**RULE-MAKING ORDER**  
**PERMANENT RULE ONLY**

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

<table>
<thead>
<tr>
<th>Agency:</th>
<th>Health Care Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective date of rule:</td>
<td>Permanent Rules</td>
</tr>
<tr>
<td>☒ 31 days after filing.</td>
<td>☐ 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)</td>
</tr>
<tr>
<td>Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?</td>
<td>☐ Yes   ☒ No   If Yes, explain:</td>
</tr>
<tr>
<td>Purpose:</td>
<td>The agency is amending subsection (3)(c) of this rule, which states that the agency does not pay separately for certain services provided within one calendar day of an inpatient hospital admission. The agency is adding to this section to state that separate payments are not made for certain services provided within one calendar day of discharge. The agency is also removing subsections (6) and (7). These subsections reference the maximum allowable fee schedule and the hospital outpatient rate for payment of certain services. The agency is making these changes because it does not use these payment methods, but instead uses the enhanced ambulatory payment group (EAPG) method to determine payments, consistent with WAC 182-550-7200</td>
</tr>
<tr>
<td>Citation of rules affected by this order:</td>
<td>New:</td>
</tr>
<tr>
<td></td>
<td>Repealed: 182-550-6000</td>
</tr>
<tr>
<td></td>
<td>Amended:</td>
</tr>
<tr>
<td></td>
<td>Suspended:</td>
</tr>
<tr>
<td>Statutory authority for adoption:</td>
<td>RCW 41.05.021, 41.05.160</td>
</tr>
<tr>
<td>Other authority:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 22-01-045 on December 7, 2021 (date).  
Describe any changes other than editing from proposed to adopted version: None

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
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<tbody>
<tr>
<td>Phone:</td>
<td>Fax:</td>
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<tr>
<td>TTY:</td>
<td>Email:</td>
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<tr>
<td>Web site:</td>
<td>Other:</td>
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</tbody>
</table>
Note: If any category is left blank, it will be calculated as zero.
No descriptive text.

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

The number of sections adopted in order to comply with:

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

The number of sections adopted at the request of a nongovernmental entity:
- New ___
- Amended ___
- Repealed ___

The number of sections adopted on the agency’s own initiative:
- New ___
- Amended ___
- Repealed ___

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

The number of sections adopted using:

- Negotiated rule making: 
  - New ___
  - Amended ___
  - Repealed ___
- Pilot rule making: 
  - New ___
  - Amended ___
  - Repealed ___
- Other alternative rule making: 
  - New ___
  - Amended ___
  - Repealed ___

Date Adopted: January 27, 2022

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature: [Signature]

Page 2 of 2
WAC 182-550-6000  Outpatient hospital services—Conditions of payment and payment methods.  (1) The medicaid agency pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 182-550-1700. All professional medical services must be billed according to chapter 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 agency;
   (b) Bill the agency according to the conditions of payment under WAC 182-502-0100;
   (c) Bill the agency according to the time limits under WAC 182-502-0150; and
   (d) Meet program requirements in other applicable WAC and the agency's published issuances.

(3) The agency does not pay separately for any services:
   (a) Included in a hospital's room charges;
   (b) Included as covered under the agency's definition of room and board (e.g., nursing services). See WAC 182-550-1050; or
   (c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission or discharge.

(4) The agency does not pay:
   (a) A hospital for outpatient hospital services when a managed care plan is contracted with the 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 agency uses the outpatient weighted costs-to-charges (OWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 182-550-2598.

(6) (The 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 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 agency.

(7) The agency uses the hospital outpatient rate as described in WAC 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 or requested by the agency.

((9)) (7) All hospital providers must present final charges to the agency within ((three hundred sixty-five)) 365 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)) 365 days from the "statement covers period from date" shown on the claim.