PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

☒ **Preproposal Statement of Inquiry was filed as WSR** 15-20-075**; 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).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

Title of rule and other identifying information:
182-500-0015, 182-500-0095 Medical definitions – "B" and "R"
182-531-1400 Psychiatric physician-related services and other professional mental health services
182-546-5500 Nonemergency transportation—Covered trips
182-550-1050, -1100, -2650 Hospital services

Hearing location:
Health Care Authority
Cherry Street Plaza Building; Pear Conf Rm 107
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: (360) 725-1000

Date: **February 23, 2016** Time: **10:00 a.m.**

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360) 586-9727

by **5:00 pm on February 23, 2016**

Date of intended adoption: Not sooner than February 24, 2016
(Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Amber Lougheed by February 19, 2016
e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349

TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

Amendments to rules on the subject of Regional Support Networks (RSNs) and Behavioral Health Organizations (BHOs) are necessary to comply with Second Substitute Senate Bill (2SSB) 6312, Chapter 225, Laws of 2014. During the course of this review, the agency may identify additional changes that are required in order to improve clarity or update policy.

Reasons supporting proposal: See Purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160, 2SSB 6312

Statute being implemented: RCW 41.05.021, 41.05.160, 2SSB 6312

Is rule necessary because of a:

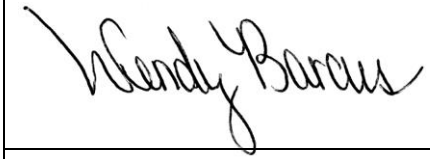
Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE
January 13, 2016

NAME
Wendy Barcus

SIGNATURE



TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: January 13, 2016
TIME: 10:13 AM

WSR 16-03-038

(COMPLETE REVERSE SIDE)

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

Name of proponent: Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Chantelle Diaz	PO Box 42716, Olympia WA, 98504-2716	(360) 725-1842
Implementation....	Alison Robbins	PO Box 45530, Olympia WA, 98504-5530	(360) 725-1634
Enforcement.....	Alison Robbins	PO Box 45530, Olympia WA, 98504-5530	(360) 725-1634

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( )
fax ( )
e-mail

☒ No. Explain why no statement was prepared.

The agency has determined that the proposed filing does not impose a disproportionate cost impact on small businesses or nonprofits.

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 ( )
e-mail

☒ 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.

AMENDATORY SECTION (Amending WSR 15-21-063, filed 10/19/15, effective 11/19/15)

WAC 182-500-0015 Medical assistance definitions—B. **"Behavioral health organization"** means a single- or multiple-county authority or other entity operating as a prepaid health plan with which the medicaid agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area.

"Benefit package" means the set of health care service categories included in a client's health care program. See WAC 182-501-0060.

"Benefit period" means the time period used to determine whether medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary receives inpatient hospital or extended care services from a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for medicare payments.

"Billing instructions" means provider guides. See WAC 182-500-0085.

"Blind" is a category of medical program eligibility that requires:

(a) A central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(b) A field of vision limitation so the widest diameter of the visual field subtends an angle no greater than twenty degrees from central.

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

AMENDATORY SECTION (Amending WSR 14-01-021, filed 12/9/13, effective 1/9/14)

WAC 182-500-0095 Medical assistance definitions—R. "Reasonably compatible" means the amount of a person's self-attested income (as defined in WAC 182-500-0100) and the amount of a person's income verified via electronic data sources are either both above or both below the applicable income standard for Washington apple health (WAH). When self-attested income is less than the standard for WAH, but income from available data sources is more than the WAH standard, or when the self-attested income cannot be verified via electronic data sources, the self-attested income is considered not reasonably compatible.

((~~**"Regional support network (RSN)"** means a single or multiple-county authority or other entity operating as a prepaid health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health services system in a defined geographic area.~~))

"Retroactive period" means approval of medical coverage for any or all of the retroactive period. A client may be eligible only in the retroactive period or may have both current eligibility and a separate retroactive period of eligibility approved.

