



RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

- 31 days after filing.
- Other (specify) January 1, 2016 (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

- Yes
 - No
- If Yes, explain:

Purpose:

These rules are necessary to implement recommendations from The American College of Obstetricians and Gynecologists (ACOG) and The Bree Collaborative, which advise against nonmedically indicated elective deliveries before 39 weeks gestation. The agency will only pay for a medically indicated delivery before 39 weeks gestation, and will no longer pay for elective deliveries before 39 weeks gestation.

Citation of existing rules affected by this order:

Repealed:
 Amended: 182-500-0030, 182-533-0400, 182-531-0150, 182-550-2900
 Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-19-157 and WSR 15-19-161 on September 23, 2015.
Describe any changes other than editing from proposed to adopted version: See attachment.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: _____ phone () _____
 Address: _____ fax () _____
 e-mail _____

Date adopted: November 19, 2015

NAME (TYPE OR PRINT)

Wendy Barcus

SIGNATURE

TITLE

HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 19, 2015

TIME: 3:56 PM

WSR 15-24-021

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	<u>4</u>	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>4</u>	Repealed	_____

ATTACHMENT

Note: Strikeouts and underlines indicate language deleted or added since the proposal under WSR 15-19-157 and 15-19-161.

WAC 182-531-0150 (1)

(1) The medicaid agency evaluates a request for noncovered services in this chapter under WAC 182-501-0160. In addition to noncovered services found in WAC 182-501-0070, except as provided in subsection (2) of this section, the medicaid agency does not cover:

WAC 182-533-0400 (2)

The agency covers full scope medical maternity care and newborn delivery services ~~for~~ fee-for-service and managed care clients under WAC 182-501-0060. ~~who are categorically needy (CN) under WAC 182-510-0001, medically needy (MN) under WAC 182-519-0050, or who qualify for an alternative benefit plan under WAC 182-501-0060.~~ Clients enrolled in an agency managed care plan must receive all medical maternity care and newborn delivery services through the plan. See subsection (21) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

WAC 182-533-0400 (20)

(20) The agency pays for an early delivery, including induction or cesarean section, before thirty-nine weeks of gestation only if medically necessary. The agency considers an early delivery to be medically necessary:

(a) If ~~if~~ the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation; or

(b) If the provider documents a clinical situation that supports medical necessity.

WAC 182-550-2900 (2)(j)

(i) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before thirty-nine weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400 (20).

WAC 182-500-0030 Medical assistance definitions—E. "Early and periodic screening, diagnosis and treatment (EPSDT)" is a comprehensive child health program that entitles infants, children, and youth to preventive care and treatment services. EPSDT is available to ~~((persons twenty years of age))~~ people age twenty and younger who are eligible for any agency health care program. Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B. See ~~((also))~~ chapter 182-534 WAC.

"Early elective delivery" means any nonmedically necessary induction or cesarean section before thirty-nine weeks of gestation. Thirty-nine weeks of gestation is greater than thirty-eight weeks and six days.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or in part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.

"Evidence-based medicine (EBM)" means the application of a set of principles and a method for the review of well-designed studies and objective clinical data to determine the level of evidence that proves to the greatest extent possible, that a health care service is safe, effective, and beneficial when making:

- (1) Population-based health care coverage policies (WAC 182-501-0055 describes how the agency or its designee determines coverage of services for its health care programs by using evidence and criteria based on health technology assessments); and
- (2) Individual medical necessity decisions (WAC 182-501-0165 describes how the agency or its designee uses the best evidence available to determine if a service is medically necessary as defined in WAC 182-500-0030).

"Exception to rule." See WAC 182-501-0160 for exceptions to non-covered health care services, supplies, and equipment. See WAC 182-503-0090 for exceptions to program eligibility.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected health care services in which providers use a set of numeric codes to indicate to the agency or the agency's designee which acceptable indications, conditions, or agency or agency's designee-defined criteria are applicable to a particular request for authorization. EPA is a form of "prior authorization."

"Extended care services" means nursing and rehabilitative care in a skilled nursing facility provided to a recently hospitalized medicare patient.

