



RULE-MAKING ORDER

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

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

- 31 days after filing.
- Other (specify) _____ (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 making housekeeping rule changes to correct agency names, program names, rule numbers, and to make other clarifications that do not change the effect of the rules.

Citation of existing rules affected by this order:

Repealed:

Amended: 182-550-1000, -1100, -1300, -1350, -1400, -1500, -1600, -1900, -2100, -2200, -2301, -2400, -2431, -2500, -2501, -2531, -2541, -2561, -2565, -2575, -2580, -2585, -2590, -2595, -2596, -2598, -2600, -3470, -4200, -4550, -4690, -4700, -4925, -4935, -5000, -5130, -5200, -5210, -5220, -5410, -5425, -5500, -5550, -5600, -5700, -5800, -6000, -6100, -6150, -6200, -6250, -6300, -6400, -6450, -6500, -6600

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-15-090 on July 15, 2015.

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

Date adopted: August 27, 2015

NAME (TYPE OR PRINT)

Wendy Barcus

SIGNATURE

TITLE

HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 27, 2015

TIME: 3:05 PM

WSR 15-18-065

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

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

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

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

New	_____	Amended	_____	Repealed	_____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

New	_____	Amended	_____	Repealed	_____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

New	_____	Amended	<u>56</u>	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>56</u>	Repealed	_____

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1000 Applicability. The ((department)) medicaid agency pays for hospital services provided to eligible clients when:

(1) The eligible client is a patient in an acute care hospital and the hospital meets the definition of hospital or psychiatric hospital in RCW 70.41.020, ((WAC 388-500-0005 or 388-550-1050)) chapter 182-500 or WAC 182-550-1050;

(2) The services are medically necessary as defined under WAC ((388-500-0005)) 182-500-0070; and

(3) The conditions, exceptions and limitations in this chapter are met.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

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

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

(i) Are covered according to WAC ((388-501-0050, 388-501-0060 and 388-501-0065)) 182-501-0050, 182-501-0060 and 182-501-0065;

(ii) Are medically necessary as defined in WAC ((388-500-0005)) 182-500-0070;

(iii) Are determined according to WAC ((388-501-0165)) 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 ((388-502-0020)) 182-502-0020.

(3) The ((department)) agency:

(a) Pays for a hospital covered service provided to an eligible ((medical-assistance)) WAH client enrolled in ((a-department)) 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 ((department)) agency and meets prior authorization requirements. (See WAC ((388-550-2600)) 182-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to a ((medical-assistance)) WAH client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC ((388-550-4600 and 388-550-4700)) 182-550-4700 apply. The ((department's)) agency's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The ~~((department))~~ 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 ~~((388-533-0701 through 388-533-0730))~~ 182-533-0701 through 182-533-0730.

(5) The ~~((department))~~ 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 ~~((department))~~ agency to perform these services and the services are approved by the division of alcohol and substance abuse (DASA); or

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

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

(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) 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 ~~((department's))~~ agency's chemical-using pregnant (CUP) women program; and

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

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

(a) Are provided ~~((in accordance with chapter 388-535))~~ 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 ~~((department))~~ 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 ~~((in accordance with chapter 388-535))~~ under chapter 182-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least ~~((on))~~ one of the following is true:

(i) The dental-related service(s) is provided to an eligible ~~((medical assistance))~~ 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 ~~((department))~~ agency.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC ~~((388-550-2600))~~ 182-550-2600.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1300 Revenue code categories and subcategories. (1) Revenue code categories and subcategories listed in this chapter are published in the UB-92 (~~and~~) or UB-04 National Uniform Billing Data Element Specifications Manual.

(2) The (~~department~~) medicaid agency requires a hospital provider to report and bill all hospital services provided to (~~medical assistance~~) Washington apple health clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals. (1) The (~~department~~) medicaid agency requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or health care common procedure coding system (HCPCS) codes in addition to the required revenue codes on an outpatient claim line when using any of the following revenue code categories and subcategories:

(a) "IV therapy," only subcategories "general classification" and "infusion pump";

(b) "Medical/surgical supplies and devices," only subcategory "other supplies/devices";

(c) "Oncology";

(d) "Laboratory";

(e) "Laboratory pathological";

(f) "Radiology - Diagnostic";

(g) "Radiology - Therapeutic and/or chemotherapy administration";

(h) "Nuclear medicine";

(i) "CT scan";

(j) "Operating room services," only subcategories "general classification" and "minor surgery";

(k) "Blood and blood components";

(l) "Administration, processing, and storage for blood components";

(m) "Other imaging services";

(n) "Respiratory services";

(o) "Physical therapy";

(p) "Occupational therapy";

(q) "Speech therapy - Language pathology";

(r) "Emergency room," only subcategories "general classification" and "urgent care";

(s) "Pulmonary function";

(t) "Audiology";

(u) "Cardiology";

(v) "Ambulatory surgical care";

(w) "Clinic," only subcategories "general classification" and "other clinic";

(x) "Magnetic resonance technology (MRT)";

(y) "Medical/surgical supplies - Extension," only subcategory "surgical dressings";

(z) "Pharmacy - Extension" subcategories "Erythropoietin (EPO) less than ten thousand units," "Erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(aa) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(bb) "EKG/ECG (electrocardiogram)";

(cc) "EEG (electroencephalogram)";

(dd) "Gastro-intestinal services";

(ee) "Specialty room - Treatment/observation room," subcategory "treatment room and observation room";

(ff) "Telemedicine," only subcategory "other telemedicine";

(gg) "Extra-corporeal shock wave therapy (formerly lithotripsy)";

(hh) "Acquisition of body components," only subcategories "general classification" and "cadaver donor";

(ii) "Hemodialysis - Outpatient or home," only subcategory "general classification";

(jj) "Peritoneal dialysis - Outpatient or home," only subcategory "general classification";

(kk) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," only subcategory "general classification";

(ll) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," only subcategory "general classification";

(mm) "Miscellaneous dialysis," only subcategories "general classification" and "ultrafiltration";

(nn) "Behavioral health treatments/services," only subcategory "electroshock therapy";

(oo) "Other diagnostic services";

(pp) "Other therapeutic services," only subcategories "general classification," "cardiac rehabilitation," and "other therapeutic service"; and

(qq) Other revenue code categories and subcategories identified and published by the ((department)) agency.

(2) For an outpatient claim line requiring a CPT or HCPCS code((+)), the ((department)) agency denies payment if the required code is not reported on the line.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1400 Covered and noncovered revenue codes categories and subcategories for inpatient hospital services. Subject to the limitations and restrictions listed, this section identifies covered and noncovered revenue code categories and subcategories for inpatient hospital services.

(1) The ((department)) medicaid agency pays for an inpatient hospital covered service in the following revenue code categories and subcategories when the hospital provider accurately bills:

(a) "Room & board - Private (one bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(b) "Room & board - Semi-private (two bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(c) "Room & board - Semi-private - (three and four beds)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(d) "Room & board - Deluxe private," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(e) "Nursery," only subcategories "general classification," "newborn - level I," "newborn - level II," "newborn - level III," and "newborn - level IV";

(f) "Intensive care unit," only subcategories "general classification," "surgical," "medical," "pediatric," "intermediate ICU," "burn care," and "trauma";

(g) "Coronary care unit," only subcategories "general classification," "myocardial infarction," "pulmonary care," and "intermediate CCU";

(h) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(i) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery" and "IV therapy/supplies";

(j) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(k) "Oncology," only subcategory "general classification";

(l) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "nonroutine dialysis," "hematology," "bacteriology & microbiology," and "urology";

(m) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(n) "Radiology - Diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X ray";

(o) "Radiology - Therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy administration - injected," "chemotherapy administration - oral," "radiation therapy," and "chemotherapy administration - IV";

(p) "Nuclear medicine," only subcategories "general classification," "diagnostic," "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(q) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(r) "Operating room services," only subcategories "general classification" and "minor surgery";

(s) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(t) "Administration, processing and storage for blood and blood component," only subcategories "general classification" and "administration";

(u) "Other imaging services," only subcategories "general classification," "diagnostic mammography," "ultrasound," and "positron emission tomography";

(v) "Respiratory services," only subcategories "general classification," "inhalation services" and "~~((hyper-baric))~~ hyperbaric oxygen therapy";

(w) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(x) "Speech therapy - Language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(y) "Emergency room," only subcategories "general, urgent care classification" and "urgent care";

(z) "Pulmonary function," only subcategory "general classification";

(aa) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(bb) "Ambulatory surgical care," only subcategory "general classification";

(cc) "Outpatient services," only subcategory "general classification";

(dd) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - Brain (including brainstem)," "MRI - Spinal cord (including spine)," "MRI-other," "MRA - Head and neck," "MRA - Lower extremities," and "MRA-other";

(ee) "Medical/surgical supplies - Extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(ff) "Pharmacy-extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(gg) "Cast room," only subcategory "general classification";

(hh) "Recovery room," only subcategory "general classification";

(ii) "Labor room/delivery," only subcategory "general classification," "labor," "delivery," and "birthing center";

(jj) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(kk) "EEG (Electroencephalogram)," only subcategory "general classification";

(ll) "Gastro-intestinal services," only subcategory "general classification";

(mm) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(nn) "Extra-corporeal shock wave therapy (formerly lithotripsy)," only subcategory "general classification";

(oo) "Inpatient renal dialysis," only subcategories "general classification," "inpatient hemodialysis," "inpatient peritoneal (non-CAPD)," "inpatient continuous ambulatory peritoneal dialysis (CAPD)," and "inpatient continuous cycling peritoneal dialysis (CCPD)";

(pp) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(qq) "Miscellaneous dialysis," only subcategory "ultra filtration";

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," and "pregnancy test"; and

(ss) "Other therapeutic services," only subcategory "general classification."

(2) The ((~~department~~)) agency pays for an inpatient hospital covered service in the following revenue code subcategories only when the hospital provider is approved by the ((~~department~~)) agency to provide the specific service:

- (a) "All_inclusive rate," only subcategory "all-inclusive room & board plus ancillary";
- (b) "Room & board - Private (one bed)," only subcategory "psychiatric";
- (c) "Room & board - Semi-private (two beds)," only subcategories "psychiatric," "detoxification," "rehabilitation," and "other";
- (d) "Room & board - Semi-private three and four beds," only subcategories "psychiatric" and "detoxification";
- (e) "Room & board - Deluxe private," only subcategory "psychiatric";
- (f) "Room & board - Ward," only subcategories "general classification" and "detoxification";
- (g) "Room & board - Other," only subcategories "general classification" and "other";
- (h) "Intensive care unit," only subcategory "psychiatric";
- (i) "Coronary care unit," only subcategory "heart transplant";
- (j) "Operating room services," only subcategories "organ transplant-other than kidney" and "kidney transplant";
- (k) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate" and "evaluation or reevaluation";
- (l) "Clinic," only subcategory "chronic pain clinic";
- (m) "Ambulance," only subcategory "neonatal ambulance services";
- (n) "Behavioral health treatment/services," only subcategory "electroshock treatment"; and
- (o) "Behavioral health treatment/services - Extension," only subcategory "rehabilitation."

(3) The ((~~department~~)) agency pays revenue code category "occupational therapy," subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation" when:

- (a) A client is in an acute PM&R facility;
- (b) A client is age twenty or younger; or
- (c) The diagnosis code is listed in the ((~~department's~~)) agency's published billing instructions.