AMENDATORY SECTION (Amending WSR 15-03-041, filed 1/12/15, effective 2/12/15)

WAC 182-531-1400 Psychiatric physician-related services and other professional mental health services. (1) The mental health services covered in this section are different from the mental health services covered under chapter 388-865 WAC, Community mental health and involuntary treatment programs, administered by the division of behavioral health and recovery within the department of social and health services.

(2) Inpatient and outpatient mental health services not covered under chapter 388-865 WAC, may be covered by the agency ((~~according to~~)) under this section.

Inpatient mental health services

(3) For hospital inpatient psychiatric admissions, providers must comply with ((~~the rules of the department of social and health services in~~)) chapter 388-865 WAC((~~, Community mental health and involuntary treatment programs~~)).

(4) The agency covers professional inpatient mental health services as follows:

(a) When provided by a psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), or psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(b) The agency pays only for the total time spent on direct psychiatric client care during each visit, including services ((~~rendered~~)) provided when making rounds. The agency considers services ((~~rendered~~)) provided during rounds to be direct client care services and may include, but are not limited to:

(i) Individual psychotherapy up to one hour;

(ii) Family/group therapy; or

(iii) Electroconvulsive therapy.

(c) One electroconvulsive therapy or narcosynthesis per client, per day, and only when performed by a psychiatrist.

Outpatient mental health services

(5) The agency covers outpatient mental health services when provided by the following licensed health care professionals who are ((~~in good standing with the agency and who are without restriction by the department of health under their appropriate licensure~~)) eligible providers under chapter 182-502 WAC:

(a) Psychiatrists;

(b) Psychologists;

(c) Psychiatric advanced registered nurse practitioners (ARNP) ((~~or~~));

(d) Psychiatric mental health nurse practitioners-board certified (PMHNP-BC);

((~~(d)~~)) (e) Mental health counselors;

((~~(e)~~)) (f) Independent clinical social workers;

((~~(f)~~)) (g) Advanced social workers; or

((~~(g)~~)) (h) Marriage and family therapists.

(6) With the exception of licensed psychiatrists and psychologists, qualified health care professionals who treat clients age eighteen ((~~years of age~~)) and younger must have a minimum of two years' experience in the diagnosis and treatment of clients age eighteen ((~~years of age~~)) and younger, including one year of supervision by

a mental health professional trained in child and family mental health.

(7) The agency does not limit the total number of outpatient mental health visits a licensed health care professional can provide.

(8) ((~~The agency covers outpatient mental health services with the following limitations.~~)) The agency evaluates a request for covered outpatient mental health services ((~~that is~~)) in excess of the limitations or restrictions ((~~according to WAC 182-501-0169~~)) in this section under WAC 182-501-0169. The agency covers outpatient mental health services with the following limitations:

(a) One psychiatric diagnostic evaluation, per provider, per client, per calendar year, unless significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the agency.

(b) One individual or family/group psychotherapy visit, with or without the client, per day, per client.

(c) One psychiatric medication management service, per client, per day, in an outpatient setting when performed by one of the following:

(i) Psychiatrist;

(ii) Psychiatric advanced registered nurse practitioner (ARNP); or

(iii) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC).

(9) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for outpatient mental health services when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

(10) ((~~The agency requires~~)) Mental health services must be provided in the appropriate place of service. The provider is responsible for referring the client to the ((~~regional support network (RSN)~~)) behavioral health organization (BHO) to assess whether the client meets the ((~~RSN~~)) BHO access to care standards.

(11) If anytime during treatment the provider suspects the client meets the ((~~RSN~~)) BHO access to care standards, an assessment must be conducted. This assessment may be completed by either a health care professional listed in subsection (5) of this section or a representative of the ((~~RSN~~)) BHO.

(12) After the client completes fifteen outpatient mental health visits under this benefit, the agency may request a written attestation that the client has been assessed for meeting access to care standards. This written attestation ((~~assures~~)) verifies the mental health services are being provided in the appropriate place of service. ((~~This~~)) The treating provider must respond to this request.

