



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 striking WAC 182-550-4690(3)(b), which states the agency performs utilization reviews on seven-day readmissions for claims that qualified for diagnosis related group payment before July 1, 2005.

The agency is also striking subsection (5)(c), which refers to WAC 182-550-3000 for inpatient hospital claims that involve a client's seven-day readmission.

This 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.

Citation of existing rules affected by this order:

Repealed:

Amended: 182-550-4690

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 15-23-060 on November 13, 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: December 23, 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: December 23, 2015

TIME: 11:20 AM

WSR 16-01-204

**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Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____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New	_____	Amended	_____	Repealed	_____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>1</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>1</u>	Repealed	_____

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 182-550-2600.

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

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

(a) Admissions 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 agency's (or an agency designee's) established length of stay (LOS) standards.

(3) For CPE inpatient admissions before August 1, 2007, the agency performs utilization reviews(~~(+~~

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

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

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

(a) Is paid under a non-DRG payment method if the 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 182-550-1050 and 182-550-4500(8)) if the 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 agency determines it was not medically necessary.

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

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

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

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