(4) The ((~~department~~)) agency does not pay for inpatient hospital services in the following revenue code categories and subcategories:

- (a) "All_inclusive rate," subcategory "all-inclusive room and board";
- (b) "Room & board - Private (one bed)" subcategories "hospice," "detoxification," "rehabilitation," and "other";
- (c) "Room & board - Semi-private (two bed)," subcategory "hospice";
- (d) "Room & board - Semi-private - (three and four beds)," subcategories "hospice," "rehabilitation," and "other";
- (e) "Room & board - Deluxe private," subcategories "hospice," "detoxification," "rehabilitation," and "other";
- (f) "Room & board - Ward," subcategories "medical/surgical/gyn," "OB," "pediatric," "psychiatric," "hospice," "oncology," "rehabilitation," and "other";

(g) "Room & board - Other," subcategories "sterile environment," and "self care";

(h) "Nursery," subcategory "other nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit," subcategory "other intensive care";

(l) "Coronary care unit," subcategory "other coronary care";

(m) "Special charges";

(n) "Incremental nursing charge";

(o) "All_inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotics devices," "oxygen - take home," and "other supplies/devices";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)";

(u) "Laboratory," subcategories "renal patient (home)," and "other laboratory";

(v) "Laboratory pathology," subcategory "other laboratory - pathological";

(w) "Radiology - Diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - Therapeutic," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategory "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture," and "other anesthesia";

(cc) "Blood and blood components";

(dd) "Administration, processing and storage for blood and blood components," subcategory "other processing and storage";

(ee) "Other imaging services," subcategories "screening mammography," and "other imaging services";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy," subcategory "other physical therapy";

(hh) "Occupational therapy," subcategory "other occupational therapy";

(ii) "Speech therapy - Language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening," and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services," subcategory "other outpatient service";

(pp) "Clinic," subcategories "general classification," "dental clinic," "psychiatric clinic," "OB-gyn clinic," "pediatric clinic," "urgent care clinic," "family practice clinic," and "other clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance," subcategories "general classification," "supplies," "medical transport," "heart mobile," "oxygen," "air ambulance," "pharmacy," "telephone transmission EKG," and "other ambulance";

(tt) "Home health (HH) skilled nursing";

(uu) "Home health (HH) medical social services";

(vv) "Home health (HH) - Aide";

(ww) "Home health (HH) - Other visits";

(xx) "Home health (HH) - Units of service";

(yy) "Home health (HH) - Oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";

(aaa) "Medical" "medical/surgical supplies - extension," subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Specialty room - Treatment/observation room," subcategory "other (~~speciality~~) specialty rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine";

(ppp) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis," subcategory "other inpatient dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - Outpatient or home";

(ttt) "Peritoneal dialysis - Outpatient or home";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home";

(www) "Miscellaneous dialysis," subcategories "general classification," "home dialysis aid visit," and "other miscellaneous dialysis";

(xxx) "Behavioral health treatments/services," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive outpatient services - chemical dependency," "community behavioral health program (day treatment)";

(yyy) "Behavioral health treatment/services" - (extension), subcategories "rehabilitation," "partial hospitalization - less intensive," "partial hospitalization - intensive," "individual therapy," "group therapy," "family therapy," "bio feedback," "testing," and "other behavioral health treatment/services";

(zzz) "Other diagnostic services," subcategories "general classification," "pap smear," "allergy test," and "other diagnostic service";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services," subcategories "recreational therapy," "cardiac rehabilitation," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," and "other therapeutic services";

(cccc) "Other therapeutic services - extension," subcategories "athletic training" and "kinesiotherapy";

(dddd) "Professional fees";

(eeee) "Patient convenience items"; and

(ffff) Revenue code categories and subcategories that are not identified in this section.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services. (1) The ((department)) medicaid agency pays for an outpatient hospital covered service in the following revenue code categories and subcategories when the hospital provider accurately bills:

(a) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(b) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery," and "IV therapy/supplies";

(c) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant," and "other supplies/devices";

(d) "Oncology," only subcategory "general classification";

(e) "Durable medical equipment (other than renal)," only subcategory "general classification";

(f) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "renal patient (home)," "nonroutine dialysis," "hematology," "bacteriology and microbiology," and "urology";

(g) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(h) "Radiology - Diagnostic," only subcategories "general classification," "angiocardiology," "arthrography," "arteriography," and "chest X ray";

(i) "Radiology - Therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(j) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(k) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(l) "Operating room services," only subcategories "general classification" and "minor surgery";

(m) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(n) "Administration, processing and storage for blood and blood components," only subcategories "general classification" and "administration";

(o) "Other imaging," only subcategories "general classification," "diagnostic mammography," "ultrasound," "screening mammography," and "positron emission tomography";

(p) "Respiratory services," only subcategories "general classification," "inhalation services," and "~~((hyper baric))~~ hyperbaric oxygen therapy";

(q) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(r) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(s) "Speech therapy - Language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(t) "Emergency room," only subcategories "general classification" and "urgent care";

(u) "Pulmonary function," only subcategory "general classification";

(v) "Audiology," only subcategories "general classification," "diagnostic," and "treatment";

(w) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(x) "Ambulatory surgical care," only subcategory "general classification";

(y) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - Brain (including brainstem)," "MRI - Spinal cord (including spine)," "MRI-other," "MRA - Head and neck," "MRA - Lower extremities" and "MRA-other";

(z) "Medical/surgical supplies - Extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(aa) "Pharmacy - Extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(bb) "Cast room," only subcategory "general classification";

(cc) "Recovery room," only subcategory "general classification";

(dd) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(ee) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(ff) "EEG (Electroencephalogram)," only subcategory "general classification";

(gg) "Gastro-intestinal services," only subcategory "general classification";

(hh) "Specialty room - Treatment/observation room," only subcategories "treatment room," and "observation room";

(ii) "Telemedicine," only subcategory "other telemedicine";

(jj) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "general classification";

(kk) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(ll) "Hemodialysis - Outpatient or home," only subcategory "general classification";

(mm) "Peritoneal dialysis - Outpatient or home," only subcategory "general classification";

(nn) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," only subcategory "general classification";

(oo) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," only subcategory "general classification";

(pp) "Miscellaneous dialysis," only subcategories "general classification," and "ultra filtration";

(qq) "Behavioral health treatments/services," only subcategory "electroshock treatment"; and

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," "pap smear," and "pregnancy test."

(2) The ((department)) agency pays for an outpatient hospital covered service in the following revenue code subcategories only when the outpatient hospital provider is approved by the ((department)) agency to provide the specific service((+s+)):

(a) "Clinic," subcategories "general classification," "dental clinic," and "other clinic"; and

(b) "Other therapeutic services," subcategories, "general classification," "education/training," "cardiac rehabilitation," and "other therapeutic service."

(3) The ((department)) agency does not pay for outpatient hospital services in the following revenue code categories and subcategories:

(a) "All_inclusive rate";

(b) "Room & board - Private (one bed)";

(c) "Room & board - Semi-private (two beds)";

(d) "Room & board - Semi-private (three and four beds)";

(e) "Room & board - Deluxe private";

(f) "Room & board - Ward";

(g) "Room & board - Other";

(h) "Nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit";

(l) "Coronary care unit";

(m) "Special charges";

(n) "Incremental nursing charge rate";

(o) "All_inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotic devices," and "oxygen - take home";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)," subcategories "rental," "purchase of new DME," "purchase of used DME," "supplies/drugs for DME effectiveness (home health agency only)," and "other equipment";

(u) "Laboratory," subcategory "other laboratory";

(v) "Laboratory pathology," subcategory "other laboratory pathological";

(w) "Radiology - Diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - Therapeutic and/or chemotherapy administration," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategories "organ transplant - other than kidney," "kidney transplant," and "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture" and "other anesthesia";

(cc) "Blood and blood components";

(dd) "Administration, processing and storage for blood and blood component," subcategory "other processing and storage";

(ee) "Other imaging," subcategory "other imaging service";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy services," subcategory "other physical therapy";

(hh) "Occupational therapy services," subcategory "other occupational therapy";

(ii) "Speech therapy - Language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening" and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology," subcategory "other audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services";

(pp) "Clinic," subcategories "chronic pain center," "psychiatric clinic," "OB-GYN clinic," "pediatric clinic," "urgent care clinic," and "family practice clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance";

(tt) "Home health (HH) - Skilled nursing";

(uu) "Home health (HH) - Medical social services";

(vv) "Home health (HH) - Aide";

(ww) "Home health (HH) - Other visits";

(xx) "Home health (HH) - Units of service";

(yy) "Home health (HH) - Oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";

(aaa) "Medical/surgical supplies - Extension," only subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Speciality room - Treatment/observation room," subcategories "general classification" and "other speciality rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine," subcategory "general classification";

(ppp) "Extra-corporal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - Outpatient or home," subcategories "hemodialysis/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient hemodialysis (home)";

(ttt) "Peritoneal dialysis - Outpatient or home," subcategories "peritoneal/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient peritoneal dialysis (home)";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - Outpatient or home," subcategories "CAPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient CAPD (home)";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - Outpatient or home," subcategories "CCPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient CCPD (home)";

(www) "Miscellaneous dialysis," subcategories "home dialysis aid visit" and "other miscellaneous dialysis";

(xxx) "Behavioral health treatments/services," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive outpatient services - chemical dependency," and "community behavioral health program (day treatment)";

(yyy) "Behavioral health treatment/services (extension)";

(zzz) "Other diagnostic services," subcategories "allergy test" and "other diagnostic services";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services - extension," subcategories "recreational therapy," "drug rehabilitation," "alcohol rehabilita-

tion," "complex medical equipment - routine," "complex medical equipment - ancillary," "athletic training," and "kinesiotherapy";
(cccc) "Professional fees";
(dddd) "Patient convenience items"; and
(eeee) Revenue code categories and subcategories that are not identified in this section.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1600 Specific items/services not covered. The ((~~department~~)) medicaid agency does not pay for an inpatient or outpatient hospital service, treatment, equipment, drug, or supply that is not listed or referred to as a covered service in this chapter. The following list of noncovered items and services is not intended to be all-inclusive. Noncovered items and services include, but are not limited to:

- (1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;
- (2) Telephone/telegraph services or television/radio rentals;
- (3) Medical photographic or audio/videotape records;
- (4) Crisis counseling;
- (5) Psychiatric day care;
- (6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;
- (7) Standby personnel and travel time;
- (8) Routine hospital medical supplies and equipment such as bed scales;
- (9) Handling fees and portable X-ray charges;
- (10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;
- (11) Cafeteria charges; and
- (12) Services and supplies provided to nonpatients, such as meals and "father packs."

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1900 Transplant coverage. (1) The ((~~department~~)) medicaid agency pays for medically necessary transplant procedures only for eligible ((~~medical assistance~~)) Washington apple health clients who are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the alien emergency medical (AEM) program are not eligible for transplant coverage.

(2) The ((~~department~~)) agency covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the ((~~department~~)) agency as a "center of excellence" for transplant procedures and meet that hospital's criteria for establishing appropriateness and the medical necessity of the procedures:

- (a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas, and small bowel;
- (b) Bone marrow and peripheral stem cell (PSC);
- (c) Skin grafts; and
- (d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the ~~((department))~~ agency pays facility charges only to those hospitals that meet the standards and conditions:

- (a) Established by the ~~((department))~~ agency; and
- (b) Specified in WAC ~~((388-550-2100 and 388-550-2200))~~ 182-550-2100 and 182-550-2200.

(4) The ~~((department))~~ agency pays for skin grafts and corneal transplants to any qualified hospital, subject to the limitations in this chapter.

(5) The ~~((department))~~ agency deems organ procurement fees as being included in the payment to the transplant hospital. The ~~((department))~~ agency may make an exception to this policy and pay these fees separately to a transplant hospital when an eligible medical ~~((medical))~~ client is covered by a third-party payer ~~((which))~~ that will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The ~~((department))~~ agency, without requiring prior authorization, pays for up to fifteen matched donor searches per client approved for a bone marrow transplant. The ~~((department))~~ agency requires prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The ~~((department))~~ agency does not pay for experimental transplant procedures. In addition, the ~~((department))~~ agency considers as experimental those services including, but not limited to, the following:

- (a) Transplants of three or more different organs during the same hospital stay;
- (b) Solid organ and bone marrow transplants from animals to humans; and
- (c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The ~~((department))~~ agency pays for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

(9) The ~~((department))~~ agency pays for bone marrow, PSC, skin grafts, and corneal transplants when medically necessary.