(13) To support continuity of care, the client may continue under the care of the provider until ((~~an RSN~~)) a BHO can receive the client.

(14) To be paid for providing mental health services, providers must bill the agency using the agency's published billing instructions.

(15) The agency considers a provider's acceptance of multiple payments for the same client for the same service on the same date to be a duplication of payment. Duplicative payments may be recouped by the agency under WAC 182-502-0230. Providers must keep documentation identifying the type of service provided and the contract or agreement under which it is provided.

AMENDATORY SECTION (Amending WSR 15-03-050, filed 1/14/15, effective 2/14/15)

WAC 182-546-5500 Nonemergency transportation—Covered trips. (1) The medicaid agency covers nonemergency transportation for ((~~medical assistance clients~~)) a Washington apple health client to and from health care services ((~~when~~)) if all of the following apply:

(a) The health care services are:

(i) Within the scope of coverage of the eligible client's benefit services package;

(ii) Covered as defined in WAC 182-501-0050 through 182-501-0065 and the specific program rules; and

(iii) Authorized, ((~~when~~)) as required ((~~within~~)) under specific program rules.

(b) The health care service is medically necessary as defined in WAC 182-500-0070;

(c) The health care service is being provided ((~~as follows (see subsection (3) of this section for exceptions)~~)):

(i) Under fee-for-service, by an agency-contracted provider;

(ii) Through an agency-contracted managed care organization (MCO), by an MCO provider;

(iii) Through a ((~~regional support network (RSN), by an RSN~~)) behavioral health organization (BHO), by a BHO contractor; or

(iv) Through one of the following providers, as long as the provider is eligible for enrollment as a medicaid provider (see WAC 182-502-0012):

(A) A medicare enrolled provider;

(B) A provider in the network covered by the client's primary insurance where there is third-party insurance;

(C) A provider performing services paid for by the Veteran's Administration, charitable program, or other voluntary program (Shriners, etc.).

(d) The trip is to a local provider as defined in WAC 182-546-5100 (see WAC 182-546-5700(3) for local provider exceptions);

(e) The transportation is the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;

(f) The trip is authorized by the broker before a client's travel; and

(g) The trip is a minimum of three-quarters of a mile from pick-up point to the drop-off point (see WAC 182-546-6200(7) for exceptions to the minimum distance requirement).

(2) Coverage for nonemergency medical transportation is limited to one roundtrip per day, with the exception of multiple medical appointments which cannot be accessed in one roundtrip.

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

WAC 182-550-1050 Hospital services definitions. The following definitions and abbreviations, those found in chapter 182-500 WAC, Medical definitions, and definitions and abbreviations found in other sections of this chapter apply to this chapter. When a term is not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the medical definitions found in *Taber's Cyclopedic Medical Dictionary* apply.

"Accommodation costs" - The expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Accredited" or **"accreditation"** - A term used by nationally recognized health organizations, such as the commission on accreditation of rehabilitation facilities (CARF), to indicate a facility meets both professional and community standards of medical care.

"Acute" - A medical condition of severe intensity with sudden onset. For the purposes of the acute physical medicine and rehabilitation (Acute PM&R) program, acute means an intense medical episode, not longer than three months.

"Acute care" - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional ((~~in order~~)) to maintain their health status.

"Acute physical medicine and rehabilitation (acute PM&R)" - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"Administrative day" or **"administrative days"** - One or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate.

"Administrative day rate" - The agency's statewide medicaid average daily nursing facility rate.

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

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

"All-patient DRG grouper (AP-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions between August 1, 2007, and June 30, 2014.

"All-patient refined DRG grouper (APR-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions on and after July 1, 2014.

"Allowable" - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

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

"Allowed charges" - The total billed charges for allowable services.

"Allowed covered charges" - The total billed charges for services minus the billed charges for noncovered ((~~and/or~~)) services, denied services, or both.

