, 2007.

(iii) For SFY 2007 and thereafter, each CPE hospital is required to submit the medicaid cost report schedules to the department within thirty calendar days after the medicare cost report is due to its medicare fiscal intermediary or medicare administrative contractor, whichever is applicable.

(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 department'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 is applicable), final medicaid cost report schedules must be submitted to the department 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 department will then provide the hospitals with updated PS&R reports for medicaid and state program claims processed by the department 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 department 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 department:

(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 388-550-4670 is applicable.

[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. 08-20-032, § 388-550-5410, filed 9/22/08, effective 10/23/08; 07-14-090, § 388-550-5410, filed 6/29/07, effective 8/1/07.]

(6/30/11)

WAC 182-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. (1) The upper payment limit (UPL) program is terminated effective July 1, 2007. The department will not make UPL payments after June 30, 2007.

[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. 07-14-090, § 388-550-5425, filed 6/29/07, effective 8/1/07; 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 legislatively appropriated to the department each biennium, at the legislature's sole discretion, for the purpose of supplementing the department's payments to eligible trauma service centers for providing qualified trauma services to medicaid fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for supplemental distributions from the TCF.

(2) The department makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section and subject to legislative action.

(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 WAC;

(c) Meet the billing requirements in this section and other applicable WAC;

(d) Submit all information the department 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 each eligible hospital's qualifying payments since the beginning of the service year and expressing this amount as a percentage of 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 state fiscal year. 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 department 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. This method for determining supplemental distributions to hospitals applies to TCF allotments beginning with state fiscal year (SFY) 2008. Eligible hospitals and qualifying payments are described in (i) through (iii) of this subsection:

(i) Qualifying payments are the department's payments to Level I, Level II, and Level III trauma service centers for qualified medicaid trauma cases since the beginning of the service year. The department determines the countable payment for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The department's payments to Level I, Level II, and Level III hospitals for trauma cases transferred in 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 the enhanced payment, regardless of the client's injury severity score (ISS); and

(iii) The department's payments to Level II and Level III hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in subsection (4)(b) of this section) 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 subsection (4)(c).

(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) It 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 (b)(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 supplemental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in subsection (4)(b) of this section.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the department 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. Beginning with qualifying trauma services provided in SFY 2007, the department allows a hospital with this dual status to receive distributions from the TCF; 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 subsection (c);

(c) The final distribution from the TCF for the same SFY is:

(i) Made after the end of the SFY;

(ii) Based on the SFY that the TCF designated amount relates to; and

(iii) Distributed based on each eligible hospital's percentage of the total payments made by the department to all designated trauma service centers for qualified trauma cases during the relevant SFY.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) The department considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the department within three hundred sixty-five calendar days from the date of the initial trauma service. At its discretion, and with sufficient public notice, the department may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary program needs;

(b) Except as provided in subsection (6)(a) of this section, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the department as specified in WAC 388-502-0150(3). See WAC 388-502-0150 (11) and (12) for other time limits applicable to TCF claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the department in any biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[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. 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. 08-08-065, § 388-550-5450, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5450, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]

WAC 182-550-5500 Payment—Hospital-based

RHCs. (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department 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 department shall determine the hospital-based rural health clinic's RCC from the hospital's annual medicare cost report, pursuant to WAC 388-550-4500(1).

[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. 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 the manner in which the department, 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 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department 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 department.

(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) "Web site" means the department's internet home page on the worldwide web: <http://www.wa.gov/dshs/maa> is the internet address.

(3) The department 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 such rates, and justifications for such 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 such rates, and justifications for such 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 department 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 department 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 department will post proposed rates on the department's web site.

(c) Publication of final medicaid hospital rates will occur as follows:

(i) The department 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 department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, 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 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such 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 rulemaking 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 department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department 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 department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(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 department in proposing or implementing a change to medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such 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 department; 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 department under which hospital providers may appeal their medicaid rates.

[11-14-075, recodified as § 182-550-5550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 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 388-502-0220.

[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. 03-13-055, § 388-550-5600, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 74.09.730. 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. 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 shall complete and submit a copy of their annual medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(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 department:

(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 prior to the due date of the report. Hospital providers shall 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 department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[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. 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 182-550-5800 Outpatient and emergency hospital services. The department shall 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. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[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. 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 department pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 388-550-1700. All professional medical services must be billed according to chapter 388-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

(a) Have a current core provider agreement with the department;

(b) Bill the department according to the conditions of payment under WAC 388-502-0100;

(c) Bill the department according to the time limits under WAC 388-502-0150; and

(d) Meet program requirements in other applicable WAC and the department's published issuances.