(10) The ~~((department))~~ agency may conduct a post-payment retrospective utilization review as described in WAC ~~((388-550-1700))~~ 182-550-1700, and may adjust the payment if the ~~((department))~~ agency determines the criteria in this section are not met.

WAC 182-550-2100 Requirements—Transplant hospitals. This section applies to requirements for hospitals that perform the ~~((department))~~ medicaid agency-approved transplants described in WAC ~~((388-550-1900))~~ 182-550-1900(2).

(1) The ~~((department))~~ agency requires instate transplant hospitals to meet the following requirements ~~((in order))~~ to be paid for transplant services provided to ~~((medical assistance))~~ Washington apple health clients. A hospital must have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type~~((s))~~ of transplant procedure~~((s))~~ to be performed, except that the ~~((department))~~ agency does not require CON approval for a hospital that provides peripheral stem cell (PSC), skin graft or corneal transplant services;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that the ~~((department))~~ agency does not require UNOS approval for a hospital that provides PSC, skin graft, or corneal transplant services; and

(c) Been approved by the ~~((department))~~ agency as a center of excellence transplant center for the specific organ~~((s))~~ or procedure~~((s))~~ the hospital proposes to perform.

(2) The ~~((department))~~ agency requires an out-of-state transplant center, including bordering city and critical border hospitals, to be a medicare-certified transplant center in a hospital participating in that state's medicaid program. All out-of-state transplant services, excluding those provided in ~~((department))~~ agency-approved centers of excellence (COE) in bordering city and critical border hospitals, must be prior authorized.

(3) The ~~((department))~~ agency considers a hospital for approval as a transplant center of excellence when the hospital submits to the ~~((department))~~ agency a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members must be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The ~~((department))~~ agency considers this requirement met when the hospital submits to the ~~((department))~~ agency a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams must include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times; and

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.

(c) Other resources that the transplant hospital must have include:

(i) Pathology resources for studying and reporting the pathological responses of transplantation;

- (ii) Infectious disease services with both the professional skills and the laboratory resources needed to identify and manage a whole range of organisms; and
 - (iii) Social services resources.
 - (d) An organ procurement coordinator;
 - (e) A method ensuring that transplant team members are familiar with transplantation laws and regulations;
 - (f) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;
 - (g) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;
 - (h) Extensive blood bank support;
 - (i) Patient management plans and protocols; and
 - (j) Written policies safeguarding the rights and privacy of patients.
- (4) In addition to the requirements of subsection (3) of this section, the transplant hospital must:
- (a) Satisfy the annual volume and survival rates criteria for the particular transplant procedures performed at the hospital, as specified in WAC (~~(388-550-2200)~~) 182-550-2200(2).
 - (b) Submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the hospital:
 - (i) Participates in the national donor procurement program and network; and
 - (ii) Systematically collects and shares data on its transplant (~~(program(s))~~) programs with the network.
- (5) The (~~(department)~~) agency applies the following specific requirements to a PSC transplant hospital:
- (a) A PSC transplant hospital must be (~~(a department)~~) an agency-approved COE to perform any of the following PSC services:
 - (i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;
 - (ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and
 - (iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.
 - (b) A (~~(PCS-[PSC])~~) PSC transplant hospital may purchase PSC processing and harvesting services from other (~~(department)~~) agency-approved processing providers.
- (6) The (~~(department)~~) agency does not pay a PSC transplant hospital for AABB inspection and certification fees related to PSC transplant services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2200 Transplant requirements—COE. (1) The (~~(department)~~) medicaid agency measures the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the (~~(department)~~) agency, the (~~(department)~~) agency applies these criteria to a hospital during both initial and periodic evaluations for designation as a transplant COE.

The COE performance criteria (~~(shall)~~) must include, but not be limited to:

- (a) Meeting annual volume requirements for the specific transplant procedures for which approved;
- (b) Patient survival rates; and
- (c) Relative cost per case.

(2) A transplant COE must meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

- (a) Twelve or more heart transplants;
- (b) Ten or more lung transplants;
- (c) Ten or more heart-lung transplants;
- (d) Twelve or more liver transplants;
- (e) Twenty-five or more kidney transplants;
- (f) Eighteen or more pancreas transplants;
- (g) Eighteen or more kidney-pancreas transplants;
- (h) Ten or more bone marrow transplants; and
- (i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant hospital within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the (~~(department)~~) agency for conditional approval as a transplant COE. The (~~(department)~~) agency considers the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the department of health (DOH).

(4) An in-state hospital granted conditional approval by the (~~(department)~~) agency as a transplant COE must meet the (~~(department's)~~) agency's criteria, as established in this chapter, within one year of the conditional approval. The (~~(department)~~) agency must automatically revoke such conditional approval for any hospital (~~(which)~~) that fails to meet the (~~(department's)~~) agency's published criteria within the allotted one year period, unless:

(a) The hospital submits a written request for extension of the conditional approval thirty calendar days (~~(prior to)~~) before the expiration date; and

(b) (~~(Such)~~) The request is granted by the (~~(department)~~) agency.

(5) A transplant center of excellence must meet medicare's survival rate requirements for the transplant procedure(~~(+)~~s(~~(+)~~) performed at the hospital.

(6) A transplant COE must submit to the (~~(department)~~) agency annually, at the same time the hospital submits a copy of its medicare cost report (Form 2552-96) documentation showing:

(a) The numbers of transplants performed at the hospital during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7) Transplant hospitals must:

(a) Submit to the (~~(department)~~) agency, within sixty days of the date of the hospital's approval as a COE, a complete set of the comprehensive patient selection criteria and treatment protocols used by the hospital for each transplant procedure it has been approved to perform.

(b) Submit to the ((department)) agency annual updates to the documents listed in ((subsection)) (a) of this ((section)) subsection, or ((whenever)) when the hospital makes a change to the criteria ((and/)) or protocols.

(c) Notify the ((department)) agency if no changes occurred during a reporting period.

(8) The ((department)) agency evaluates compliance with the provisions of WAC ((388-550-2100-(2)(d) and (e))) 182-550-2100(3) based on the protocols and criteria submitted to the ((department)) agency by a transplant COE ((in accordance with)) under subsection (7) of this section. The ((department)) agency terminates a hospital's designation as a transplant COE if a review or audit finds that hospital in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9) The ((department)) agency:

(a) Provides notification to a transplant COE it finds in noncompliance with subsection (8) of this section, and may allow from the date of notification sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) Does not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC ((388-502-0030)) 182-502-0030;

(c) Requires, within six months of submitting a plan to correct a breach of compliance, a center to report that:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting ((such)) the breach of compliance exists.

(10) The ((department)) agency periodically reviews the list of approved transplant COEs. The ((department)) agency may limit the number of hospitals it designates as a transplant COE or contracts with to provide services to ((medical assistance)) Washington apple health clients if, in the ((department's)) agency's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The ((department)) agency pays ((a department)) an agency-approved COE for covered transplant procedures using methods identified in chapter ((388-550)) 182-550 WAC.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2301 Hospital and medical criteria requirements for bariatric surgery. (1) The ((department)) medicaid agency pays a hospital for bariatric surgery and bariatric surgery-related services only when the surgery is provided in an inpatient hospital setting and only when:

(a) The client qualifies for bariatric surgery by successfully completing all requirements under WAC ((388-531-1600)) 182-531-1600;

(b) The client continues to meet the criteria to qualify for bariatric surgery under WAC ((388-531-1600)) 182-531-1600 up to the actual surgery date;

(c) The hospital providing the bariatric surgery and bariatric surgery-related services meets the requirements in this section and other applicable WAC; and

(d) The hospital receives prior authorization from the ~~((department prior to))~~ agency before performing a bariatric surgery for a ~~((medical assistance))~~ Washington apple health client.

(2) A hospital must meet the following requirements ~~((in order))~~ to be paid for bariatric surgery and bariatric surgery-related services provided to an eligible ~~((medical assistance))~~ Washington apple health client. The hospital must:

(a) Be approved by the ~~((department))~~ agency to provide bariatric surgery and bariatric surgery-related services and~~((+))~~:

(i) For dates of admission ~~((on or))~~ after ~~((July 1))~~ June 30, 2007, be located in Washington state or approved bordering cities (see WAC ~~((388-501-0175))~~ 182-501-0175).

(ii) For dates of admission ~~((on or))~~ after ~~((July 1))~~ June 30, 2007, be located in Washington state, or be ~~((a department))~~ an agency-designated critical border hospital.

(b) Have an established bariatric surgery program in operation under which at least one hundred bariatric surgery procedures have been performed. The program must have been in operation for at least five years and be under the direction of an experienced board-certified surgeon. In addition, ~~((department))~~ the agency requires the bariatric surgery program to:

(i) Have a mortality rate of two percent or less;

(ii) Have a morbidity rate of fifteen percent or less;

(iii) Document patient follow-up for at least five years postsurgery;

(iv) Have an average loss of at least fifty percent of excess body weight achieved by patients at five years postsurgery; and

(v) Have a reoperation or revision rate of five percent or less.

(c) Submit documents to the ~~((department's))~~ agency's division of health care services that verify the performance requirements listed in this section.

(3) The ~~((department))~~ agency waives the program requirements listed in subsection (2)(b) of this section if the hospital participates in a statewide bariatric surgery quality assurance program such as the surgical Clinical Outcomes Assessment Program (COAP).

(4) See WAC ~~((388-531-1600))~~ 182-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(5) Authorization does not guarantee payment. Authorization for bariatric surgery and bariatric surgery-related services is valid only if:

(a) The client is eligible on the date of admission and date of service; and

(b) The hospital and professional providers meet~~((s))~~ the criteria in this section and other applicable WAC to perform bariatric surgery ~~((and/))~~ or to provide bariatric surgery-related services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2400 Inpatient chronic pain management services.

(1) The ~~((department))~~ medicaid agency pays a hospital that is specif-

ically approved by the ((department)) agency to provide inpatient chronic pain management services, an all-inclusive per diem facility fee. The ((department)) agency pays professional fees for chronic pain management services to performing providers ((in accordance with the department's)) under the agency's fee schedule.

(2) A client qualifies for inpatient chronic pain management services when all ((of)) the following apply:

(a) The client has had pain for at least three months and has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done ((in relation to)) concerning the pain problem; and

(c) A client with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs and/or alcohol for at least six months.

(3) The ((department)) agency:

(a) Covers inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) Pays for only one inpatient hospital stay, up to a maximum of twenty-one consecutive days, for chronic pain management training per a client's lifetime.

(c) Does not require prior authorization for chronic pain management services.

(d) Does not pay for services unrelated to the chronic pain management services that are provided during the client's inpatient stay, unless the hospital requests and receives prior authorization from the ((department)) agency.

(4) All applicable claim payment adjustments for client responsibility, third party liability, medicare crossover, etc., apply to the ((department)) agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2431 Hospice services—Inpatient payments. See chapter ((388-551)) 182-551 WAC((7)) Alternatives to hospital services, subchapter I—Hospice services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2500 Inpatient hospice services. (1) The ((department)) medicaid agency pays hospice agencies participating in the ((medical assistance)) Washington apple health program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of ((such)) the inpatient services; and

(b) ((Such)) The services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies must bill the ((department)) agency for their services using revenue codes. The ((department)) agency pays hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The ((department)) agency pays hospital providers directly ((pursuant)) according to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. Acute physical medicine and rehabilitation (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. The ((department)) medicaid agency requires prior authorization for acute PM&R services. (See WAC ((388-550-2561)) 182-550-2561 for prior authorization requirements.)

(1) An interdisciplinary team coordinates individualized acute PM&R services at ((a department)) an agency-approved rehabilitation hospital to achieve the following for a client:

- (a) Improved health and welfare; and
- (b) Maximum physical, social, psychological, and educational or vocational potential.

(2) The ((department)) agency determines and authorizes a length of stay based on:

- (a) The client's acute PM&R needs; and
- (b) Community standards of care for acute PM&R services.