"Ambulatory payment classification (APC)" - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

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

"Ancillary services" - Additional or supporting services provided by a hospital to a client during the client's hospital stay. These services include, but are not limited to: Laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" - The level of care required to best manage a client's illness or injury based on:

(1) The severity of illness and the intensity of services required to treat the illness or injury; or

(2) A condition-specific episode of care.

"Audit" - An assessment, evaluation, examination, or investigation of a health care provider's accounts, books, and records, including:

(1) Health, financial, and billing records pertaining to billed services paid by the agency through Washington apple health, by a person not employed or affiliated with the provider, ((~~for the purpose of verifying~~)) to verify the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical, and health records, including mathematical computations and special studies conducted supporting the medicare cost report (Form 2552-96 and 2552-10 or successor form), submitted to the agency ((~~for the purpose of establishing~~)) to establish program rates for payment to hospital providers.

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

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

"Bedside nursing services" - Services included under the room and board services paid to the facility and provided by nursing service personnel. These services include, but are not limited to: Medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing and other point of care testing, catheterizations, tube feedings and irrigations, and equipment monitoring services.

"Billed charge" - The charge submitted to the agency by the provider.

"Bordering city hospital" - A hospital located in one of the cities listed in WAC 182-501-0175.

"Budget neutral" - A condition in which a claims model produces aggregate payments to hospitals that are the same under two separate payment systems. See also **"budget neutrality factor."**

"Budget neutrality factor" - A multiplier used by the agency to ensure that modifications to the payment method and rates are budget neutral. See also **"budget neutral."**

"Budget target" - Funds appropriated by the legislature or through the agency's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjuster" - A multiplier applied to the outpatient prospective payment system (OPPS) payment to ensure aggregate payments do not exceed the established budget target.

"Bundled services" - Interventions integral to or related to the major procedure. The agency does not pay separately for these services.

"Case mix" - A relative value assigned to a DRG or classification of patients in a medical care environment representing the resource intensity demands placed on an institution.

"Case mix index (CMI)" - The average relative weight of all cases treated in a hospital during a defined period.

"Centers for Medicare and Medicaid Services (CMS)" - See WAC 182-500-0020.

"Charity care" - See chapter 70.170 RCW.

"Chemical dependency" - An addiction or dependence on alcohol or drugs, or both.

"Children's health insurance program (CHIP)" - The federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen. Part of Washington apple health.

"Children's hospital" - A hospital primarily serving children.

"Client" - A person who receives or is eligible to receive services through agency programs.

"Commission on accreditation of rehabilitation facilities (CARF)" - See http://www.carf.org/home/.

"CMS PPS input price index" - A measure, expressed as a percentage, of the annual inflationary costs for hospital services.

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

"Condition-specific episode of care" - Care provided to a client based on the client's primary condition, complications, comorbidities, standard treatments, and response to treatments.

"Contract hospital" - A hospital contracted by the agency to provide specific services.

"Conversion factor" - A hospital-specific dollar amount that is used in calculating inpatient payments.

"Core provider agreement (CPA)" - The basic contract the agency holds with providers serving Washington apple health clients.

"Cost report" - See **"medicare cost report."**

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

"Covered charges" - Billed charges submitted to the agency on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" - See **"hospital covered service"** and WAC 182-501-0050.

"Critical border hospital" - An acute care hospital located in a bordering city (see WAC 182-501-0175 for list) that the agency has, through analysis of admissions and hospital days, designated as critical to provide health care for Washington apple health clients.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Deductible" - The dollar amount a client is responsible for before an insurer, such as medicare, starts paying or the initial specific dollar amount for which the client is responsible.

"Department of social and health services (DSHS)" - The Washington state agency that provides food assistance, financial aid, medical and behavioral health care, and other services to eligible children, families, and vulnerable adults and seniors of Washington state.

"Diabetes education program" - A comprehensive, multidisciplinary program of instruction offered by a DOH-approved diabetes education provider to diabetic clients for managing diabetes. This includes instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" - A set of numeric or alphanumeric characters assigned by the current published ICD-CM coding guidelines used by the agency as a shorthand symbol to represent the nature of a disease or condition.