(3) The department does not pay separately for any services:

(a) Included in a hospital's room charges;

(b) Included as covered under the department's definition of room and board (e.g., nursing services). See WAC 388-550-1050; or

(c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.

(4) The department does not pay:

(a) A hospital for outpatient hospital services when a managed care plan is contracted with the department to cover these services;

(b) More than the "acquisition cost" ("A.C.") for HCPCS (healthcare 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 department uses the outpatient departmental weighted costs-to-charges (ODWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 388-550-2598.

(6) The department uses the maximum allowable fee schedule to pay non-OPPS hospitals and non-CAH hospitals for the following types of covered outpatient hospital services listed in the department's current published outpatient hospital fee schedule and billing instructions:

(a) EKG/ECG/EEG and other diagnostics;

(b) Imaging services;

(c) Immunizations;

- (d) Laboratory services;
- (e) Occupational therapy;
- (f) Physical therapy;
- (g) Sleep studies;
- (h) Speech/language therapy;
- (i) Synaxis; and
- (j) Other hospital services identified and published by the department.

(7) The department uses the hospital outpatient rate as described in WAC 388-550-4500 to pay for covered outpatient hospital services when:

(a) A hospital provider is a non-OPPS or a non-CAH provider; and

(b) The services are not included in subsection (6) of this section.

(8) Hospitals must provide documentation as required and/or requested by the department.

(9) All hospital providers must present final charges to the department 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 based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[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, 07-13-100, § 388-550-6000, filed 6/20/07, effective 8/1/07; 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, 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, 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, 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 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, 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6100 Outpatient hospital physical therapy. (1) The department pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 388-545-500 and 388-550-6000.

(2) A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

[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, 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, 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6150 Outpatient hospital occupational therapy. (1) The department pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 388-545-300 and 388-550-6000.

(2) The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

(6/30/11)

[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, 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, 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 department pays for speech therapy services provided to eligible clients as an outpatient hospital service according to this section and WAC 388-545-700 and 388-550-6000.

(2) The department 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 department 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 department's current published billing instructions. The department does not pay the outpatient hospital a facility fee for these services.

[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, 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, 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits. The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[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, 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6300 Outpatient nutritional counseling. (1) The department shall cover nutritional counseling services only for eligible medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[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. 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department pays for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department pays for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the department as centers of excellence for sleep apnea/sleep study programs.

(3) The department does not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals must bill the department for sleep studies using current procedural terminology codes. The department does not pay hospitals for these services when billed under revenue codes alone.

[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, 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. 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6400 Outpatient hospital diabetes education. (1) The department 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 department 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 department pays for a maximum of six hours of individual core survival skills outpatient diabetes education per calendar year per client.

(4) The department requires DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue code(s) designated and published by the department.

(5) The department 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.

[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, 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. 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6450 Outpatient hospital weight loss program. The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[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. 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6500 Blood and blood components. (1) The department 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 department does not pay for blood and blood components.

(3) The department 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 department pays a hospital no more than the hospital's cost, as determined by the department, for the services

identified in subsection (1) when the hospital is paid using the ratio of costs-to-charges (RCC) or departmental weighted costs-to-charges (DWCC) payment method.

[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, 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, 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 182-550-6600 Hospital-based physician services. See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[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, 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 department pays:

(a) For dates of admission before August 1, 2007 for only emergency care for an eligible medicaid and SCHIP 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 388-501-0175 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 SCHIP clients based on the medical necessity and utilization review standards and limits established by the department.

(i) Prior authorization by the department is required for the nonemergency out-of-state hospital medical care provided to medicaid and SCHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As in-state hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. Department designated critical border hospitals are paid as in-state hospitals. See WAC 388-550-3900 and 388-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible medicaid and SCHIP clients based on authorization by a mental health division designee.

(d) Based on the department's limitations on hospital coverage under WAC 388-550-1100 and 388-550-1200 and other applicable rules.

(2) The department authorizes and pays for comparable hospital services for a medicaid and SCHIP 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 388-550-3900 and 388-550-4000.