(3) When the ((department's)) agency's authorized acute period of rehabilitation ends, the hospital provider discharges the client to the client's residence, or to an appropriate level of care. Therapies may continue to help the client achieve maximum potential through other ((department)) agency programs such as:

- (a) Home health services;
- (b) Nursing facilities;
- (c) Outpatient physical, occupational, and speech therapies; or
- (d) Neurodevelopmental centers.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2531 Requirements for becoming an acute PM&R provider. (1) Before August 1, 2007, only an in-state or bordering city hospital may apply to become a ((department)) medicaid agency-approved acute PM&R hospital. ((On and after August 1)) After July 31, 2007 an instate, bordering city((τ)) or critical border hospital may apply to become ((a department)) an agency-approved acute PM&R hospital. To ap-

ply, the ((department)) agency requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Division of Health Care Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia, WA 98504-5506

(2) A hospital that applies to become ((a-department)) an agency-approved acute PM&R facility must provide the ((department)) agency with documentation that confirms the facility is all ((of)) the following:

(a) A medicare-certified hospital;
(b) Accredited by the joint commission on accreditation of health care organizations (JCAHO);
(c) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010;

(d) Commission on accreditation of rehabilitation facilities (CARF) accredited as a comprehensive integrated inpatient rehabilitation program or as a pediatric family centered rehabilitation program, unless subsection (3) of this section applies;

(e) For dates of admission before July 1, 2007, contracted under the ((department's)) agency's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the ((department)) agency; and

(f) Operating per the standards set by DOH (excluding the certified rehabilitation registered nurse (CRRN) requirement) in either:

(i) WAC ((246-976-830,)) 246-976-800 Level I trauma rehabilitation designation; or

(ii) WAC ((246-976-840,)) 246-976-800 Level II trauma rehabilitation designation.

(3) A hospital not yet accredited by CARF:

(a) May apply for or be awarded a twelve-month conditional written approval by the ((department)) agency if the facility:

(i) Provides the ((department)) agency with documentation that it has started the process of obtaining full CARF accreditation; and

(ii) Is actively operating under CARF standards.

(b) ((Is required to)) Must obtain full CARF accreditation within twelve months of the ((department's)) agency's conditional approval date. If this requirement is not met, the ((department)) agency sends a letter of notification to revoke the conditional approval.

(4) A hospital qualifies as ((a-department)) an agency-approved acute PM&R hospital when:

(a) The hospital meets all the applicable requirements in this section;

(b) The ((department's)) agency's clinical staff has conducted a facility site visit; and

(c) The ((department)) agency provides written notification that the hospital qualifies to be paid for providing acute PM&R services to eligible ((medical-assistance)) Washington apple health clients.

(5) The ((department)) agency-approved acute PM&R hospitals must meet the general requirements in chapter ((388-502)) 182-502 WAC((7)) Administration of medical programs—Providers.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2541 Quality of care—(~~Department~~) Agency-approved acute PM&R hospital. (1) To ensure quality of care, the (~~department~~) medicaid agency may conduct reviews (e.g., post-pay, on-site) of any (~~department~~) agency-approved acute PM&R hospital.

(2) A provider of acute PM&R services must act on any report of substandard care or violation of the hospital's medical staff bylaws and CARF standards. The provider must have and follow written procedures that:

(a) Provide a resolution to either a complaint or grievance or both; and

(b) Comply with applicable CARF standards for adults or pediatrics as appropriate.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of health care organizations (JCAHO);

(c) CARF;

(d) The (~~department~~) agency; or

(e) Other agencies with review authority for the (~~department's~~) medicaid agency's programs.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2561 The (~~department's~~) agency's prior authorization requirements for acute PM&R services. (1) The (~~department~~) medicaid agency requires prior authorization for acute PM&R services. The acute PM&R provider of services must obtain prior authorization:

(a) Before admitting a client to the rehabilitation unit; and

(b) For an extension of stay before the client's current authorized period of stay expires.

(2) For an initial admit:

(a) A client must:

(i) Be eligible under one of the programs listed in WAC (~~(388-550-2521)~~) 182-550-2521, subject to the restrictions and limitations listed in that section;

(ii) Require acute PM&R services as determined in WAC (~~(388-550-2551)~~) 182-550-2551;

(iii) Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program; and

(iv) Be willing and capable to participate at least three hours per day, seven days per week, in acute PM&R activities.

(b) The acute PM&R provider of services must:

(i) Submit a request for prior authorization to the (~~department's~~) agency's clinical consultation team by fax, electronic mail, or telephone as published in the (~~department's~~) agency's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify that:

(A) Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care ~~((and/))~~ or independence;

(B) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive acute PM&R services be provided in ~~((a department))~~ an agency-approved acute PM&R facility; and

(C) The client suffers from severe disabilities including, but not limited to, neurological ~~((and/))~~ or cognitive deficits.

(3) For an extension of stay:

(a) A client must meet the conditions listed in subsection (2)(a) of this section and have observable and significant improvement; and

(b) The acute PM&R provider of services must:

(i) Submit a request for the extension of stay to the ~~((department))~~ agency clinical consultation team by fax, electronic mail, or telephone as published in the ~~((department's))~~ agency's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify the extension and include documentation that the client's condition has observably and significantly improved.

(4) If the ~~((department))~~ agency denies the request for an extension of stay, the client must be transferred to an appropriate lower level of care as described in WAC ~~((388-550-2501))~~ 182-550-2501(3).

(5) The ~~((department's))~~ agency's clinical consultation team approves or denies authorization for acute PM&R services for initial stays or extensions of stay based on individual circumstances and the medical information received. The ~~((department))~~ agency notifies the client and the acute PM&R provider of a decision.

(a) If the ~~((department))~~ agency approves the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The allowed dates of service;

(iii) ~~((A department))~~ An agency-assigned authorization number;

(iv) Applicable limitations to the authorized services; and

(v) The ~~((department's))~~ agency's process to request additional services.

(b) If the ~~((department))~~ agency denies the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The reason for the denial;

(iii) Alternative services available for the client; and

(iv) The client's right to request a fair hearing. (See subsection (7) of this section.)

(6) A hospital or other facility intending to transfer a client to ~~((a department))~~ an agency-approved acute PM&R hospital ~~((, and/or a department))~~ or an agency-approved acute PM&R hospital requesting an extension of stay for a client ~~((,))~~ must:

(a) Discuss the ~~((department's))~~ agency's authorization decision with the client ~~((and/))~~ or the client's legal representative; and

(b) Document in the client's medical record that the ~~((department's))~~ agency's decision was discussed with the client ~~((and/))~~ or the client's legal representative.

(7) A client who does not agree with a decision regarding acute PM&R services has a right to a fair hearing under chapter ~~((388-02))~~ 182-526 WAC. After receiving a request for a fair hearing, the ~~((department))~~ agency may request additional information from the client and the facility, or both. After the ~~((department))~~ agency reviews the available information, the result may be:

(a) A reversal of the initial ~~((department))~~ agency decision;

- (b) Resolution of the client's issue(s); or
- (c) A fair hearing conducted per chapter ~~((388-02))~~ 182-526 WAC.
- (8) The ~~((department))~~ agency may authorize administrative ~~((day(s)))~~ days for a client who:
 - (a) Does not meet requirements described in subsection (3) of this section; or
 - (b) Is waiting for a discharge destination or a discharge plan.
- (9) The ~~((department))~~ agency does not authorize acute PM&R services for a client who:
 - (a) Is deconditioned by a medical illness or by surgery; or
 - (b) Has loss of function primarily as a result of a psychiatric condition~~((s)))~~; or
 - (c) Has had a recent surgery and has no complicating neurological deficits. Examples of surgeries that do not qualify a client for inpatient acute PM&R services without extenuating circumstances are:
 - (i) Single amputation;
 - (ii) Single extremity surgery; and
 - (iii) Spine surgery.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2565 The long-term acute care (LTAC) program—General. The long-term acute care (LTAC) program is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a ~~((department))~~ medicaid agency-approved LTAC hospital during the acute phase of a client's care. The ~~((department))~~ agency requires prior authorization for LTAC stays. See WAC ~~((388-550-2590))~~ 182-550-2590 for prior authorization requirements.

(1) A facility's multidisciplinary team coordinates individualized LTAC services at ~~((a department))~~ an agency-approved LTAC hospital.

(2) The ~~((department))~~ agency determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in WAC ~~((388-550-2590))~~ 182-550-2590.

(3) When the ~~((department))~~ agency-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2575 Client eligibility requirements for LTAC services. Only a client who is eligible for one of the following programs may receive LTAC services, subject to the restrictions and limitations in WAC ~~((388-550-2565, 388-550-2570, 388-550-2580, 388-550-2585, 388-550-2590, 388-550-2595, 388-550-2596))~~ 182-550-1050, 182-550-2565,

182-550-2580, 182-550-2585, 182-550-2590, 182-550-2595, 182-550-2596,
and other rules:

- (1) Categorically needy program (CNP);
- (2) State children's health insurance program (SCHIP);
- (3) Limited casualty program - Medically needy program (LCP-MNP);
- (4) Alien emergency medical (AEM)(CNP); or
- (5) Alien emergency medical (AEM)(LCP-MNP).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2580 Requirements for becoming an LTAC hospital.

(1) To apply to become a ~~((department))~~ medicaid agency-approved long-term acute care (LTAC) hospital, the ~~((department))~~ agency requires a hospital to:

(a) Submit a letter of request to:

LTAC Program Manager
Division of Health Care Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia WA 98504-5506; and

(b) Include in the letter required under (a) of this subsection, documentation that confirms the hospital is:

- (i) Medicare-certified for LTAC;
- (ii) Accredited by the joint commission on accreditation of health care organizations (JCAHO);
- (iii) Licensed as an acute care hospital by the department of health (DOH) under chapter 246-320 WAC (if an in-state hospital), or by the state in which the hospital is located (if an out-of-state hospital); and
- (iv) Enrolled with the ~~((department))~~ agency as a medicaid participating provider.

(2) A hospital qualifies as ~~((a department))~~ an agency-approved LTAC hospital when:

- (a) The hospital meets all the requirements in this section;
- (b) The ~~((department's))~~ agency's clinical staff has conducted an on-site visit and recommended approval of the hospital's request for LTAC designation; and
- (c) The ~~((department))~~ agency provides written notification to the hospital that it qualifies for payment when providing LTAC services to eligible ~~((medical assistance))~~ Washington apple health clients.

(3) ~~((Department))~~ Agency-approved LTAC hospitals must meet the general requirements in chapter ~~((388-502))~~ 182-502 WAC.

(4) The ~~((department))~~ agency may, in its sole discretion, approve a hospital located in Idaho or Oregon that is not in a designated bordering city as an LTAC hospital if:

- (a) The hospital meets the requirements of this section; and
- (b) The hospital provider signs a contract with the ~~((department))~~ agency agreeing to the payment rates established for LTAC services in accordance with WAC ~~((388-550-2595))~~ 182-550-2595.

(5) The ~~((department))~~ agency does not have any legal obligation to approve any hospital or other entity as an LTAC hospital.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2585 LTAC hospitals—Quality of care. (1) To ensure quality of care, the ~~((department))~~ medicaid agency may conduct post-pay or on-site reviews of any ~~((department))~~ agency-approved LTAC hospital. See chapter 182-502A WAC ~~((388-502-0240, Audits and the audit appeal process for contractors/providers,))~~ for additional information on audits conducted by ~~((department))~~ agency staff.

(2) A provider of LTAC services must act on any reports of sub-standard care or violations of the hospital's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or grievance or both.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of health care organizations (JCAHO);

(c) The ~~((department))~~ agency; or

(d) Other agencies with review authority for the ~~((department's))~~ agency's programs.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

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

(a) For an initial thirty-day stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC ~~((388-550-2575))~~ 182-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC ~~((388-550-2570))~~ 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 ~~((department))~~ agency by fax, electronic mail, or telephone, as published in the ~~((department's))~~ agency's LTAC billing instructions;

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

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

(D) Meet all the requirements in WAC ~~((388-550-2580))~~ 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 ~~((department))~~ agency with sufficient medical justification.

