PROPOSED RULE MAKING

CR-102 (December 2017)  
(Implements RCW 34.05.320)  
Do NOT use for expedited rule making

**Agency:** Health Care Authority

- ☒ Original Notice
- ☐ Supplemental Notice to WSR _____
- ☐ Continuance of WSR _____
- ☒ Preproposal Statement of Inquiry was filed as WSR 21-12-057; or
- ☐ Expedited Rule Making--Proposed notice was filed as WSR _____; or
- ☐ Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or
- ☐ Proposal is exempt under RCW _____.

**Title of rule and other identifying information:** (describe subject)

WAC 182-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services  
WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits  
WAC 182-550-2900 Payment limits—Inpatient hospital services

**Hearing location(s):**

<table>
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<th>Date</th>
<th>Time</th>
<th>Location (be specific)</th>
<th>Comment</th>
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| August 24, 2021 | 10:00 AM | The Health Care Authority (HCA) remains closed in response to the coronavirus disease (COVID-19) public health emergency. Until further notice, HCA continues to hold public hearings virtually without a physical meeting place. This promotes social distancing and the safety of the residents of Washington State | To attend the virtual public hearing, you must register in advance:  
https://zoom.us/webinar/register/WN_BNCWCw0FQSOhcaAMJzTrTw  
After registering, you will receive a confirmation email containing information about joining the public hearing. |

**Date of intended adoption:** Not sooner than August 25, 2021 (Note: This is NOT the effective date)

**Submit written comments to:**

Name: HCA Rules Coordinator  
Address: PO Box 42716, Olympia WA 98504-2716  
Email: arc@hca.wa.gov  
Fax: (360) 586-9727  
Other:  
By (date) August 24, 2021

**Assistance for persons with disabilities:**

Contact Amber Lougheed  
Phone: (360) 725-1349  
Fax: (360) 586-9727  
TTY: Telecommunication Relay Services (TRS): 711  
Email: amber.lougheed@hca.wa.gov  
Other:  
By (date) August 23, 2021
Purpose of the proposal and its anticipated effects, including any changes in existing rules: The Health Care Authority (HCA) is amending these rules to update outdated references, terminology, and language to align with behavioral health integration.

Reasons supporting proposal: See purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

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<tr>
<td>Federal Law?</td>
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<td>Federal Court Decision?</td>
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<td>State Court Decision?</td>
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If yes, CITATION:

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

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

Name of agency personnel responsible for:

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<tr>
<th>Role</th>
<th>Name</th>
<th>Office Location</th>
<th>Phone</th>
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<tr>
<td>Drafting</td>
<td>Michael Williams</td>
<td>PO Box 42716, Olympia WA 98504-2716</td>
<td>360-725-5282</td>
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<tr>
<td>Implementation</td>
<td>Cynthia Rivers</td>
<td>PO Box 45111 Olympia, WA 98504-5111</td>
<td>360-725-5282</td>
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<tr>
<td>Enforcement</td>
<td>Cynthia Rivers</td>
<td>PO Box 45111 Olympia, WA 98504-5111</td>
<td>360-725-5282</td>
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Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☑ No

If yes, insert statement here:

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

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Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:

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

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

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

Citation and description:
☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.
☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.
☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:
  ☐ RCW 34.05.310 (4)(b) (Internal government operations)
  ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
  ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
  ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
  ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
  ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

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

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

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

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The proposed amendments are updates to terminology, references, and language and do not impose any cost to businesses.
☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

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

Name: Wendy Barcus
Title: HCA Rules Coordinator

Date: July 14, 2021

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

WAC 182-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services. (1) This section applies to the agency's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to Washington apple health (WAH) clients receiving services through the fee-for-service program. For clients enrolled in an agency-contracted managed care organization (MCO), see chapters 182-538 and 182-538D WAC. See chapter 182-554 WAC for transportation services.

(2) All hospital services paid for by the agency are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The agency will deny, recover, or adjust hospital payments if the agency or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The agency may perform one or more types of UR described in subsection (6) of this section.

(6) The agency's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review"—An evaluation performed by the agency or its designee during a client's course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review"—An evaluation performed by the agency or its designee prior to the provision of health care services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"—An evaluation performed by the agency or its designee following the provision of health care services that includes both a post-payment retrospective UR (performed after health care services are provided and paid), and a prepayment retrospective UR (performed after health care services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the agency or its designee notifies the appropriate oversight entity if either of the following is identified:

(a) A quality of care concern; or

(b) Fraudulent conduct.
**WAC 182-550-2900 Payment limits—Inpatient hospital services.**

(1) To be eligible for payment for covered inpatient hospital services, a hospital must:
   (a) Have a core-provider agreement with the medicaid agency; and
   (b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of that hospital, as defined in WAC 182-550-1050; or
   (c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:
   (a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.
   (b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.
   (c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.
   (d) Additional days of hospitalization on a non-DRG claim when:
      (i) Those days exceed the number of days established by the agency or the agency's designee as specified in WAC 182-550-2600, as the approved length of stay (LOS); and
      (ii) The hospital or distinct unit has not received prior authorization for an extended LOS from the agency or the agency's designee as specified in WAC 182-550-4300(4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. (An agency designee may also perform those utilization reviews to evaluate an extended LOS.
   (e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.
   (f) Two separate inpatient hospitalizations if a client is readmitted to the same or affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines that one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000 (7)(f) for the agency's review of fourteen-day readmissions.
   (g) Inpatient claims for fourteen-day readmissions considered to be provider preventable as described in WAC 182-550-2950.
   (h) A client's day(s) of absence from the hospital or distinct unit.
   (i) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.
   (j) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.
An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before thirty-nine weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

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

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:
   (i) Be submitted in sixty-calendar-day intervals, unless the client is discharged before the next sixty-calendar-day interval.
   (ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:
       (A) All inpatient hospital services provided; and
       (B) All applicable diagnosis codes and procedure codes.
   (iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the agency is not the primary payer:
   (i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and
   (ii) Either of the following:
       (A) Sixty calendar days have passed from the date the agency became the primary payer; or
       (B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

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

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

(5) To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:
   (a) Under the current national uniform billing data element specifications:
      (i) Developed by the National Uniform Billing Committee (NUBC);
      (ii) Approved or modified, or both, by the Washington state payer group or the agency; and
      (iii) In effect on the date of the client's admission.
   (b) Under the current published international classification of diseases clinical modification coding guidelines;
   (c) Subject to the rules in this section and other applicable rules;
   (d) Under the agency's published billing instructions and other documents; and
   (e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;
   (f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:
      (i) All inpatient hospital services provided; and
(ii) All applicable diagnosis codes and procedure codes; and
(g) With the appropriate NUBC revenue code specific to the service or treatment provided to the client.

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

(7) The agency allows hospitals an administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care, as provided in WAC 182-550-4550.

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

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:
   (a) Client participation (e.g., spenddown);
   (b) Any third-party liability amount, including medicare part A and part B; and
   (c) Any other adjustments as determined by the agency.

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

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

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

WAC 182-550-6250 Pregnancy—Enhanced outpatient benefits. The medicaid agency will provide outpatient ((chemical dependency)) substance use disorder treatment in programs qualified under ((chapter 388-810)) WAC 182-538C-230 and certified under chapter ((388-805 WAC or its successor)) 246-341 WAC or its successor. See RCW 71.24.385.