



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSRs 15-07-046; 15-07-045; or
- Expedited Rule Making--Proposed notice was filed as WSR _____; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice
- Supplemental Notice to WSR _____
- Continuance of WSR _____

Title of rule and other identifying information:

WAC 182-550-2900 Payment limits – Inpatient hospital services

Hearing location(s):

Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

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

Date: October 27, 2015 Time: 10:00 a.m.

Date of intended adoption: Not sooner than October 28, 2015
(Note: This is **NOT** the **effective** date)

Submit written comments to:

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

by October 27, 2015

Assistance for persons with disabilities:

Amber Lougheed by October 20, 2015
e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349
TTY (800) 848-5429 or 711

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

The agency is striking WAC 182-550-2900(2)(f), which states that the agency will not pay for two hospitalizations within 14 days for the same client in certain cases. The amendment aligns with amendments proposed under WSR 15-19-159 which will implement a population-based, data-driven approach to reduce hospital readmission rates and related costs.

The agency is adding 182-550-2900(2)(i). The amendment aligns with amendments proposed under WSR 15-19-157. The agency will no longer pay for early deliveries before 39 weeks of gestation unless medically necessary, including inductions and cesarean sections. The American College of Obstetricians and Gynecologists advises against these deliveries as they can increase the risk of signification complications for the mother and the baby.

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:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 23, 2015

TIME: 10:12 AM

WSR 15-19-161

DATE
September 23, 2015

NAME
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

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

N/A

Name of proponent: Health Care Authority

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Melinda Froud/Chantelle Diaz	P.O. Box 42716, Olympia, WA 98504-2716	(360) 725-1408; (360) 725-1842
Implementation....Gail Kreiger	P.O. Box 45506, Olympia, WA 98504-5506	(360) 725-1681
Enforcement.....Gail Kreiger	P.O. Box 45506, Olympia, WA 98504-5506	(360) 725-1681

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

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

A copy of the statement may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No. Explain why no statement was prepared.

The Joint Administrative Review Committee has not requested the filing of a small business economic impact statement, and these rules do not impose a disproportionate cost impact on small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

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

Name:

Address:

phone () _____

fax () _____

e-mail _____

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

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 ~~((such a))~~ that hospital, ~~((and meet the definition))~~ as defined in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the agency or mental health designee ~~((+see))~~ under WAC 182-550-2600~~((+))~~, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received ~~((approval))~~ prior authorization for an extended LOS from the agency or mental health designee as specified in WAC 182-550-4300~~((+6))~~ (4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. A mental health designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

~~((f))~~ ~~((Two separate inpatient hospitalizations if a client is re-admitted to the same or an affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000.~~

~~((g))~~ A client's day(s) of absence from the hospital or distinct unit.

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

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

(i) An early elective delivery as defined in WAC 182-500-0030.

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

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged (~~(prior to)~~) 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) (~~(In accordance with)~~) 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) (~~(In accordance with)~~) 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) (~~(In accordance with)~~) Under the agency's published (~~(provider guides)~~) 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 (~~(National Uniform Billing Committee (+))~~)NUBC(~~(+)~~) revenue code(~~(+s)~~) 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 C.F.R. §447.271.

(7) The agency allows hospitals an all-inclusive administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care. The agency allows this day rate only when an appropriate placement outside the hospital is not available.

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

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client (~~responsibility~~) 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.