(2) The ((department)) 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 ((388-02)) 182-526 WAC. After receiving a request for a fair hearing, the ((department)) agency may request additional information from the client and the facility, or both. After the ((department)) agency reviews the available information, the result may be:

(a) A reversal of the initial ((department)) agency decision;

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

(c) A fair hearing conducted ((per chapter 388-02)) according to chapter 182-526 WAC.

(4) The ((department)) agency may authorize an administrative day rate payment 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.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2595 Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate. (1) In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the following (see the ((department's)) medicaid agency's LTAC billing instructions for applicable revenue codes):

(a) Room and board - Rehabilitation;

(b) Room and board - Intensive care;

(c) Pharmacy - Up to and including two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and((/or)) epogen((/)) or neupogen therapy;

(d) Medical/surgical supplies and devices;

(e) Laboratory - General;

(f) Laboratory - Chemistry;

(g) Laboratory - Immunology;

(h) Laboratory - Hematology;

(i) Laboratory - Bacteriology and microbiology;

(j) Laboratory - Urology;

(k) Laboratory - Other laboratory services;

(l) Respiratory services;

(m) Physical therapy;

(n) Occupational therapy; and

(o) Speech-language therapy.

(2) The ((department)) agency pays the LTAC hospital for services covered by the LTAC fixed per diem rate by the rate in effect at the date of admission, minus the sum of:

(a) Client liability, whether or not collected by the provider;
and

(b) Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:

(i) Insurers and indemnitors;

(ii) Other federal or state health care programs;

(iii) Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and

(iv) Any other contractual or legal entitlement of the client, including, but not limited to:

(A) Crime victims' compensation;

(B) Workers' compensation;

(C) Individual or group insurance;

(D) Court-ordered dependent support arrangements; and

(E) The tort liability of any third party.

(3) The ~~((department))~~ agency may make annual rate increases to the LTAC fixed per diem rate by using a vendor rate increase. The ~~((department))~~ agency may rebase the LTAC fixed per diem rate periodically.

(4) When the ~~((department))~~ agency establishes a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the ~~((department))~~ agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2596 Services and equipment covered by the ~~((department))~~ agency but not included in the LTAC fixed per diem rate. (1) The ~~((department))~~ medicaid agency uses the ratio of costs-to-charges (RCC) payment method to pay an LTAC hospital for the following that are not included in the LTAC fixed per diem rate:

(a) Pharmacy - After the first two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and ~~((+or+))~~ epogen ~~((+))~~ or neupogen therapy;

(b) Radiology services;

(c) Nuclear medicine services;

(d) Computerized tomographic (CT) scan;

(e) Operating room services;

(f) Anesthesia services;

(g) Blood storage and processing;

(h) Blood administration;

(i) Other imaging services - Ultrasound;

(j) Pulmonary function services;

(k) Cardiology services;

(l) Recovery room services;

(m) EKG/ECG services;

(n) Gastro-intestinal services;

(o) Inpatient hemodialysis; and

(p) Peripheral vascular laboratory services.

(2) The ((department)) agency uses the appropriate inpatient or outpatient payment method described in other published WAC to pay providers other than LTAC hospitals for services and equipment that are covered by the ((department)) agency but not included in the LTAC fixed per diem rate. The provider must bill the ((department)) agency directly and the ((department)) agency pays the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC hospital, or related to transporting a client to another facility after discharge from the LTAC hospital:

(a) Are not covered or reimbursed through the LTAC fixed per diem rate;

(b) Are not payable directly to the LTAC hospital;

(c) Are subject to the provisions in chapter ((388-546)) 182-546 WAC; and

(d) Must be billed directly to the:

(i) ((Department)) Agency by the transportation company to be reimbursed if the client required ambulance transportation; or

(ii) ((Department's)) Agency's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter ((388-546)) 182-546 WAC, if the client:

(A) Required nonemergency transportation; or

(B) Did not have a medical condition that required transportation in a prone or supine position.

(4) The ((department)) agency evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves ((such)) the services beyond those limitations or restrictions under ((the provisions of WAC 388-501-0165 and 388-501-0169)) WAC 182-501-0165 and 182-501-0169.

(5) When the ((department)) agency established a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the ((department)) agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-2598 Critical access hospitals (CAHs). (1) The following definitions and abbreviations and those found in ((WAC 388-500-0005 and 388-550-1050)) chapter 182-500 WAC and WAC 182-182-1050 apply to this section:

(a) "CAH((7))" see "critical access hospital."

(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled medicare cost report (Form 2552-96) after the end of the CAH's HFY.

(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.

(d) (~~("Departmental weighted costs to charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (5) of this section for how the department calculates a DWCC rate.~~

~~(e) "DWCC rate" see "departmental weighted costs to charges (DWCC) rate."~~

~~(f)) "HFY" see "Hospital fiscal year."~~

~~((g)) (e) "Hospital fiscal year" means each individual hospital's medicare cost report fiscal year.~~

~~((h)) (f) "Interim CAH payment" means the actual payment the ((department)) medicaid agency makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate ((DWCC)) weighted costs-to-charges (WCC) rate, as determined by the ((department)) agency.~~

~~((i)) (g) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's medicare cost report.~~

~~(h) "Weighted costs-to-charges (WCC) rate" means a rate the agency uses to determine a CAH payment. See subsection (5) of this section for how the agency calculates a WCC rate.~~

~~(i) "WCC rate" see "weighted costs-to-charges rate."~~

(2) To be paid as a CAH by the ((department)) agency, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the ((department)) agency upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter ((388-502)) 182-502 WAC. For information on audits and the audit appeal process, see ((WAC-388-502-0240)) chapter 182-502A WAC.

(3) The ((department)) agency pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service ((medical assistance)) Washington apple health clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using ((departmental)) weighted costs-to-charges ((+DWCC)) WCC rates and a retrospective cost settlement process. The ((department)) agency pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, ((DWCC)) WCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The ((department)) agency considers managed care health options and MHD designee ((DWCC)) WCC payment rates to be cost. Cost settlements are not performed by the ((department)) agency for managed care claims.

(5) The ((department)) agency prospectively calculates fee-for-service and managed care inpatient and outpatient ((DWCC)) WCC rates separately for each CAH.

(a) ((Prior to the department's)) Before the agency's calculation of the prospective interim inpatient ((DWCC)) WCC and outpatient ((DWCC)) WCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the ((department)) agency:

(i) Within twenty working days of receiving the request from the ((department)) agency, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the medicare cost report the CAH initially submits to the medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same medicare cost report;

(iii) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's medicare cost report;

(iv) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the ((department)) agency provides to the CAH from the ((department's)) agency's CAH ((DWCC)) WCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the ((department)) agency that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the ((department's)) agency's CAH ((DWCC)) WCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The ((department)) agency:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH ((DWCC)) WCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely submit the document, the ((department)) agency may use the CAH ((DWCC)) WCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH ((DWCC)) WCC rate calculation model when the ((department)) agency calculates the ((DWCC)) WCC rates. This is a standard the ((department)) agency follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH ((DWCC)) WCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the medicare cost report. (For example, a CAH reports to the ((department)) agency that in the ((department's)) agency's standard radiology cost center grouping in the CAH ((DWCC)) WCC rate calculation model, the hospital has established three costs centers in the medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the ((department)) agency combines these three cost centers under the standard radiology cost center grouping. No unbundling of the standard cost center grouping is allowed.)

(c) The ((department)) agency:

(i) Obtains from its medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:

(A) ((Medical-assistance)) Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);

(D) Claim allowed charges, third party liability, client paid amounts, and ~~((department))~~ agency paid amounts; and

(E) Units of service.

(ii) Obtains Level III trauma payment data from the department of health (DOH).

(iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.

(iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:

(A) ~~((Medical assistance))~~ Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and

(D) Claim allowed charges.

(v) Separates the inpatient claims data and outpatient hospital claims data;

(vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" medicare cost report the CAH initially submits to the ~~((department))~~ agency.

(vii) Uses the claims classifications and cost center combinations as defined in the ~~((department's))~~ agency's CAH ~~((DWCC))~~ WCC rate calculation model;

(viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;

(x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);

(xi) Determines the ~~((departmental))~~ agency-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;

(xii) Sums all:

(A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.

(B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.

(xiii) Sums all:

(A) ~~((Departmental))~~ Agency-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

(B) ~~((Departmental))~~ Agency-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.

(xiv) Multiplies each hospital's total ((departmental)) agency-weighted costs from (c)(xiii) of this subsection by the centers for medicare and medicaid services (CMS) medicare market basket inflation rate to update costs from the HFY to the rate setting period. The medicare market basket inflation rate is published and updated by CMS periodically;

(xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is not submitted timely by the hospital (see (a)(i) of this subsection), the ((department)) agency will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient ((DWCC)) WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(B) The outpatient ((DWCC)) WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective ((DWCC)) WCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) MCO clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(7) For a newly licensed hospital that is also a CAH, the ((department)) agency uses the current statewide average ((DWCC)) WCC rates for the initial prospective ((DWCC)) WCC rates.

(8) For a CAH that comes under new ownership, the ((department)) agency uses the prior owner's ((DWCC)) WCC rates until:

(a) The new owner submits its first "as filed" medicare cost report to the medicare fiscal intermediary, and at the same time to the ((department)) agency, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The ((department)) agency has calculated new ((DWCC)) WCC rates based on the new owner's "as filed" medicare cost report and other timely submitted documents.

(9) In addition to the prospective managed care inpatient and outpatient ((DWCC)) WCC rates, the ((department)) agency:

(a) Incorporates the ((DWCC)) WCC rates into the calculations for the ((department's)) agency's MCO capitated premium that will be paid to the MCO plan; and

(b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient ((DWCC)) WCC rates applicable to managed care claims. For purposes of this section, the ((department)) agency considers the ((DWCC)) WCC rates used to pay CAHs for care given to clients enrolled in an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the ((department)) agency uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" medicare cost report

data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the ~~((department))~~ agency:

(a) Compares actual ~~((department))~~ agency total interim CAH payments to the ~~((departmental))~~ agency-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, ~~((department))~~ agency claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The ~~((department))~~ agency recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The ~~((department))~~ agency performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the ~~((department))~~ agency uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the ~~((department))~~ agency by the sixtieth day of the hospital's receipt of that medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for ~~((department))~~ agency programs.

(14) The ~~((department))~~ agency pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than ~~((DWCC))~~ WCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the ~~((department))~~ agency uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission ~~((on and after August 1))~~ after July 31, 2007, the ~~((department))~~ agency uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The ~~((department))~~ agency may conduct a post pay or on-site review of any CAH.

WAC 182-550-2600 Inpatient psychiatric services. (1) The (~~de-~~partment) medicaid 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 (~~medical assistance~~) 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 (~~388-550-0005 and 388-550-1050~~) 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 (~~medical assistance~~) 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 (~~medical assistance~~) 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 (~~persons~~) 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 trans-

fer. 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 ~~((medical assistance))~~ Washington apple health client. Retrospective authorization can be ~~((prior to))~~ 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 ~~((medical assistance))~~ 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 ~~((medical assistance))~~ 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 ~~((prior to))~~ 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 ~~((388-502-0100))~~ 182-502-0100; and

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

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

(A) Be medically necessary as defined in WAC ~~((388-500-0005))~~ 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 ~~((medical assistance))~~ Washington apple health program, the ~~((department))~~ agency pays secondary to medicare.

(iii) For a client eligible for both medicare and a ~~((medical assistance))~~ 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 ~~((in accordance with))~~ under medicare standards.

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

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

(ii) Must meet the applicable general conditions of payment criteria in WAC ~~((388-502-0100))~~ 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 ~~((medical assistance))~~ 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 ~~((medical assistance))~~ 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 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 ~~((prior to))~~ 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 ~~((prior to))~~ before the transfer.

