WSR 23-04-049
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed January 26, 2023, 2:45 p.m., effective February 26, 2023]

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

Purpose: The health care authority (HCA) is changing the name of the chemical-using pregnant women program to substance-using pregnant people program. Due to this name change, HCA is fixing all references to the old program name in the above-mentioned rules.

Citation of Rules Affected by this Order: Amending WAC 182-550-1100, 182-550-1200, 182-550-3000, 182-550-3850, and 182-550-4300.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 22-23-106 on November 16, 2022.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 5, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: January 26, 2023.

Wendy Barcus
Rules Coordinator

OTS-4213.2

AMENDATORY SECTION (Amending WSR 21-15-128, filed 7/21/21, effective 8/21/21)

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

(a) Pays for an eligible Washington apple health client's admission to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered under WAC 182-501-0050, 182-501-0060 and 182-501-0065;

(ii) Are medically necessary as defined in WAC 182-500-0070;

(iii) Are determined according to WAC 182-501-0165 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 182-502-0020.

(3) The agency:

(a) Pays for a hospital covered service provided to an eligible apple health client enrolled in an agency-contracted managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the agency and meets prior authorization requirements. (See WAC 182-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to an apple health client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 182-550-4700 apply. The agency's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The agency pays up to ((~~twenty-six~~)) 26 days of inpatient hospital care for hospital-based withdrawal management, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program.

See WAC 182-533-0701 through 182-533-0730.

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

(a) In a withdrawal management unit in a hospital that has a withdrawal management provider agreement with the agency to perform these services and the services are approved by the division of behavioral health and recovery (DBHR) within the health care authority (HCA); or

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

(i) The hospital does not have a withdrawal management specific provider agreement with DBHR;

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

(iii) Nonhospital-based withdrawal management 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 the agency or the agency's 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 agency's ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program; and

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

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

(a) Are provided under chapter 182-535 WAC; and

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

(7) The agency 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 under chapter 182-535 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 apple health 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 agency.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 182-550-2600.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-1100, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-1100, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1100, filed 8/27/15, effective 9/27/15. WSR 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. WSR 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. WSR 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090. WSR 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. WSR 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

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

WAC 182-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a person eligible under a Washington apple health (WAH) program that is paid by the agency's fee-for-services payment system must be within the scope of the person's WAH program. Coverage restriction includes, but is not limited to the following:

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

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

(3) For emergency care exemptions for persons described in subsections (1) and (2) of this section, see WAC 182-538-100;

(4) Health care services provided by a hospital located out-of-state are:

(a) Not covered for persons eligible under the medical care services (MCS) program. However, persons eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and CHIP persons without prior authorization, based on the medical necessity and utilization review standards and limits established by the agency.

(ii) Nonemergency out-of-state care for medicaid and CHIP persons when prior authorized by the agency based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC 182-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and CHIP clients based on authorization by a division of behavioral health and recovery (DBHR) designee.

(5) See WAC 182-550-1100 for hospital services for ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program clients;

(6) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a DBHR designee. See WAC 182-550-2600;

(7) For persons eligible for both medicare and medicaid (dual eligibles), the agency pays deductibles and coinsurance, unless the person has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the agency pays for hospitalization for such persons subject to agency rules. See also chapter 182-502 WAC;

(8) The agency does not pay for covered inpatient hospital services for a WAH client:

(a) Who is discharged from a hospital by a physician because the person no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(9) If the hospital's utilization review committee determines the person's stay is beyond the period of medical necessity, as described in subsection (8) of this section, the hospital must:

(a) Inform the person in a written notice that the agency is not responsible for payment (42 C.F.R. 456);

(b) Comply with the requirements in WAC 182-502-0160 in order to bill the person for the service(s); and

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

(10) Other coverage restrictions, as determined by the agency.

[Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-1200, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

AMENDATORY SECTION (Amending WSR 21-15-128, filed 7/21/21, effective 8/21/21)

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

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, 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;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, withdrawal management, or ((~~CUP~~)) SUPP) times covered allowable days	182-550-2600 and 182-550-3381
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500

Payment Method	General Description of Payment Formula	WAC Reference
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health 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, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges;

(f) A client is discharged from an inpatient hospital stay and, within ((~~fourteen~~)) 14 calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or the agency's designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and all readmissions to determine which inpatient hospital stays qualify for payment. The review may determine:

(i) If both admissions qualify for separate reimbursement;

(ii) If both admissions must be combined to be reimbursed as one payment; or

(iii) Which inpatient hospital stay qualifies for individual payment.

(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition described in WAC 182-502-0022). The agency or the agency's designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments; or

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express lan-

guage in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency 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 agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

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

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

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

(10) The agency 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 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described under WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described under WAC 182-550-4000.

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

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

(16) Hospitals participating in the apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) 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 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) 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 agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

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

(20) The agency 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.

(21) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the

agency may manually price the claim at the hospital's psychiatric per diem rate.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-3000, filed 7/21/21, effective 8/21/21; WSR 19-04-004, § 182-550-3000, filed 1/23/19, effective 3/1/19; WSR 18-11-074, § 182-550-3000, filed 5/16/18, effective 7/1/18; WSR 15-24-096, § 182-550-3000, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3000, filed 5/29/14, effective 7/1/14. WSR 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). WSR 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3000, 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. WSR 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

AMENDATORY SECTION (Amending WSR 14-14-049, filed 6/25/14, effective 7/26/14)

WAC 182-550-3850 Budget neutrality adjustment and measurement. (1) The medicaid agency measures the effectiveness of budget neutral rebasing by applying a budget neutrality adjustment factor to the base payment rates for both inpatient and outpatient hospitals as needed to maintain aggregate payments under rebased payment systems.