(3) The department limits out-of-state hospital coverage for clients eligible under state-administered programs as follows:

(a) For a client eligible under the psychiatric indigent inpatient (PII) program or who receives services under the Involuntary Treatment Act (ITA), the department does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(6/30/11)

(b) For a client eligible under a department's general assistance program, the department pays only for hospital services covered under the client's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The department does not pay for hospital services provided to clients eligible under a general assistance program in other hospitals located outside the state of Washington. The department or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC 388-550-1200.

(4) The department covers hospital care provided to medicaid or SCHIP clients in areas of Canada as described in WAC 388-501-0180, and based on the limitations described in the state plan.

(5) The department 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 client's medical assistance program.

(6) If the client can claim deductible or coinsurance portions of medicaid, the provider must submit the claim to the intermediary or carrier in the provider's own state on the appropriate medicaid 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 388-550-3900 and 388-550-4000.

(8) Out-of-state providers, including bordering city hospitals and critical border hospitals, must present final charges to the department 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.

[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, 07-14-051, § 388-550-6700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 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, 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 department's outpatient prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement methodology as its primary reimbursement method. The department is basing its OPPS on the centers for medicaid and medicaid services (CMS) prospective payment system for hospital outpatient department services.

(2) For a complete description of the CMS outpatient hospital prospective payment system, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419. The Code of Federal Regulations (CFR) is available from the CFR web site and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

[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, 07-13-100, § 388-550-7000, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7000, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7050 OPSS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the department's outpatient prospective payment system (OPSS):

"Ambulatory payment classification (APC)" means 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.

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

"Budget target adjustor" means a department-established component of the APC payment calculation applied to all payable ambulatory payment classifications (APCs) to allow the department to reach and not exceed the established budget target.

"Discount factor" means 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.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is 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)" is 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 Association's 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/NationalCorrectCodingInitiative/>.

"National payment rate (NPR)" means a rate for a given procedure code, published by the centers for medicare and medicaid (CMS), that does not include a state or location specific adjustment.

"Nationwide rate" see "national payment rate."

"NCCI edit" is 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, department fee schedules, billing instructions, and other publications. The department 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 department policy.

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program that the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPSS.

"Outpatient prospective payment system (OPSS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system (OPSS) conversion factor" see "outpatient prospective payment system (OPSS) rate."

"Outpatient prospective payment system (OPSS) rate" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for medicare and medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

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

"SI" see "status indicator."

[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. 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). 09-12-062, § 388-550-7050, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7050, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7100 OPSS—Exempt hospitals. (1) The department exempted the following hospitals from the initial implementation of the department's outpatient prospective payment system (OPSS) in 2004:

- (a) Cancer hospitals;
- (b) Critical access hospitals (CAHs);
- (c) Free-standing psychiatric hospitals;
- (d) Pediatric hospitals;
- (e) Peer group A hospitals;
- (f) Rehabilitation hospitals; and
- (g) Veterans' and military hospitals.

(2) Effective for dates of service on and after July 1, 2009:

- (a) Only CAHs remain exempt from OPSS; and
- (b) The department pays all covered outpatient hospital services (except for those provided in CAHs), under the OPSS methodology.

(3) Refer to the applicable sections in chapter 388-550 WAC for outpatient payment methods used to pay hospitals exempted from OPPS (see subsections (1) and (2) of this section).

[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). 09-12-062, § 388-550-7100, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7100, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7200 OPPS—Billing requirements and payment method. (1) This section describes hospital provider billing requirements and the payment methods the department uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPPS).

(2) Providers must bill according to national correct coding initiative (NCCI) standards. NCCI standards are based on:

- (a) Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual;
- (b) Current standards of medical and surgical coding practice;
- (c) Input from specialty societies; and
- (d) Analysis of current coding practices.

The centers for medicare and medicaid services (CMS) maintains NCCI policy.

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(3) The department uses the APC method when (CMS) has established a national payment rate to pay for covered services. The APC method is the primary payment methodology for OPPS. Examples of services paid by the APC methodology include, but are not limited to:

- (a) Ancillary services;
- (b) Medical visits;
- (c) Nonpass-through drugs or devices;
- (d) Observation services;
- (e) Packaged services subject to separate payment when criteria are met;
- (f) Pass-through drugs;
- (g) Significant procedures that are not subject to multiple procedure discounting (except for dental-related services);
- (h) Significant procedures that are subject to multiple procedure discounting; and
- (i) Other services as identified by the department.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(4) The department uses the outpatient fee schedule published in the department's billing instructions to pay for covered:

- (a) Services that are exempted from the APC payment methodology or services for which there are no established weight(s);
- (b) Procedures that are on the CMS inpatient only list;
- (c) Items, codes, and services that are not covered by medicare;
- (d) Corneal tissue acquisition;
- (e) Devices that are pass-throughs (see WAC 388-550-7050 for definition of pass-throughs); and

(6/30/11)

(f) Dental clinic services.