(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 ~~((prior to))~~ 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 ~~((medical assistance))~~ 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 ~~((department))~~ agency uses the payment methods described in WAC ~~((388-550-2650 through 388-550-5600))~~ 182-550-2650 through 182-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to ~~((medical assistance))~~ Washington apple health clients, unless otherwise specified in this section.

(11) Covered days for a voluntary psychiatric admission are determined by ((a)) 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 ((prior to)) before the expiration of the previously authorized days. Extension requests may not be denied for a person 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 ((department)) agency pays the administrative day rate for any authorized days that meet the administrative day definition in WAC ((388-550-1050)) 182-550-1050, and when all ((of)) 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 ((medical assistance)) 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 ((medical assistance)) 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 ((department)) agency will recover any unauthorized days paid.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-3470 Payment method—Bariatric surgery—Per case rate. (1) The ((department)) medicaid agency:

(a) Pays for bariatric surgery provided in designated ((department)) agency-approved hospitals when all criteria established in WAC ((388-550-2301 and 388-550-3020)) 182-550-2301 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC ((~~388-550-2301~~)) 182-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the ((~~department~~)) agency determines the per case rate by using a hospital-specific medicare fee schedule rate the ((~~department~~)) agency used to pay for bariatric surgery.

(3) For dates of admission ((~~on and after August 1~~)) after July 31, 2007, the ((~~department~~)) agency determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the ((~~department's~~)) agency's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the ((~~department~~)) agency:

(i) Inflates the hospital-specific operating, capital, and direct medical education routine costs from the hospital's medicare cost report fiscal year to the mid-point of the state fiscal year.

(ii) Divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index in effect for the medicare inpatient prospective payment system federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations.

(b) To determine the statewide standardized weighted average cost per case by using the adjusted hospital-specific operating and capital costs derived in (a) of this subsection, the ((~~department~~)) agency:

(i) Adjusts the hospital-specific operating and capital costs to remove the indirect costs associated with approved medical education programs; then

(ii) Calculates the operating standardized amount by dividing statewide aggregate adjusted operating costs by the statewide aggregate number cases in the base year claims data; then

(iii) Calculates the capital standardized amount by dividing statewide aggregate adjusted capital costs by the statewide aggregate number of cases in the base year claims data.

(c) To make hospital-specific adjustments to the statewide operating and capital standardized amounts, the ((~~department~~)) agency:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all in-state hospitals operating standardized amount after making adjustments for the wage index and the indirect medical education. The ((~~department~~)) agency:

(A) To determine the labor portion, uses the factor established by medicare multiplied by the statewide operating standardized amount, then multiplies the labor portion of the operating standardized amount by (1.0 plus the most currently available hospital-specific medicare wage index); then

(B) Adds the nonlabor portion of the operating standardized amount to the labor portion derived in (c)(i)(A) of this subsection; then

(C) Multiplies the amount derived in (c)(i)(B) of this subsection by 1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor to derive the operating standardized amount for bariatric services; then

(D) Adjusts the hospital-specific operating standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index lev-

els between the base year data and the payment system implementation year.

(E) Calculates the statewide bariatric operating payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(i)(D) of this subsection for each hospital approved by the ((department)) agency to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of in-state hospitals approved by the ((department)) agency to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all in-state hospitals capital standardized amount after adjusting for the indirect medical education. The ((department)) agency:

(A) Multiplies the amount derived in (b)(iii) of this subsection by (1.0 plus the most currently available hospital-specific medicare capital indirect medical education factor) to derive the adjusted indirect medical education capital standardized amount for bariatric services.

(B) Adjusts the hospital-specific capital standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(C) Calculates the statewide bariatric capital payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(ii)(B) of this subsection for each hospital approved by the ((department)) agency to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of in-state hospitals approved by the ((department)) agency to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the in-state hospitals hospital-specific direct medical education weighted cost per case multiplied by the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year. The ((department)) agency calculates the statewide bariatric direct medical education standardized payment per case by:

(A) Multiplying the hospital-specific direct medical education weighted cost per case for each hospital approved by the ((department)) agency to provide bariatric services by the CMS PPS input price index; then

(B) Totaling the hospital-specific amounts derived in (iii)(A) of this subsection for each hospital approved by the ((department)) agency to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the ((department)) agency sums for each hospital the in-state statewide bariatric operating payment per case, the in-state statewide bariatric capital payment per case, and the hospital-specific direct medical education payment per case. (For critical border hospitals, the direct medical education payment per case is limited at the highest direct medical education payment per case amount for the in-state hospitals approved by the ((department)) agency to provide bariatric services.)

(e) The ((department)) agency adjusts the hospital-specific bariatric payment per case amount by a factor to achieve budget neutrality

for the state's aggregate inpatient payments for all hospital inpatient services.

(f) The ~~((department))~~ agency may make other necessary adjustments as directed by the legislature ~~((i.e.))~~ e.g., rate rebasing and other changes as directed by the legislature).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4200 Change in hospital ownership. (1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;
(b) A sale of an unincorporated sole proprietorship;
(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition, or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital must notify the ~~((department))~~ medicaid agency in writing ninety days ~~((prior to))~~ before the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the ~~((department))~~ agency sets the new provider's cost-based conversion factor (CBCF), conversion factor, per diem rates, per case rate, at the same level as the prior owner's, except as provided in subsection (4) ~~((below))~~ of this section.

(4) The ~~((department))~~ agency sets for a hospital formed as a result of a merger:

(a) A blended CBCF, conversion factor, per diem rate, per case rate, based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC ~~((388-550-4500))~~ 182-550-4500. Partial year cost reports will not be used for this purpose.

(5) The ~~((department))~~ agency recaptures depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

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

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

(b) The ((department)) agency does not pay for ancillary services provided during administrative days.

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

(d) The ((department)) 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 ((sub-acute)) subacute placement can be made.

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

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

(b) The ((department's)) 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 ((388-550-6000 and 388-550-7200)) 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 ((department)) agency allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving ((department)) agency-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The ((department)) agency does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4690 Authorization requirements and utilization review for hospitals eligible for CPE payments. This section does not apply to psychiatric certified public expenditure (CPE) inpatient hospital admissions. See WAC ((388-550-2600)) 182-550-2600.

(1) CPE inpatient hospital claims submitted to the ~~((department))~~ medicaid agency must meet all authorization and program requirements in WAC and current ~~((department))~~ agency-published issuances.

(2) The ~~((department))~~ agency performs utilization reviews of inpatient hospital:

(a) Admissions ~~((in accordance with))~~ under the requirements of 42 C.F.R. 456, subparts A through C; and

(b) Claims for compliance with medical necessity, appropriate level of care and the ~~((department's (or a department))~~ agency's (or an agency designee's) established length of stay (LOS) standards.

(3) For CPE inpatient admissions ~~((prior to))~~ before August 1, 2007, the ~~((department))~~ agency performs utilization reviews:

(a) Using the professional activity study (PAS) length of stay (LOS) standard in WAC ~~((388-550-4300))~~ 182-550-4300 on claims that qualified for ratio of costs-to-charges (RCC) payment ~~((prior to))~~ before July 1, 2005.

(b) On seven-day readmissions according to the diagnosis related group (DRG) payment method described in WAC ~~((388-550-3000 (5)(f)))~~ 182-550-3000 for claims that qualified for DRG payment ~~((prior to))~~ before July 1, 2005.

(4) For claims identified in this subsection, the ~~((department))~~ agency may request a copy of the client's hospital medical records and itemized billing statements. The ~~((department))~~ agency sends written notification to the hospital detailing the ~~((department's))~~ agency's findings. Any day of a client's hospital stay that exceeds the LOS standard:

(a) Is paid under a ~~((nonDRG))~~ non-DRG payment method if the ~~((department))~~ agency determines it to be medically necessary for the client at the acute level of care;

(b) Is paid as an administrative day (see WAC ~~((388-550-1050 and 388-550-4500))~~ 182-550-1050 and 182-550-4500(8)) if the ~~((department))~~ agency determines it to be medically necessary for the client at the subacute level of care; and

(c) Is not eligible for payment if the ~~((department))~~ agency determines it was not medically necessary.

(5) For CPE inpatient admissions ~~((on and after August 1))~~ after July 31, 2007, CPE hospital claims are subject to the same utilization review rules as ~~((nonCPE))~~ non-CPE hospital claims.

(a) LOS reviews may be performed under WAC ~~((388-550-4300))~~ 182-550-4300.

(b) All claims are subject to the ~~((department's))~~ agency's medical necessity review under WAC ~~((388-550-1700))~~ 182-550-1700(2).

(c) For inpatient hospital claims that involve a client's seven-day readmission, see WAC ~~((388-550-3000 (5)(f)))~~ 182-550-3000.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4700 Payment—Non-SCA participating hospitals. This section applies only for dates of admission before July 1, 2007. The hospital selective contracting program ends on June 30, 2007.

(1) In a selective contracting area (SCA), ~~((MAA))~~ the medicaid agency pays any qualified hospital for inpatient hospital services

provided to an eligible medical care client for treatment of an emergency medical condition.

(2) ((MAA)) The agency pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the ((department)) agency to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

<u>County</u>	<u>Community Travel Distance Standard</u>
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles

<u>County</u>	<u>Community Travel Distance Standard</u>
Yakima	15 miles

(b) If a client must travel outside his(+) or her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain ~~((such))~~ the services from a contracting hospital appropriate to the client's condition.

(3) ~~((MAA))~~ The agency requires prior authorization for all non-emergent admissions to nonparticipating hospitals in an SCA. See WAC ~~((388-550-1700-2)(a))~~ 182-550-1700.

(4) ~~((MAA))~~ The agency pays a licensed hospital all applicable medicare deductible and coinsurance amounts for inpatient services provided to medicaid clients who are also beneficiaries of medicare Part A subject to the medicaid maximum allowable as established in WAC ~~((388-550-1200))~~ 182-550-1200 (8)(a).

(5) The ~~((department))~~ agency pays any licensed hospital DRG-exempt services as listed in WAC ~~((388-550-4400))~~ 182-550-4400.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4925 Eligibility for DSH programs—New hospital providers. To be eligible for disproportionate share hospital (DSH) payments, a new hospital provider must have claims data, audited financial statements, and an "as filed" or finalized medicare cost report for the hospital base year used by the ~~((department))~~ medicaid agency in calculating DSH payments for the state fiscal year (SFY) for which the hospital provider is applying. See WAC ~~((388-550-4900))~~ 182-550-4900(9).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-4935 DSH eligibility—Change in hospital ownership. (1) For purposes of eligibility for disproportionate share hospital (DSH) payments, a change in hospital ownership has occurred if any of the criteria in WAC ~~((388-550-4200))~~ 182-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the ~~((department))~~ medicaid agency in writing no later than thirty days after the change in ownership becomes final. The notice must include the new entity's fiscal year end.

(3) A hospital that did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted, and changes ownership after that date is not eligible for DSH unless it continues to be classified as an acute care hospital serving pediatric and/or adult patients. See WAC ~~((388-550-4900))~~ 182-550-4900(5) for the obstetric services and utilization rate requirements for DSH eligibility.

(4) If the fiscal year reported on a hospital's medicare cost report does not exactly match the fiscal year reported on the hospital's

DSH application to the ((department)) agency, and if therefore the utilization data reported to the ((department)) agency do not agree, the ((department)) agency will use as the data source the document that gives the higher number of total inpatient hospital days for purposes of calculating the hospital's medicaid inpatient utilization rate (MIPUR). See WAC ((388-550-4900)) 182-550-4900 (6)(b).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) The ((department)) medicaid agency makes low income disproportionate share hospital (LIDSH) payments to qualifying hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an LIDSH payment, a hospital must:

(a) Not be a hospital eligible for public disproportionate share (PHDSH) payments (see WAC ((388-550-5400)) 182-550-5400);

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC ((388-550-2600)) 182-550-2600 (2)(d);

(c) Meet the criteria in WAC ((388-550-4900)) 182-550-4900 (4) and (5);

(d) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive LIDSH payments; and

(e) Meet at least one of the following requirements. The hospital must:

(i) Have a medicaid inpatient utilization rate (MIPUR) as defined in WAC ((388-550-4900)) 182-550-4900 (3)(h) at least one standard deviation above the mean medicaid inpatient utilization rate of in-state hospitals that receive medicaid payments; or

(ii) Have a low income utilization rate (LIUR) as defined in WAC ((388-550-4900)) 182-550-4900 (3)(g) that exceeds twenty-five percent.