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) ~~((Except as provided in WAC 182-531-0100 and subsection (2) of this section, the medicaid agency does not cover the following:))~~ The medicaid agency evaluates a request for noncovered services in this chapter under WAC 182-501-0160. In addition to noncovered services found in WAC 182-501-0070, except as provided in subsection (2) of this section, the agency does not cover:

- (a) Acupuncture, massage, or massage therapy;
- (b) Any service specifically excluded by statute;
- (c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;
- (d) Hysterectomy performed solely for the purpose of sterilization;
- (e) Cosmetic treatment or surgery, except as provided in WAC 182-531-0100 (4)(x);
- (f) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165;
- (g) Hair transplantation;
- (h) Marital counseling or sex therapy;
- (i) More costly services when the medicaid agency determines that less costly, equally effective services are available;
- (j) Vision-related services as follows:
 - (i) Services for cosmetic purposes only;
 - (ii) Group vision screening for eyeglasses; and
 - (iii) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens correction. This refractive surgery does not include intraocular lens implantation following cataract surgery.
- (k) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 182-531-1750;
- (l) Physician-supplied medication, except those drugs which the client cannot self-administer and therefore are administered by the physician in the physician's office;
- (m) Physical examinations or routine checkups, except as provided in WAC 182-531-0100;
- (n) Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300, as follows:
 - (i) Routine foot care(~~(, such as)~~) including, but not limited to:
 - (A) Treatment of tinea pedis;
 - (B) Cutting or removing warts, corns and calluses; and
 - (C) Trimming, cutting, clipping, or debriding of nails.
 - (ii) Nonroutine foot care(~~(, such as)~~) including, but not limited to, treatment of:
 - (A) Flat feet;
 - (B) High arches (cavus foot);
 - (C) Onychomycosis;
 - (D) Bunions and tailor's bunion (hallux valgus);

- (E) Hallux malleus;
- (F) Equinus deformity of foot, acquired;
- (G) Cavovarus deformity, acquired;
- (H) Adult acquired flatfoot (metatarsus adductus or pes planus);
- (I) Hallux limitus.

(iii) Any other service performed in the absence of localized illness, injury, or symptoms involving the foot;

(o) Except as provided in WAC 182-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services;

(p) Nonmedical equipment;

(q) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas; (~~and~~)

(r) Vaccines recommended or required for the sole purpose of international travel. This does not include routine vaccines administered according to current centers for disease control (CDC) advisory committee on immunization practices (ACIP) immunization schedule for adults and children in the United States; and

(s) Early elective deliveries as defined in WAC 182-500-0030.

(2) The medicaid agency covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A Washington apple health program for qualified **medicare** beneficiaries (QMBS); or

(c) A waiver program.

WAC 182-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in ((WAC 388-500-0005)) chapter 182-500 WAC apply to this chapter.

(a) "**Birthing center**" means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) "**Bundled services**" means services integral to the major procedure that are included in the fee for the major procedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

(c) "**Facility fee**" means the portion of the ((department's)) medicaid agency's payment for the hospital or birthing center charges. This does not include the ((department's)) agency's payment for the professional fee ((defined below)).

(d) "**Global fee**" means the fee the ((department)) agency pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) "**High-risk**" pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) "**Professional fee**" means the portion of the ((department's)) agency's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC ((388-531-1850)) 182-531-1850 for reimbursement methodology.)

(2) The ((department)) agency covers full scope medical maternity care and newborn delivery services ((to)) for fee-for-service and managed care clients ((who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility)). Clients enrolled in the department managed care plan must receive all medical maternity care and newborn delivery services through the plan)) under WAC 182-501-0060. See subsection ((+20+)) (21) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

(3) The ((department)) agency does not provide maternity care and delivery services to ((its)) clients who are eligible for:

(a) Family planning only (a pregnant client under this program should be referred to the local community services office for eligibility review); or

(b) Any other program not listed in this section.

(4) The ((department)) agency requires providers of maternity care and newborn delivery services to meet all ((of)) the following((-Providers must)) requirements:

(a) ((Be currently licensed)) Providers must be currently licensed:

(i) By the state of Washington's department of health (DOH) ((and/)), or department of licensing, or both; or

(ii) According to the laws and rules of any other state, if exempt under federal law;

(b) Have a signed core provider agreement((s)) with the ((department)) agency;

(c) Be practicing within the scope of their licensure; and

(d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA) (7 etc.)).

(5) The ((department)) agency covers total obstetrical care services (paid under a global fee). Total obstetrical care includes all ((of)) the following:

(a) Routine antepartum care that begins in any trimester of a pregnancy;

(b) Delivery (intrapartum care(+) and birth) services; and

(c) Postpartum care. This includes family planning counseling.

(6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, the ((department)) agency pays that provider a global obstetrical fee.