"Diagnosis-related group (DRG)" - A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use. Classification of patients is based on the current published ICD-CM coding guidelines used by the agency, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

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

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

"Discount factor" - The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Disproportionate share hospital (DSH) payment" - A supplemental payment made by the agency to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan. See WAC 182-550-4900.

"Disproportionate share hospital (DSH) program" - A program through which the agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients in accordance with legislative direction and established payment methods. See 1902 (a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4900 through 182-550-5400.

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

"Distinct unit" - A distinct area for psychiatric, rehabilitation, or detox services which has been certified by medicare within an acute care hospital or approved by the agency within a children's hospital.

"**Division of behavioral health and recovery services (DBHR)**" - The division within DSHS that administers mental health, problem gambling, and substance abuse programs authorized by chapters 43.20A, 71.05, 71.24, 71.34, and 70.96A RCW.

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

"DRG allowed amount" - The DRG relative weight multiplied by the conversion factor.

"DRG average length-of-stay" - The agency's average length-of-stay for a DRG classification established during an agency DRG rebasing and recalibration project.

"DRG-exempt services" - Services paid through methods other than DRG, such as per diem rate, per case rate, or ratio of costs-to-charges (RCC).

"DRG payment" - The total payment made by the agency for a client's inpatient hospital stay. The DRG payment is the DRG allowed amount plus the high outlier minus any third-party liability, client participation, medicare payment, and any other adjustments applied by the agency.

"DRG relative weight" - A factor used in the calculation of DRG payments. As of July 1, 2014, the medicaid agency uses the 3M™ Corporation's national weights developed for the all-patient refined-diagnosis-related group (APR-DRG) software.

"Enhanced ambulatory patient groupings (EAPG)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after July 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency room" or **"emergency facility"** or **"emergency department"** - A distinct hospital-based facility which provides unscheduled services to clients who require immediate medical attention. An emergency department must be capable of providing emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week. A physically separate extension of an existing hospital emergency department may be considered a freestanding emergency department as long as the extension provides comprehensive emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week.

"Emergency services" - Health care services required by and provided to a client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are considered emergency services by the agency.

"Equivalency factor (EF)" - A factor that may be used by the agency in conjunction with other factors to determine the level of a state-administered program payment. See WAC 182-550-4800.

"Exempt hospital - DRG payment method" - A hospital that for a certain client category is reimbursed for services to Washington apple health clients through methodologies other than those using DRG conversion factors.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Experimental service" - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of

safety and effectiveness. See WAC 182-531-0050. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the federal Food and Drug Administration (FDA) or other requisite government body if ((~~such~~)) approval is required.

"Fee-for-service" - See WAC 182-500-0035.

"Fiscal intermediary" - Medicare's designated fiscal intermediary for a region or category of service, or both.

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

"Formal release" - When a client:

(1) Discharges from a hospital or distinct unit;

(2) Dies in a hospital or distinct unit;

(3) Transfers from a hospital or distinct unit as an acute care transfer; or

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

"Global surgery days" - The number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

"Graduate medical education costs" - The direct and indirect costs of providing medical education in teaching hospitals. See "direct medical education costs" and "indirect medical education costs."

"Grouper" - See **"all-patient DRG grouper (AP-DRG)"** and **"all-patient refined DRG grouper (APR-DRG)."**

"Health care authority (medicaid agency)" - The Washington state agency that administers Washington apple health.

"High outlier" - A DRG claim classified by the agency as being allowed a high outlier payment that is paid under the DRG payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the agency. See WAC 182-550-3700.

"Hospice" - A medically directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice.

"Hospital" - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a medicare or state-certified distinct rehabilitation unit, a "psychiatric hospital" as defined in this section, or any other distinct unit of the hospital.

"Hospital covered service" - Any service, treatment, equipment, procedure, or supply provided by a hospital, covered under a Washington apple health program, and within the scope of an eligible client's Washington apple health program.

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

"Hospital readmission" - A situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital.