HOSPITAL OUTPATIENT RATE

(5) The department uses the hospital outpatient rate described in WAC 388-550-3900 and 388-550-4500 to pay for the services listed in subsection (4) of this section for which the department has not established a maximum allowable fee.

[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. 10-08-023, § 388-550-7200, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7200, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7300 OPPS—Payment limitations. (1) The department limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule and published in the department's hospital billing instructions, subject to the following:

(a) To receive payment for services, providers must bill claims according to national correct coding initiative (NCCI) standards. See WAC 388-550-7200(2) for more information on NCCI standards. When a unit limit for services is not stated in the outpatient fee schedule, department pays for services according to the program's unit limits stated in applicable WAC and published issuances.

(b) Because multiple units for services may be factored into the ambulatory payment classification (APC) weight, department pays for services according to the unit limit stated in the outpatient fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published issuances.

(2) The department does not pay separately for covered services that are packaged into the APC rates. These services are paid through the APC rates.

(3) The department:

(a) Limits surgical dental services payment to the ambulatory surgical services fee schedule and pays:

(i) The first surgical procedure at the applicable ambulatory surgery center group rate; and

(ii) The second surgical procedure at fifty percent of the ambulatory surgery center group rate.

(b) Considers all surgical procedures not identified in subsection (a) to be bundled.

(4) The department limits outpatient services billing to one claim per episode of care. If there are late charges, or if any line of the claim is denied, the department requires the entire claim to be adjusted.

[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. 10-08-023, § 388-550-7300, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7300, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7400 OPPS APC relative weights. The department uses the ambulatory payment classification (APC) relative weights established by the centers for medicare and medicaid services (CMS) at the time the budget tar-

get adjustor is established. See WAC 388-550-7050 for the definition of budget target adjustor.

[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, 07-13-100, § 388-550-7400, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7400, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7450 OPPS budget target adjustor.

(1) The outpatient prospective payment system (OPPS) budget target adjustor is a component of the ambulatory payment classification (APC) payment calculation. The budget target adjustor allows the department to reach but not exceed the established budget target. The same OPPS budget target adjustor value is applied to payments for all hospitals.

(2) The department calculates the OPPS budget target adjustor using:

(a) A payment system model developed by the department;

(b) The department's budget target;

(c) The department's outpatient fee schedule;

(d) Addendum B to 42 CFR Part 410 (medicare's hospital outpatient regulations and notices); and

(e) The wage index established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS budget target adjustor is set for the upcoming year.

(3) In response to direction from the legislature, the department may change the method for calculating the OPPS budget target adjustor 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 department in the Biennial Appropriations Act.

[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). 09-12-062, § 388-550-7450, filed 5/28/09, effective 7/1/09.]

WAC 182-550-7500 OPPS rate. (1) The department calculates hospital-specific outpatient prospective payment system (OPPS) rates using:

(a) A payment method model established by the department; and

(b) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) at the time 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) The department may adjust OPPS rates to pay for graduate medical education (GME) costs. The department obtains the GME information from a hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(a) The hospital's "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year. In the case where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the hospital's OPPS rate.

(b) The department may not pay GME expenses for hospitals in specified categories, and hospitals that meet, or fail to meet, conditions specified in statute or WAC.

(3) In response to direction from the legislature, the department may change the method for calculating OPPS rates 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 department in the Biennial Appropriations Act.

[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). 09-12-062, § 388-550-7500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7600 OPPS payment calculation. (1)

The department follows the discounting and modifier policies of the centers for medicare and medicaid services (CMS). The department calculates the ambulatory payment classification (APC) payment as follows:

APC payment =

National payment rate x Hospital OPPS rate x

Discount factor (if applicable) x Units of service (if applicable) x

Budget target adjustor

(2) The total OPPS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

(3) The department pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

(a) Billed amount minus the third-party payment amount; or

(b) Allowed amount minus the third-party payment amount.

(4) In response to direction from the legislature, the department may change the method for calculating OPPS payments 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 department in the Biennial Appropriations Act.

[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). 09-12-062, § 388-550-7600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7600, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]