



PROPOSED RULE MAKING

CR-102 (December 2017) (Implements RCW 34.05.320)

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DATE: July 22, 2019

TIME: 2:26 PM

WSR 19-15-105

Agency: Health Care Authority

Original Notice

Supplemental Notice to WSR _____

Continuance of WSR _____

Preproposal Statement of Inquiry was filed as WSR 19-08-067 ; or

Expedited Rule Making--Proposed notice was filed as WSR _____; or

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or

Proposal is exempt under RCW _____.

Title of rule and other identifying information: (describe subject) 182-550-2590 Agency prior authorization requirements for Level 1 and Level 2 LTAC services; 182-550-2600 Inpatient psychiatric services; 182-550-2900 Payment limits – Inpatient hospital services; and 182-550-4550 Administrative day rate and swing bed day rate.

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
August 27, 2019	10:00 AM	Health Care Authority Cherry Street Plaza Sue Crystal Conf Room 106A 626 8 th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than August 28, 2019 (Note: This is **NOT** the effective date)

Submit written comments to:

Name: HCA Rules Coordinator

Address: PO Box 42716, Olympia WA 98504-2716

Email: arc@hca.wa.gov

Fax: (360) 586-9727

Other:

By (date) August 27, 2019

Assistance for persons with disabilities:

Contact Amber Lougheed

Phone: (360) 725-1349

Fax: (360) 586-9727

TTY: Telecommunication Relay Services (TRS): 711

Email: amber.lougheed@hca.wa.gov

Other:

By (date) August 23, 2019

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is amending these rules to clarify that pharmacy and pharmacy services may be billed when a client is admitted under administrative status for inpatient hospital stays.

Reasons supporting proposal: See purpose above

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law? Yes No
Federal Court Decision? Yes No
State Court Decision? Yes No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Health Care Authority Private
 Public
 Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia WA 98504-2716	360-725-1408
Implementation:	Joan Chappell	PO Box 45506, Olympia, WA 98504-5506	360-725-1071
Enforcement:	Joan Chappell	PO Box 45506, Olympia, WA 98504-5506	360-725-1071

Is a school district fiscal impact statement required under RCW 28A.305.135? Yes No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- RCW 34.05.310 (4)(b) (Internal government operations)
- RCW 34.05.310 (4)(c) (Incorporation by reference)
- RCW 34.05.310 (4)(d) (Correct or clarify language)
- RCW 34.05.310 (4)(e) (Dictated by statute)
- RCW 34.05.310 (4)(f) (Set or adjust fees)
- RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

No Briefly summarize the agency's analysis showing how costs were calculated. These rules do not impose a cost on businesses.

Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

- Name:
- Address:
- Phone:
- Fax:
- TTY:
- Email:
- Other:

Date: July 22, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-550-2590 Agency prior authorization requirements for Level 1 and Level 2 LTAC services. (1) The medicaid agency requires prior authorization for Level 1 and Level 2 long term acute care (LTAC) inpatient stays. The prior authorization process includes all the following:

(a) For an initial thirty-day stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC 182-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC 182-550-1050.

(ii) The LTAC provider of services must:

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

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

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

(D) Meet all the requirements in WAC 182-550-2580.

(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 agency with sufficient medical justification.

(2) The agency 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 182-526 WAC. After receiving a request for a fair hearing, the agency may request additional information from the client and the facility, or both. After the agency reviews the available information, the result may be:

(a) A reversal of the initial agency decision;

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

(c) A fair hearing conducted according to chapter 182-526 WAC.

(4) The agency may authorize an administrative day rate payment, as well as payment for pharmacy services and pharmaceuticals, 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.

WAC 182-550-2600 Inpatient psychiatric services. (1) The medic-aid agency, 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 Washington apple health 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 182-550-1050 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 Washington apple health 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 Washington apple health 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 people 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 Washington apple health client. Retrospective authorization can be before 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 Washington apple health 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 Washington apple health 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 before 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 182-502-0100; and

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

(i) For a client eligible for Washington apple health, the admission to voluntary inpatient psychiatric care must:

(A) Be medically necessary as defined in WAC 182-500-0070;

(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 Washington apple health program, the agency pays secondary to medicare.

(iii) For a client eligible for both medicare and a Washington apple health 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 under medicare standards.

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

(v) When a liable third party is identified (other than medicare) for a client eligible for a Washington apple health program, the hospital provider or hospital unit provider must obtain an 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 under 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 under chapter 388-865 WAC;

(ii) Must meet the applicable general conditions of payment criteria in WAC 182-502-0100; 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 Washington apple health 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 Washington apple health 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)~~) ICD-10-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 before 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 before the transfer~~(-)~~; or

(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 discharge. 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 time frames stated in this section. For a retrospective certification request before 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 Washington apple health 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 agency uses the payment methods described in WAC 182-550-2650 through 182-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to Washington apple health clients, unless otherwise specified in this section.

(11) Covered days for a voluntary psychiatric admission are determined by an 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 before the expiration of the previously authorized days. Extension requests may not be denied for a per-

son 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 agency pays the administrative day rate and pays for pharmacy services and pharmaceuticals for any authorized days that meet the administrative day definition in WAC 182-550-1050(~~(7—and)~~) when all 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 Washington apple health 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 Washington apple health 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 agency will recover any unauthorized days paid.

AMENDATORY SECTION (Amending WSR 19-13-006, filed 6/6/19, effective 7/7/19)

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 that hospital, as defined in WAC 182-550-1050; or
- (c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) 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 under WAC 182-550-2600, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received prior authorization for an extended LOS from the agency or mental health designee as specified in WAC 182-550-4300(4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. 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 readmitted to the same or affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines that one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000 (7)(f) for the agency's review of fourteen-day readmissions.

(g) Inpatient claims for fourteen-day readmissions considered to be provider preventable as described in WAC 182-550-2950.

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

(i) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

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

(k) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before 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 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) Under the current national uniform billing data element specifications:

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

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

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

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

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

(d) Under the agency's published billing instructions and other documents; and

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

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

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate NUBC revenue code specific to the service or treatment provided to the client.

(6) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by 42 C.F.R. Sec. 447.271.

(7) 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))~~, as provided in WAC 182-550-4550.

(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 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.

AMENDATORY SECTION (Amending WSR 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-4550 Administrative day rate and swing bed day rate.

(1) **Administrative day rate.** The medicaid agency 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 agency uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1st of each year.

(b) The agency does not pay for ancillary services, except for pharmacy services and pharmaceuticals, provided during administrative days.

(c) The agency identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(d) The agency 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 subacute placement can be made.

(2) **Swing bed day rate.** The agency allows hospitals a swing bed day rate for those days when a client is receiving agency-approved nursing service level of care in a swing bed. The agency's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The agency 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 agency-approved nursing service level of care in a swing bed.

(b) The agency's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 182-550-6000 and 182-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The agency allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving agency-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The agency does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.