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

"Inflation adjustment" - For cost inflation, this is the hospital inflation adjustment. This adjustment is determined by using the inflation factor method approved by the legislature. For charge inflation, this is the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) Hospital Census and Charges by Payer report.

"Inpatient hospital admission" - A formal admission to a hospital based on an evaluation of the client using objective clinical indicators ((~~for the purpose of providing~~)) to provide medically necessary, acute inpatient care. These indicators include assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury. All applicable indicators must be documented in the client's health record. The decision to admit a client to inpatient status should be based on the condition-specific episode of care, severity of illness presented, and the intensity of services rendered. The agency does not deem inpatient hospital admissions as covered or noncovered solely on the basis of the length of time the client actually spends in the hospital. Generally, a client remains overnight and occupies a bed. Inpatient status can apply even if the client is discharged or transferred to another acute hospital and does not actually use a hospital bed overnight. For the agency to recognize a stay as inpatient there must be a physician admission order in the client's medical record indicating the status as inpatient.

"Inpatient medicaid DRG conversion factor" - A dollar amount that represents selected hospitals' average costs of treating medicaid and CHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay medicaid and CHIP claims under the DRG payment method. See WAC 182-550-3800 for how this conversion factor is calculated.

"Inpatient services" - Health care services provided to a client during hospitalization whose condition warrants formal admission and treatment in a hospital.

"Inpatient state-administered program conversion factor" - A DRG conversion factor reduced from the inpatient medicaid DRG conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims under the DRG payment method.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases (ICD-9-CM and ICD-10-CM)" - The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding).

"Length of stay (LOS)" - The number of days of inpatient hospitalization, calculated by adding the total number of days from the admission date to the discharge date, and subtracting one day.

"Long-term acute care (LTAC) services" - Inpatient intensive long-term care services provided in agency-approved LTAC hospitals to eligible Washington apple health clients who meet criteria for level 1 or level 2 services. See WAC 182-550-2565 through 182-550-2596.

"LTAC level 1 services" - LTAC services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care

due to clinical complexity. Level 1 services include one of the following:

(1) Ventilator weaning care; or

(2) Care for a client who has:

(a) Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and

(b) At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

"LTAC level 2 services" - LTAC services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

(1) Ventilator care for a client who is ventilator-dependent and is not weanable and has complex medical needs; or

(2) Care for a client who:

(a) Has a tracheostomy;

(b) Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and

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

"Major diagnostic category (MDC)" - One of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG and APR-DRG classification systems.

"Medical care services (MCS)" - See WAC 182-500-0070.

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

"Medical visit" - Diagnostic, therapeutic, or consultative services provided to a client by a health care professional in an outpatient setting.

"Medicare cost report" - The medicare cost report (Form 2552-96 or Form 2552-10), or successor document, completed and submitted annually by a hospital provider.

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

"Medicare physician fee schedule (MPFS)" - The official CMS publication of relative value units and medicare payment policy indicators for the resource-based relative value scale (RBRVS) payment program.

"Medicare Part A" - See WAC 182-500-0070.

"Medicare Part B" - See WAC 182-500-0070.

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

"Mental health designee" - A professional contact person authorized by the division of behavioral health and recovery (DBHR) of DSHS, who operates under the direction of a ((~~regional support network (RSN)~~)) behavioral health organization (BHO) or a prepaid inpatient health plan (PIHP). See WAC 182-550-2600.

"Military hospital" - A hospital reserved for the use of military personnel, their dependents, and other authorized users.

"Modifier" - A two-digit alphabetic and/or numeric identifier added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its defini-

tion or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National Correct Coding Initiative (NCCI)" - A national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the *American Medical Associations' Current Procedural Terminology (CPT®)* manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National Drug Code (NDC)" - The eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The eleven-digit NDC is composed of a five-four-two grouping. The first five digits comprise the labeler code assigned to the manufacturer by the FDA. The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"National payment rate (NPR)" - A rate for a given procedure code, published by CMS, that does not include a state- or location-specific adjustment.