(a) The agency performs budget-neutrality adjustments and measurement by prospectively adjusting conversion factors and rates to offset unintentional aggregate payment system decreases or increases. The agency publishes conversion factors and rates which reflect any required budget neutrality adjustment.

(b) The following rates and factors are not adjusted by the BNAF:

(i) Inpatient per diem;

(ii) Ratio of costs-to-charges (RCC);

(iii) Critical access hospital (CAH) weighted costs-to-charges (WCC);

(iv) Inpatient pain management and rehabilitation (PM&R);

(v) Per-case rates;

(vi) Administrative day rates;

(vii) Long-term acute care (LTAC);

(viii) ((~~Chemical-using pregnant women (CUP)~~)) Substance-using pregnant people (SUPP);

(ix) Outlier parameters;

(x) Outpatient services paid at the resource-based relative value scale (RBRVS) fee;

(xi) Outpatient corneal transplants; and

(xii) Diabetic education.

(2) The agency measures budget neutrality on an ongoing basis after rebased system implementation as follows:

(a) The agency gathers inpatient and outpatient claims and encounter data from the rebased system implementation date to the end of the measurement period.

(i) The first measurement period is the initial six months following rebased payment system implementation.

(ii) Additional measurement periods occur no more frequently than quarterly thereafter.

(iii) The agency performs a final measurement period for data received through June 30, 2016.

(b) The agency sums the aggregate payment amounts separately for inpatient and outpatient services. The agency will make the following adjustments to the base data:

(i) The agency removes any reductions due to third-party liability (TPL), client responsibility, and client spenddown from the payment summary;

(ii) The agency removes any increase awarded by RCW 74.09.611(2) from inpatient services;

(iii) The agency includes any outpatient service lines which are bundled under the enhanced ambulatory patient group (EAPG) system, but would be otherwise payable under the ambulatory payment classification (APC) system; and

(iv) Other adjustments as necessary.

(c) The agency processes all claims and encounters using the rates, factors, and policies which were in effect on June 30, 2014, with the following exceptions:

(i) The agency uses the RCC effective on the date of service;

(ii) The agency uses the most recent RBRVS values for any outpatient service paid using the RBRVS; and

(iii) The agency updates APC relative weights to reflect the most recent relative weights supplied by CMS;

(iv) The agency adjusts the outpatient budget target adjuster (BTA) to offset the inflation factor applied to OPPS in the CMS OPPS final rule; and

(v) The agency may include other adjustments as necessary to ensure accurate payment determination.

(d) The agency aggregates payment amounts calculated under (c) of this subsection separately for inpatient and outpatient services.

(3) The agency will modify the conversion factors and rates to reflect aggregate changes in the overall payment system as follows:

(a) If the amount calculated in subsection (2)(b) of this section is between ((~~ninety-nine~~)) 99 percent and ((~~one hundred one~~)) 101 percent of the amount calculated in subsection (2)(d) of this section, no adjustment will be made to the conversion factors and rates currently in effect;

(b) If the amount calculated in subsection (2)(b) of this section is greater than ((~~one hundred one~~)) 101 percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure of ((~~one hundred one~~)) 101 percent from the rebased payment system implementation date to the end of the subsequent six-month period;

(c) If the amount calculated in subsection (2)(b) of this section is less than ((~~ninety-nine~~)) 99 percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure decrease of ((~~ninety-nine~~)) 99 percent from the rebased payment system implementation date to the end of the subsequent six-month period.

(4) The agency applies adjustments to the BNAF to rates prospectively at the beginning of the calendar quarter following the measurement.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-3850, filed 6/25/14, effective 7/26/14.]

AMENDATORY SECTION (Amending WSR 22-03-007, filed 1/6/22, effective 2/6/22)

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 182-550-4500, the per diem payment method described in WAC 182-550-3000, the per case rate payment method described in WAC 182-550-3000, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). Inpatient services provided by hospitals and units are exempt from the DRG payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) The agency exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to clients eligible for Washington apple health:

(a) Hospitals participating in the agency's certified public expenditure (CPE) payment program (see WAC 182-550-4650);

(b) Hospitals participating in the agency's critical access hospital program (see WAC 182-550-2598);

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000);

(d) Military hospitals when no other specific arrangements have been made with the agency. The agency, 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; and

(e) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000). An agency designee that arranges to directly pay a hospital and/or a designated distinct psychiatric unit of a hospital may use the agency's payment methods or contract with the hospital to pay using different methods.

(3) Inpatient psychiatric services, Involuntary Treatment Act services, and withdrawal management services provided in out-of-state hospitals are not covered or paid by the agency or the agency's designee. The agency 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:

(a) Medical care services; and

(b) Other state-administered programs.

(4) The agency has established an average length of stay (ALOS) for each DRG classification and publishes it on the agency's website.

The agency uses the DRG ALOS as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the agency'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 agency or the agency's designee who prior authorized the admission. See WAC 182-550-2600;

(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 agency unit that prior authorized the admission. See WAC 182-550-2561 and 182-550-2590;

(c) For an inpatient hospital stay for withdrawal management for a ((~~chemical using pregnant (CUP) client~~)) substance-using pregnant people (SUPP) program client, see WAC 182-550-1100;

(d) For other medical inpatient stays for withdrawal management, see WAC 182-550-1100;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC 182-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the agency may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-03-007, § 182-550-4300, filed 1/6/22, effective 2/6/22; WSR 21-15-128, § 182-550-4300, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4300, filed 5/29/14, effective 7/1/14. WSR 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. WSR 07-14-051, § 388-550-4300, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 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. WSR 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. WSR 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]