(7) When an eligible client receives services from more than one provider, the ((department)) agency pays each provider for the services furnished. The separate services that the ((department)) agency pays appear in subsection (5) of this section.

(8) The ((department)) agency pays for antepartum care services in one of the following two ways:

(a) Under a global fee; or

(b) Under antepartum care fees.

(9) The ((department's)) agency's fees for antepartum care include all ((of)) the following:

(a) Completing an initial and any subsequent patient history;

(b) Completing all physical examinations;

(c) Recording and tracking the client's weight and blood pressure;

(d) Recording fetal heart tones;

(e) Performing a routine chemical urinalysis (including all urine dipstick tests); and

(f) Providing maternity counseling.

(10) The ((department)) agency covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section(~~. The department pays separately for any of the following~~) as follows:

(a) The agency pays for either of the following, but not both:

(i) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). The ((department)) agency provides a list of diagnoses ((and+)), or conditions, or both, that the ((department)) agency identifies as ((justifying)) justification for more frequent monitoring visits(~~. The department pays for either (a) or (b) of this subsection, but not both;~~

~~(b+))~~; or

(ii) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife. (~~The department pays for either (a) or (b) of this subsection, but not both;~~

~~(e+))~~ (b) The agency pays for both of the following:

(i) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and(~~+e~~

~~(d+))~~ (ii) Treatment of medical problems that are not related to the pregnancy. The ((department)) agency pays these fees to physicians or advanced registered nurse practitioners (ARNP).

(11) The ~~((department))~~ agency covers high-risk pregnancies. The ~~((department))~~ agency considers a pregnant client to have a high-risk pregnancy when the client:

(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or

(b) Has a diagnosis of multiple births.

(12) The ~~((department))~~ agency covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.

(13) The ~~((department))~~ agency pays a facility fee for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(14) The ~~((department))~~ agency pays a professional fee for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;

(b) Planned home births and birthing centers.

(15) The ~~((department))~~ agency covers hospital delivery services for an eligible client as defined in subsection (2) of this section. The ~~((department's))~~ agency's bundled payment for the professional fee for hospital delivery services include:

(a) The admissions history and physical examination; and

(b) The management of uncomplicated labor (intrapartum care); and

(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or

(d) Cesarean delivery of the newborn.

(16) The ~~((department))~~ agency pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(17) In addition to the ~~((department's))~~ agency's payment for professional services in subsection (15) of this section, the ~~((department))~~ agency may pay separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery ~~((and/))~~, or newborn resuscitation, or both;

(b) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;

(c) A physician, ~~((+))~~ARNP~~((+))~~, or licensed midwife for newborn examination as the delivery setting allows; and~~((/or))~~

(d) An obstetrician~~((+))~~, or gynecologist specialist, or both, for external cephalic version and consultation.

(18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, the ~~((department))~~ agency allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. The ~~((department's))~~ agency's typical payment covers delivery of the first child. For each subsequent child, the ~~((department))~~ agency pays at fifty percent of the provider's usual and customary charge, up to the ~~((department's))~~ agency's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(19) The ~~((department))~~ agency does not pay separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. The ~~((department's))~~ agency's cesarean section surgery fee covers one or multiple surgical births;

(b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as, or part of, postpartum care.

(20) The agency pays for an early delivery, including induction or cesarean section, before thirty-nine weeks of gestation only if medically necessary. The agency considers an early delivery to be medically necessary:

(a) If the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation; or

(b) If the provider documents a clinical situation that supports medical necessity.

(21) The agency will only pay for antepartum and postpartum professional services for an early elective delivery as defined in WAC 182-500-0030.

(22) The hospital will receive no payment for an early elective delivery as defined in WAC 182-500-0030.

(23) In addition to the services listed in subsection (10) of this section, the ~~((department))~~ agency covers counseling for tobacco dependency for eligible pregnant women through two months postpregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) The ~~((department))~~ agency covers smoking cessation counseling for ~~((only those fee for service clients who are eligible for categorically needy (CN) scope of care))~~ all FFS pregnant clients except those enrolled in TAKE CHARGE, Family Planning and Alien Emergency Medical (AEM). See ~~((+f))~~ (g) of this subsection for limitations on prescribing pharmacotherapy for eligible ~~((CN))~~ clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.

(b) The ~~((department))~~ agency pays a fee to ~~((certain))~~ providers who include face-to-face smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). The ~~((department))~~ agency pays only the following providers for face-to-face smoking cessation counseling:

(i) Physicians;

(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;

(iii) ARNPs, including certified nurse midwives (CNM); ~~((and))~~

(iv) Licensed midwives (LM);

(v) Psychologists; and

(vi) Pharmacists.