"National Provider Identifier (NPI)" - A standard, unique identifier for health care providers assigned by CMS. The agency's Provider-One system pays for inpatient and outpatient services using only one NPI per provider. The agency may make an exception for inpatient claims billed with medicare-certified, distinct unit NPIs.

"Nationwide rate" - See **"national payment rate (NPR)."**

"NCCI edit" - A software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency fee schedules, billing instructions, and other publications. The agency has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards, or agency policy.

"Newborn" or **"neonate"** or **"neonatal"** - A person younger than twenty-nine days old.

"Nonallowed service or charge" - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160.

"Noncovered charges" - Billed charges a provider submits to the agency on a claim and indicates them on the claim as noncovered.

"Noncovered service or charge" - A service or charge the agency does not consider or pay for as a "hospital covered service." This service or charge may not be billed to the client, except under the conditions identified in WAC 182-502-0160.

"Nursing service personnel" - A group of health care professionals that includes, but is not limited to: Registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant/nursing assistant certified (CNA/NAC).

"Observation services" - A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed forty-eight hours. The agency or its designee may deter-

mine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service.

"Operating costs" - All expenses incurred providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Out-of-state hospital" - Any hospital located outside the state of Washington and the bordering cities designated in WAC 182-501-0175. For Washington apple health clients requiring psychiatric services, an "out-of-state hospital" is any hospital located outside the state of Washington.

"Outliers" - Cases with extraordinarily high costs when compared to other cases in the same DRG.

"Outpatient" - A client who is receiving health care services, other than inpatient services, in a hospital setting.

"Outpatient care" - See **"outpatient hospital services."**

"Outpatient code editor (OCE)" - A software program the agency uses for classifying and editing in ambulatory payment classification (APC)-based OPPS.

"Outpatient hospital" - A hospital authorized by DOH to provide outpatient services.

"Outpatient hospital services" - Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services.

"Outpatient prospective payment system (OPPS) conversion factor" - See **"outpatient prospective payment system (OPPS) rate."**

"Outpatient prospective payment system (OPPS) rate" - A hospital-specific multiplier assigned by the agency that is one of the components of the APC payment calculation.

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

"Pass-throughs" - Certain drugs, devices, and biologicals, as identified by CMS, for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own APC.

"Per diem" - A method which uses a daily rate to calculate payment for services provided as a "hospital covered service."

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

"Point of care testing (POCT)" - A test designed to be used at or near the site where the patient is located, that does not require permanent dedicated space, and that is performed outside the physical facilities of the clinical laboratory.

"Primary care case management (PCCM)" - The coordination of health care services under the agency's Indian health center or tribal clinic managed care program. See WAC 182-538-068.

"Principal diagnosis" - The condition chiefly responsible for the admission of the patient to the hospital.

"Prior authorization" - See WAC 182-500-0085.

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

"Prospective payment system (PPS)" - A payment system in which what is needed to calculate payments (methods, types of variables, and other factors) is set in advance and is knowable by all parties before care is provided. In a retrospective payment system, what is needed (actual costs or charges) is not available until after care is provided.

"Prosthetic device" or **"prosthetic"** - A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Psychiatric hospital" - A medicare-certified distinct psychiatric unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital. Eastern state hospital and western state hospital are excluded from this definition.

"Public hospital district" - A hospital district established under chapter 70.44 RCW.

"Ratable" - A factor used to calculate inpatient payments for state-administered programs.

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

"Rebasing" - The process used by the agency to update hospital payment policies, related variables (rates, factors, thresholds, multipliers, and caps), and system processes (edits, adjudication, grouping, etc.).

"Recalibration" - The process of recalculating DRG relative weights using historical data.

((~~**"Regional support network (RSN)"** - See WAC 182-500-0095.~~))

"Rehabilitation units" - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet agency and medicare criteria for distinct rehabilitation units.

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

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

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

"Room and board" - Routine supplies and services provided to a client during the client's hospital stay. This includes, but is not limited to, a regular or special care hospital room and related furnishings, room supplies, dietary and bedside nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" - See WAC 182-549-1100.

