RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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DATE: June 06, 2019
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WSR 19-13-006

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(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: The agency is amending WAC 182-550-2900 and adding WAC 182-550-2950 to describe the parameters for 14-day provider preventable readmissions. These changes distinguish provider preventable 14-day readmission from other 14-day readmissions. The amended rules also establish the agency's payment policy for provider preventable 14-day readmissions, identify claims that do not qualify as provider preventable, and describe the agency's postpayment review process.

Citation of rules affected by this order:

New: 182-550-2950
Repealed:
Amended: 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 19-10-060 on April 30, 2019 (date).

Describe any changes other than editing from proposed to adopted version: None

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

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

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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	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	New		Amended		Repealed	

The number of sections adopted on the agency's own initiative:

	New		Amended		Repealed	

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

	New	1	Amended	1	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	1	Amended	1	Repealed	

Date Adopted: June 6, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 18-11-074, filed 5/16/18, effective 7/1/18)

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.

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

((~~(i)~~)) (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.

((~~(j)~~)) (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.

(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.

NEW SECTION

WAC 182-550-2950 Payment limits—Provider preventable fourteen-day readmissions. (1) **Introduction.** The rules in this section establish the medicaid agency's payment policy for inpatient claims for provider preventable fourteen-day readmissions and do not apply to any other rules regarding payment for hospital admissions.

(2) **Applicability.** The rules in this section apply to inpatient hospital claims made for clients enrolled in the fee-for-service program and to clients enrolled in an agency-contracted managed care organization (MCO).

(a) The rules in this section do not apply to:

(i) Professional claims submitted for services rendered in the inpatient setting during a readmission; or

(ii) Claims submitted by critical access hospitals.

(b) The rules in this section apply only to provider preventable readmissions and not to other types of fourteen-day hospital inpatient readmissions that do not qualify for payment for other reasons.

(3) **Provider preventable readmission.**

(a) For the purpose of this section, readmission means an inpatient hospital admission to the same or an affiliated hospital within fourteen calendar days of a discharge from a prior admission and clinically related to the prior admission.

(b) Inpatient claims from hospitals for fourteen-day readmissions that the agency or the agency's designee considers to be provider preventable do not qualify for payment.

(c) A readmission is provider preventable if the agency or the agency's designee determines there is a reasonable expectation the hospital could have prevented the readmission by one or more of the following:

(i) Quality of care provided during the index (initial) hospitalization. The quality of care provided during the index hospitalization must follow current, evidence-based standards of care for the health care specialty at issue and must be:

(A) Safely administered without physically harming the client;

(B) Free from medical error that subsequently results in readmission due to that error;

(C) Evidence based, producing outcomes that are supported by evidence and effective in treating the client. The quality of care must follow the hospital's current standards for care of the client's diagnosis during that treatment period;

(D) Client-centered, focusing on the client's individual needs. The quality of care must be appropriate for the diagnosis and involve the patient in the planning of their care;

(E) Timely, with treatment that did not result in a delay of care, and the client was not prematurely discharged;

(F) Medically necessary for treatment of a diagnosis recognized by the current International Statistical Classification of Diseases and Related Health Problems (ICD); and

(G) Equitable in quality for all clients, regardless of differences in personal characteristics or beliefs.

(ii) Discharge planning. Discharge planning must occur as directed in the Centers for Medicare and Medicaid Services' (CMS) interpretive guidelines for 42 C.F.R. Sec. 482.43, in Publication #100-07 State Operations Manual (Rev. 183, October 12, 2018), Appendix A, Section 482.43, Conditions of Participation: Discharge planning (CMS Manual). Discharge planning must include, but is not limited to:

(A) A clearly written discharge plan that actively involves the client or client's representative in the discharge process; and

(B) An assessment of the client's capability for postdischarge care and follow up including, but not limited to:

(I) The client's functional status and cognitive ability;

(II) The type of posthospital care the client requires, and whether such care requires the services of health care professionals or facilities;

(III) The availability of the required posthospital health care services to the client; and

(IV) The availability and capability of family, or friends, or both to provide follow-up care in the home.

(iii) Discharge process. Upon discharge, the provider must meet the following discharge components:

(A) Provide the client with all required prescriptions and provide education regarding the appropriate use of these medications; and

(B) Provide the client with written instructions in the client's primary language.

(I) If written instructions cannot be provided, the hospital must provide verbal instructions through an interpreter and document that the client's questions were answered.

(II) Written instructions must include home care instructions including, but not limited to:

• Contact numbers for discharge-related questions;
• Information describing when the client should call the provider with concerns and when to call 911;
• Dietary restrictions;
• Wound care, when applicable; and
• Activity limitations.

(iv) Postdischarge follow-up. Postdischarge follow-up documents must include:

(A) A complete discharge summary, including case management discharge summaries and a risk assessment score that is accessible by outpatient clinics for ease in care coordination.

(B) Dates and contact numbers for follow-up appointments arranged with the primary care provider for all intensive and high-risk clients before the client leaves the hospital.

(C) Arrangements for medical supplies, equipment, and home care services, as needed, before the client leaves the hospital.

(4) **Exclusions.** The following types of inpatient readmission claims are exempt or do not qualify as provider preventable readmissions:

(a) Inpatient psychiatric care;

(b) Readmissions not clinically related to the index (initial) admission;

(c) Readmissions that are planned or scheduled including, but not limited to:

(i) Admissions for repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis, or other planned treatments for renal failure;

(ii) Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case; or

(iii) Planned admissions on the same day to a different hospital unit for continuing care (including transfers for mental health, chemical dependency, rehabilitation, and similar transfers that may be technically coded as discharge/admission for billing purposes).

(d) Admissions for required cancer treatments, including treatment-related toxicities or care for advanced-stage cancer;

(e) End of life and hospice care;

(f) Claims for clients who left against medical advice from index admission;

(g) Obstetrical claim admissions after an antepartum admission;

(h) Claims for readmission with a primary diagnosis of mental health or substance use disorder;

(i) Neonatal inpatient services;

(j) Transplant services, when the admission occurs within one hundred eighty days of transplant;

(k) Claims from a different hospital system other than where the index admission occurred;

(l) Claims to resume care for a client because the client did not comply with the discharge plan; or

(m) Readmissions resulting from the client's refusal of the recommended discharge plan and the index hospital making a less appropriate alternative plan to accommodate client preferences.

(5) **Postpayment utilization review.** The agency or the agency's designee performs a postpayment utilization review of the index hospital admission and all fourteen-day readmissions to determine what claims may qualify for recovery.

(6) **Client financial responsibility.** Clients are not financially liable for claims denied based on provider preventable fourteen-day readmissions that would have otherwise been paid by the agency or the agency's designee.

(7) **Dispute resolution.**

(a) Fee-for-service readmissions. If a hospital disputes a determination regarding fee-for-service readmissions, the agency follows the process in chapter 182-502A WAC and the administrative hearing procedure described in chapter 182-526 WAC.

(b) Managed care organization readmissions. MCOs must have an internal dispute resolution process for disputes arising out of a readmission. A hospital must access the MCO's internal dispute resolution process to dispute a provider preventable readmission determination by the MCO, as described in the hospital's individual contract with the MCO.

(c) Final determination review process. If the hospital has exhausted the MCO's internal dispute resolution process and the hospital continues to dispute the determination, the MCO and agency will follow the process regarding the fourteen-day readmission review program as described in the apple health managed care contract.