(c) The ~~((department covers one))~~ agency covers two face-to-face smoking cessation attempts (or up to eight cessation counseling sessions) every twelve months. A smoking cessation attempt is defined as up to four cessation counseling sessions.

(d) The agency covers one face-to-face smoking cessation counseling session per client, per day~~((, up to ten sessions per client, per pregnancy)).~~ The provider must keep written documentation in the client's file for each session. The documentation must reflect the information in ~~((e))~~ (f) of this subsection.

~~((d) The department covers two levels of counseling. Counseling levels are:~~

~~(i) Basic counseling (fifteen minutes), which includes (e)(i), (ii), and (iii) of this subsection; and~~

~~(ii) Intensive counseling (thirty minutes), which includes the entirety of (e) of this subsection.)~~ (e) The agency covers face-to-face counseling for eligible pregnant clients.

(f) Smoking cessation counseling consists of providing face-to-face information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to the ~~((department's))~~ agency's physician-related services ~~((billing instructions and births and birthing centers billing instructions))~~ provider guide for specific counseling suggestions and billing requirements):

(i) Asking the client about her smoking status;

(ii) Advising the client to stop smoking;

(iii) Assessing the client's willingness to set a quit date;

(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see ~~((f))~~ (g) of this subsection); and

(v) Arranging to track the progress of the client's attempt to stop smoking.

~~((f))~~ (g) A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. The ~~((department))~~ agency covers certain pharmacotherapy for smoking cessation, including prescription drugs and over-the-counter nicotine replacement therapy, as follows:

~~(i) ((The department covers Zyban™ only;~~

~~(ii))~~ (ii) The product must meet the rebate requirements described in WAC ~~((388-530-1125))~~ 182-530-7500;

~~((iii))~~ (iii) The product must be prescribed by a physician, ARNP, or physician assistant;

~~((iv))~~ (iv) The client for whom the product is prescribed must be age eighteen ~~((years of age))~~ or older;

~~((v))~~ (v) The pharmacy provider must obtain prior authorization from the ~~((department))~~ agency when filling the prescription for pharmacotherapy; and

~~((vi))~~ (vi) The prescribing provider must include both of the following on the client's prescription:

(A) The client's estimated or actual delivery date; and

(B) Indication the client is participating in smoking cessation counseling.

~~((g))~~ (h) The ~~((department's))~~ agency's payment for smoking cessation counseling is subject to postpay review ~~((See WAC 388-502-0230, Provider review and appeal, and WAC 388-502A-1100, Provider audit dispute process))~~ under WAC 182-502-0230 and chapter 182-502A WAC.

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 medicaid agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of ~~((such a))~~ that hospital, ~~((and meet the definition))~~ as defined in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

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

(i) Those days exceed the number of days established by the agency or mental health designee ~~((+see))~~ under WAC 182-550-2600~~((+))~~, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received ~~((approval))~~ prior authorization for an extended LOS from the agency or mental health designee as specified in WAC 182-550-4300~~((+6))~~ (4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. A mental health designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

~~((f))~~ ~~((Two separate inpatient hospitalizations if a client is re-admitted to the same or an affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000.~~

~~((g))~~ A client's day(s) of absence from the hospital or distinct unit.

~~((h) An inappropriate or))~~ (g) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

~~((i))~~ (h) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

(i) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before thirty-nine weeks gestation,

including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

(3) This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged (~~(prior to)~~) before 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 agency is not the primary payer:

(i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(4) The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less upon the client's formal release from the hospital or distinct unit.

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

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

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved or modified, or both, by the Washington state payer group or the agency; and

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

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

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

(d) (~~(In accordance with)~~) Under the agency's published (~~(provider guides)~~) billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and
(g) With the appropriate ~~((National Uniform Billing Committee~~
~~+))NUBC(~~(+))~~ revenue ~~((code(s+))~~ code specific to the service or
treatment provided to the client.~~

(6) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by C.F.R. (~~(§)~~) Sec. 447.271.

(7) The agency allows hospitals an all-inclusive administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care. The agency allows this day rate only when an appropriate placement outside the hospital is not available.

(8) The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client ~~((responsibility))~~ participation (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B; and

(c) Any other adjustments as determined by the agency.

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

(11) All hospital providers must present final charges to the agency according to WAC 182-502-0150.