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

"Semi-private room rate" - A rate customarily charged for a hospital room with two to four beds; this charge is generally lower than

a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Significant procedure" - A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

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

"Spenddown" - See chapter 182-519 WAC.

"State plan" - The plan filed by the agency with CMS, Department of Health and Human Services (DHHS), outlining how the state will administer medicaid and CHIP services, including the hospital program.

"Status indicator (SI)" - A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method.

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

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

"Swing bed" - An inpatient hospital bed certified by CMS for either acute inpatient hospital or skilled nursing services.

"Swing-bed day" - A day in which a client is receiving skilled nursing services in a hospital-designated swing bed at the hospital's census hour.

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

"Transfer" - To move a client from one acute care setting to a higher level acute care setting for emergency care or to a post-acute, lower level care setting for ongoing care.

"Transferring hospital" - The hospital or distinct unit that transfers a client to another acute care or subacute facility or distinct unit, or to a nonhospital setting.

"UB-04" - The uniform billing document required for use nationally by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing for services provided to patients. This document includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and modified by the Washington state payer group or the agency.

"Vendor rate increase" - An adjustment determined by the legislature, that may be used to periodically increase rates for payment to vendors, including health care providers, that do business with the state.

"Washington apple health program" - Any health care program administered through the medicaid agency.

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

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

(a) Pays for ((~~the admission of~~)) an eligible Washington apple health (WAH) ((~~client~~)) 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 ((~~according to~~)) 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 WAH 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 a WAH 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 days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the chemical-using pregnant (CUP) women program.

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

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

(a) In a detoxification unit in a hospital that has a detoxification provider agreement with the agency to perform these services and the services are approved by the division of ((~~alcohol and substance abuse (DASA)~~)) behavioral health and recovery (DBHR) within the department of social and health services (DSHS); or

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

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

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

(iii) Nonhospital based detoxification is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from a ((~~regional support network (RSN) or a mental health division (MHD)~~)) be-

havioral health organization (BHO) or a DBHR 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 program; and

(vii) The client's principal diagnosis meets the agency's medical inpatient detoxification 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 WAH 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.

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

WAC 182-550-2650 Base community psychiatric hospitalization payment method for medicaid and CHIP clients and nonmedicaid and non-CHIP clients. (1) Effective for dates of admission from July 1, 2005 through June 30, 2007, and in accordance with legislative directive, the agency implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and children's health insurance program (CHIP) clients and one for nonmedicaid and non-CHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and CHIP clients and nonmedicaid and non-CHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid or non-CHIP client" is defined as a client eligible under the medical care services (MCS) program, as determined by the agency.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and CHIP covered patients, paid to hospitals that accept commitments under the Involuntary Treatment Act (ITA).

(b) The nonmedicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC 182-500-0070. In addition, the agency considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The agency does not consider detoxification to be psychiatric in nature.

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

(iii) Be authorized by the appropriate division of behavioral health and recovery (DBHR) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 182-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a DBHR designee.

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

(iv) Be prior authorized by the ((~~regional support network (RSN)~~)) behavioral health organization (BHO) or its designee.

(v) Meet the criteria in WAC 182-550-2600.

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

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

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

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

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

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

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

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

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

(ii) For nonmedicaid and non-CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the agency-specified non-DRG payment method if no relative weight exists for the DRG in the agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

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

(ii) For nonmedicaid and CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the agency-specified non-DRG payment method if no relative weight exists for the DRG in the agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A nonstate-owned free-standing psychiatric hospital as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and CHIP clients, except the base community inpatient psychiatric hospital payment rate is the nonmedicaid rate, and the RCC allowable is the state-administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 182-550-4650.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 182-550-4650 in conjunction with the nonmedicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For medicaid and CHIP clients, inpatient hospital psychiatric services are paid using the agency-specified non-DRG payment method.

(ii) For nonmedicaid and non-CHIP clients, inpatient hospital psychiatric services are paid using the agency-specified non-DRG payment method.