(3) The ((department)) agency pays hospitals qualifying for LIDSH payments from a legislatively appropriated pool. The maximum amount of LIDSH payments in any state fiscal year (SFY) is the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(4) The ((department)) agency determines LIDSH payments to each LIDSH eligible hospital using the following factors from the specific hospital's base year as defined in WAC ((388-550-4900)) 182-550-4900 (3)(a):

(a) The hospital's medicaid inpatient utilization rate (MIPUR) (see WAC ((388-550-4900)) 182-550-4900 for how the ((department)) agency calculates the MIPUR).

(b) The hospital's medicaid case mix index (CMI). The ((department)) agency calculates the CMI by:

(i) Using the DRG weight for each of the hospital's paid inpatient claims assigned in the year the claim was paid;

(ii) Summing the DRG weights; and

(iii) Dividing this total by the number of claims.

The CMI the ((department)) agency uses for LIDSH calculations is not the same as the CMI the ((department)) agency uses in other hospital rate calculations.

(c) The number of the hospital's Title XIX medicaid discharges. The ((department)) agency includes in this number only the discharges pertaining to Washington state medicaid clients.

(5) The ((department)) agency calculates the LIDSH payment to an eligible hospital as follows.

(a) The ((department)) agency:

(i) Divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(ii) Multiplies the result derived in (a) of this section by the CMI (see (4)(b) of this section), and then by the discharges (see (4)(c) of this section); then

(iii) Converts the product to a percentage of the sum of all such products for individual hospitals; and

(iv) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(b) If a hospital's calculated LIDSH payment is ((greater)) more than the hospital-specific DSH cap, the payment to the hospital is limited to the hospital-specific DSH cap, and the ((department)) agency:

(i) Subtracts the LIDSH payment calculated for the hospital to determine the remaining LIDSH appropriation to distribute to the other qualifying hospitals; and

(ii) Proportionately distributes the remaining LIDSH appropriation ((in accordance with)) under the factors in (a) of this subsection.

(6) A hospital receiving LIDSH payments must comply with ((a department)) an agency request for uninsured logs (uninsured logs are documentation of payments, charges, and other information for uninsured patients) to verify its hospital-specific DSH cap.

(7) The ((department)) agency will not make changes in the LIDSH payment distribution after the applicable SFY has ended. The ((department)) agency recalculates the LIDSH payment distribution only when the applicable SFY has not yet ended at the time the alleged need for an LIDSH adjustment is identified, and if the ((department)) agency considers the recalculation necessary and appropriate under its regulations.

(8) Consistent with the provisions of subsection (7) of this section, the ((department)) agency applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs ((in accordance with the provisions of WAC 388-550-4900)) under WAC 182-550-4900 (13) through (16).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5130 Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH) and institution for mental diseases (IMD) state grants. (1) A psychiatric hospital owned and operated by the state of Washington is eligible to receive payments un-

der the institution for mental diseases disproportionate share hospital (IMDDSH) program.

(2) For the purposes of the IMDDSH program, the following definitions apply:

(a) "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 ~~((persons))~~ people with mental diseases, including medical attention, nursing care, and related services.

(b) "Psychiatric community hospital" means a psychiatric hospital other than a state-owned and operated hospital.

(c) "Psychiatric hospital" means an institution which is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill ~~((persons))~~ people. The term applies to a medicare-certified distinct psychiatric care unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital.

(d) "State-owned and operated psychiatric hospital" means eastern state hospital and western state hospital.

(3) Except as provided in subsection (4) of this section, a psychiatric community hospital, regardless of location, is not eligible to receive:

(a) IMDDSH payments; or

(b) Any other disproportionate share hospital (DSH) payment from the ~~((department))~~ medicaid agency. See WAC ~~((388-550-4800))~~ 182-550-4800 regarding payment for psychiatric claims for clients eligible under the medical care services programs.

(4) A psychiatric community hospital within the state of Washington that is designated by the ~~((department))~~ agency as an IMD is eligible to receive IMDDSH payment if:

(a) IMDDSH funds remain available after the amounts appropriated for state-owned and operated psychiatric hospitals are exhausted; and

(b) The legislature provides funds specifically for this purpose.

(5) A psychiatric community hospital within the state of Washington that is designated by the ~~((department))~~ agency as an IMD is eligible to receive a state grant amount from the ~~((department))~~ agency if the legislature appropriates funds specifically for this purpose.

(6) An institution for mental diseases located out-of-state, including an IMD located in a designated bordering city, is not eligible to receive a Washington state grant amount.

(7) Under federal law, 42 U.S.C. 1396r-4 (h)(2), the state's annual IMDDSH expenditures are capped at thirty-three percent of the state's annual statewide DSH cap. This amount represents the maximum that the state can spend in any given fiscal year on IMDDSH, but the state is under no obligation to actually spend that amount.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH). (1) The ~~((department))~~ medicaid agency makes small rural disproportionate share hospital (SRDSH) payments to quali-

fying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRDSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC ((388-550-4650)) 182-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC ((388-550-2600)) 182-550-2600 (2)(d);

(c) Meet the criteria in WAC ((388-550-4900)) 182-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRDSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for state fiscal year (SFY) 2010, which began July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(3) The ((department)) agency pays hospitals qualifying for SRDSH payments from a legislatively appropriated pool. The ((department)) agency determines each hospital's individual SRDSH payment from the total dollars in the pool using percentages established as follows:

(a) At the time the SRDSH payment is to be made, the ((department)) agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The ((department)) agency determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The ((department)) agency:

(i) Identifies the medicaid payment amounts made by the ((department)) agency to the individual hospital during the SFY two years ((prior to)) before the current SFY for which DSH application is being made. These medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total medicaid payment amount determined in subsection (i) by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised medicaid payment amount; and

(iii) Divides the revised medicaid payment amount for the individual hospital by the sum of the revised medicaid payment amounts for all qualifying hospitals during the same period.

(4) The ((department's)) agency's SRDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured patients for that hospital unless an exception is required by federal statute or regulation.

(5) The ((department)) agency reallocates dollars as defined in the state plan.

WAC 182-550-5210 Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH). (1) The ~~((department))~~ medicaid agency makes small rural indigent assistance disproportionate share hospital (SRIADSH) program payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC ~~((388-550-4650))~~ 182-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC ~~((388-550-2600))~~ 182-550-2600 (2)(d);

(c) Meet the criteria in WAC ~~((388-550-4900))~~ 182-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital that provided charity services to clients during the base year. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRIADSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by the Washington State office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population ceiling is increased by two percent.

(3) The ~~((department))~~ agency pays hospitals qualifying for SRIADSH payments from a legislatively appropriated pool. The ~~((department))~~ agency determines each hospital's individual SRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the SRIADSH payment is to be made, the ~~((department))~~ agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The ~~((department))~~ agency determines the average profitability margin for all hospitals qualifying for SRIADSH.

(c) Any qualifying hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other qualifying hospitals receive a profit factor of 1.0.

(d) The ~~((department))~~ agency:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The (~~department's~~) agency's SRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for that hospital unless an exception is required by federal statute or regulation. The (~~department~~) agency reallocates dollars as defined in the state plan.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5220 Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH). (1) The (~~department~~) medicaid agency makes nonrural indigent assistance disproportionate share hospital (NRIADSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an NRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC (~~(388-550-4650)~~) 182-550-4650;

(b) Not be designated as an "institution of mental diseases (IMD)" as defined in WAC (~~(388-550-2600)~~) 182-550-2600 (2)(d);

(c) Meet the criteria in WAC (~~(388-550-4900)~~) 182-550-4900 (4) and (5);

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC (~~(388-550-4900)~~) 182-550-4900 (3)(n); and

(e) Be an in-state or designated bordering city hospital that provided charity services to clients during the base year. For DSH purposes, the (~~department~~) agency considers as nonrural any hospital located in a designated bordering city.

(3) The (~~department~~) agency pays hospitals qualifying for NRIADSH payments from a legislatively appropriated pool. The (~~department~~) agency determines each hospital's individual NRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the NRIADSH payment is to be made, the (~~department~~) agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The (~~department~~) agency determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The (~~department~~) agency:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the NRIADSH revised costs by dividing the hospital's revised cost amount by the total revised charity costs for all qualifying hospitals during the same period.

(4) The ~~((department's))~~ agency's NRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for the hospital unless an exception is required by federal statute or regulation. The ~~((department))~~ agency reallocates dollars as defined in the state plan.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5410 CPE medicaid cost report and settlements. (1) For patients discharged ~~((on or after July 1))~~ after June 30, 2005, a certified public expenditure (CPE) hospital must annually submit to the ~~((department))~~ medicaid agency federally required medicaid cost report schedules, using schedules approved by the centers for medicare and medicaid services (CMS), that apportion inpatient and outpatient costs to medicaid clients and uninsured patients for the service year, as follows:

- (a) Title XIX fee-for-service claims;
- (b) Medicaid managed care organization (MCO) plan claims;
- (c) Uninsured patients. The cost report schedules for uninsured patients must not include services that medicaid would not have covered had the patients been medicaid eligible (see WAC ~~((388-550-1400 and 388-550-1500))~~ 182-550-1400 and 182-550-1500); and
- (d) State-administered program patients. State-administered program patients are reported separately and are not to be included on the uninsured patient cost report schedule. The ~~((department))~~ agency will provide provider statistics and reimbursements (PS&R) reports for the state-administered program claims.

(2) A CPE hospital must:

(a) Use the information on individualized PS&R reports provided by the ~~((department))~~ agency when completing the medicaid cost report schedules. The ~~((department))~~ agency provides the hospital with the PS&R reports at least thirty calendar days ~~((prior to))~~ before the appropriate deadline.

(i) For state fiscal year (SFY) 2006, the deadline for all CPE hospitals to submit the federally required medicaid cost report schedules is June 30, 2007.

(ii) For hospitals with a December 31 year end, partial year medicaid cost report schedules for the period July 1, 2005 through December 31, 2005 must be submitted to the ~~((department))~~ agency by August 31, 2007.

(iii) For SFY 2007 and thereafter, each CPE hospital ~~((is required to))~~ must submit the medicaid cost report schedules to the ~~((department))~~ agency within thirty calendar days after the medicare cost report is due to its medicare fiscal intermediary or medicare administrative contractor, whichever ~~((is applicable))~~ applies.

(b) Complete the cost report schedules for uninsured patients and medicaid clients enrolled in an MCO plan using the hospital provider's records.

(c) Comply with the ~~((department's))~~ agency's instructions regarding how to complete the required medicaid cost report schedules.

(3) The medicaid cost report schedules must be completed using the medicare cost report for the same reporting year.

(a) The ratios of costs-to-charges and per diem costs from the "as filed" medicare cost report are used to allocate the medicaid and uninsured costs on the "as filed" medicaid cost report schedules, unless expressly allowed for medicaid.

(b) After the medicare cost report is finalized by the medicare fiscal intermediary or medicare administrative contractor (whichever ~~((is applicable))~~ applies), final medicaid cost report schedules must be submitted to the ~~((department))~~ agency incorporating the adjustments to the medicare cost report, unless expressly allowed for medicaid. CPE hospitals must submit finalized medicare cost reports with the notice of amount of program reimbursement (NPR) within thirty calendar days of receipt. The ~~((department))~~ agency will then provide the hospitals with updated PS&R reports for medicaid and state program claims processed by the ~~((department))~~ agency for the medicaid cost report period. The hospitals will update the data for uninsured patients and medicaid clients enrolled in an MCO plan.

(4) The medicaid cost report schedules and supporting documentation are subject to audit by the ~~((department))~~ agency or its designee to verify that claimed costs qualify under federal and state rules governing the CPE payment program. The documentation required includes, but is not limited to:

(a) The revenue codes assigned to specific cost centers on the medicaid cost report schedules.

(b) The inpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(c) The outpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(d) All payments received for the inpatient and outpatient charges in (b) and (c) of this subsection including, but not limited to, payments for third party liability, uninsured patients, and medicaid clients enrolled in an MCO plan.

(5) The ~~((department))~~ agency:

(a) Performs cost settlements for both the "as filed" and "final" medicaid cost report schedules for all CPE hospitals;

(b) Reports to CMS as an adjustment any difference between the payments of federal funds made to the CPE hospitals and the federal share of the certified public expenditures; and

(c) Recoups from the CPE hospitals the federal payments that exceed the hospitals' costs, unless the hold harmless provision in WAC ~~((388-550-4670 is applicable))~~ 182-550-4670 applies.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. ~~((+))~~ The upper payment limit (UPL) program is terminated effective July 1, 2007. The ~~((department))~~ medicaid agency will not make UPL payments after June 30, 2007.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5500 Payment—Hospital-based RHCs. (1) The ~~((department shall))~~ medicaid agency will reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the ~~((department shall))~~ agency will not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The ~~((department shall))~~ agency will shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The ~~((department shall))~~ agency will shall determine the hospital-based rural health clinic's RCC from the hospital's annual medicare cost report, ~~((pursuant to WAC 388-550-4500))~~ according to WAC 182-550-4500(1).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5550 Public notice for changes in medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe ~~((the manner in which the department))~~ how the medicaid agency, pertaining to medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC ~~((388-550-2800 through 388-550-5500))~~ 182-550-2900 through 182-550-5500.

(d) "Justification" means an explanation of why the ~~((department))~~ agency is proposing or implementing a medicaid rate change based on a change in medicaid rate setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the ~~((department))~~ agency.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the ~~((department's))~~ agency's internet home page on the worldwide web: ~~((http://www.wa.gov/dshs/maa))~~ http://www.hca.wa.gov/ is the internet address.

(3) The ~~((department))~~ agency will notify stakeholders of proposed and final changes in individual medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed medicaid hospital rates, the methodologies underlying the establishment of ~~((such))~~ the rates, and justifications for ~~((such))~~ the rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed medicaid hospital rates, the methodologies underlying the establishment of ~~((such))~~ the rates, and justifications for ~~((such))~~ the rates; and

(c) Publish the final medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the ~~((department))~~ agency will determine the manner of publication of proposed or final medicaid hospital rates.

(b) Publication of proposed medicaid hospital rates will occur as follows:

(i) The ~~((department))~~ agency will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the ~~((department))~~ agency will post proposed rates on the ~~((department's))~~ agency's web site.

(c) Publication of final medicaid hospital rates will occur as follows:

(i) The ~~((department))~~ agency will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the ~~((department))~~ agency will post final rates on the ~~((department's))~~ agency's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter ~~((388-550))~~ 182-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The ~~((department, whenever))~~ agency, when it proposes amendments to the methodologies underlying the establishment of medicaid hospital rates as described in WAC ~~((388-550-2800 through 388-550-5500))~~ 182-550-2900 through 182-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final medicaid hospital rates or proposed and final amendments to WAC ~~((388-550-2800 through 388-550-5500))~~ 182-550-2900 through 182-550-5500 must notify the ~~((department))~~ agency in writing. The ~~((department))~~ agency will send notice of all ~~((such))~~ the actions to ~~((such))~~ the stakeholders postage prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to medicare rules, methods, or levels of reimbursement for clients who are eligible for both medicare and medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rule making is necessary to implement the change; or

(iii) Part of a nonmedicaid program.

(b) Although notice and publication are not required for medicaid rate changes described in subsection (7)(a) of this section, the ~~((department))~~ agency will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the ((department)) agency and an individual hospital negotiate or contractually agree to medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final medicaid contract rates are effective on the date contractually agreed to by the ((department)) agency and the individual hospital.

(d) ((Prior to)) Before the execution of the contract, the ((department)) agency will not publish negotiated contract prices that are agreed to between the ((department)) agency and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the ((department)) agency will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the ((department)) agency in proposing or implementing a change to medicaid hospital rates, the methodologies underlying the establishment of ((such)) the rates, or the justification for ((such)) the rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the ((department)) agency; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the ((department)) agency under which hospital providers may appeal their medicaid rates.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5600 Dispute resolution process for hospital rate reimbursement. The dispute resolution process for hospital rate reimbursement follows the procedures as stated in WAC ((388-502-0220)) 182-502-0220.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5700 Hospital reports and audits. (1) In-state and border area hospitals ((shall)) will complete and submit a copy of their annual medicare cost reports (HCFA 2552) to the ((department)) medicaid agency. These hospital providers ((shall)) will:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual medicare HCFA 2552 cost report according to the applicable medicare statutes, regulations, and instructions; and

(c) Submit a copy to the ((department)) agency:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days ((prior to)) before the due date of the report. Hospital providers ((shall)) will include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the ((department)) agency may withhold all or part of the payments due the hospital until the ((department)) agency receives the properly completed or late report.

(3) Hospitals ((shall)) will submit other financial information required by the ((department)) agency to establish rates.

(4) The ((department shall)) agency will periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-5800 Outpatient and emergency hospital services.

The ((department shall)) medicaid agency will cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients. ((The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.))

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6000 Outpatient hospital services—Conditions of payment and payment methods. (1) The ((department)) medicaid agency pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC ((388-550-1700)) 182-550-1700. All professional medical services must be billed according to chapter ((388-531)) 182-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

- (a) Have a current core provider agreement with the ~~((department))~~ agency;
- (b) Bill the ~~((department))~~ agency according to the conditions of payment under WAC ~~((388-502-0100))~~ 182-502-0100;
- (c) Bill the ~~((department))~~ agency according to the time limits under WAC ~~((388-502-0150))~~ 182-502-0150; and
- (d) Meet program requirements in other applicable WAC and the ~~((department's))~~ agency's published issuances.
- (3) The ~~((department))~~ agency does not pay separately for any services:
- (a) Included in a hospital's room charges;
- (b) Included as covered under the ~~((department's))~~ agency's definition of room and board (e.g., nursing services). See WAC ~~((388-550-1050))~~ 182-550-1050; or
- (c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.
- (4) The ~~((department))~~ agency does not pay:
- (a) A hospital for outpatient hospital services when a managed care plan is contracted with the ~~((department))~~ agency to cover these services;
- (b) More than the "acquisition cost" ("A.C.") for HCPCS (health care common procedure coding system) codes noted in the outpatient fee schedule; or
- (c) For cast room, emergency room, labor room, observation room, treatment room, and other room charges in combination when billing periods for these charges overlap.
- (5) The ~~((department))~~ agency uses the outpatient ~~((departmental))~~ weighted costs-to-charges ~~((+ODWCC))~~ (OWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC ~~((388-550-2598))~~ 182-550-2598.
- (6) The ~~((department))~~ agency uses the maximum allowable fee schedule to pay non-OPPS hospitals and non-CAH hospitals for the following types of covered outpatient hospital services listed in the ~~((department's))~~ agency's current published outpatient hospital fee schedule and billing instructions:
- (a) EKG/ECG/EEG and other diagnostics;
- (b) Imaging services;
- (c) Immunizations;
- (d) Laboratory services;
- (e) Occupational therapy;
- (f) Physical therapy;
- (g) Sleep studies;
- (h) Speech/language therapy;
- (i) Synagis; and
- (j) Other hospital services identified and published by the ~~((department))~~ agency.
- (7) The ~~((department))~~ agency uses the hospital outpatient rate as described in WAC ~~((388-550-4500))~~ 182-550-4500 to pay for covered outpatient hospital services when:
- (a) A hospital provider is a non-OPPS or a non-CAH provider; and
- (b) The services are not included in subsection (6) of this section.
- (8) Hospitals must provide documentation as required ~~((and/))~~ or requested by the ~~((department))~~ agency.
- (9) All hospital providers must present final charges to the ~~((department))~~ agency within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of

Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6100 Outpatient hospital physical therapy. (1) The ((department)) medicaid agency pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC ((388-545-500 and 388-550-6000)) 182-545-200 and 182-550-6000.

(2) A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the ((department's)) agency's current published billing instructions. The ((department)) agency does not pay outpatient hospitals a facility fee for ((such)) these services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6150 Outpatient hospital occupational therapy. (1) The ((department)) medicaid agency pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC ((388-545-300 and 388-550-6000)) 182-545-200 and 182-550-6000.

(2) The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the ((department's)) agency's current published billing instructions. The ((department)) agency does not pay outpatient hospitals a facility fee for ((such)) these services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6200 Outpatient hospital speech therapy services. (1) The ((department)) medicaid agency pays for speech therapy services provided to eligible clients as an outpatient hospital service according to this section and WAC ((388-545-700 and 388-550-6000)) 182-545-200 and 182-550-6000.

(2) The ((department)) agency requires swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(3) The ((department)) agency requires a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(4) A hospital must bill outpatient hospital speech therapy services using appropriate billing codes listed in the ~~((department's))~~ agency's current published billing instructions. The ~~((department))~~ agency does not pay the outpatient hospital a facility fee for these services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits. The ~~((department shall))~~ medicaid agency will provide outpatient chemical dependency treatment in programs qualified under chapter ~~((440-25))~~ 388-810 WAC and certified under chapter ~~((440-22))~~ 388-805 WAC or its successor.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6300 Outpatient nutritional counseling. (1) The ~~((department shall))~~ medicaid agency will cover nutritional counseling services only for eligible medicaid clients age twenty ~~((years of age))~~ and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the ~~((department shall))~~ agency will not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The ~~((department shall))~~ agency will pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth, such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge ~~((and/))~~ or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The ~~((department shall))~~ agency will pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The ~~((department shall))~~ agency will require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The ~~((department shall))~~ agency will pay the provider for a maximum of two sessions per day per client.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6400 Outpatient hospital diabetes education. (1)

The ~~((department))~~ medicaid agency pays for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility where the services are provided is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The ~~((department))~~ agency requires the diabetes education teaching curriculum to have measurable, behaviorally stated educational objectives. The diabetes education teaching curriculum must include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the women, infants, and children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long-term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin startup.

(3) The ~~((department))~~ agency pays for a maximum of six hours of individual core survival skills outpatient diabetes education per calendar year per client.

(4) The ~~((department))~~ agency requires DOH-approved centers to bill the ~~((department))~~ agency for diabetes education services on the UB92 billing form using the specific revenue code~~((+))s~~((+))~~~~ designated and published by the ~~((department))~~ agency.

(5) The ~~((department))~~ agency reimburses for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6450 Outpatient hospital weight loss program. The ~~((department))~~ medicaid agency may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the ~~((medical assistance administration. The department shall))~~ agency. The agency will deny payment for services provided by nonapproved providers.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6500 Blood and blood components. (1) The ~~((department))~~ medicaid agency pays a hospital only for:

(a) Blood bank service charges for processing and storage of blood and blood components; and

(b) Blood administration charges.

(2) The ~~((department))~~ agency does not pay for blood and blood components.

(3) The ~~((department))~~ agency does not pay a hospital separately for the services identified in subsection (1) when these services are included and paid using the diagnosis-related group (DRG), per diem, or per case rate payment rates.

(4) The ~~((department))~~ agency pays a hospital no more than the hospital's cost, as determined by the ~~((department))~~ agency, for the services identified in subsection (1) when the hospital is paid using the ratio of costs-to-charges (RCC) or ~~((departmental))~~ weighted costs-to-charges ~~((DWCC))~~ WCC payment method.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-6600 Hospital-based physician services. See chapter ~~((388-531))~~ 182-531 WAC regarding rules for inpatient and outpatient physician services.