

Chapter 182-500 WAC

MEDICAL DEFINITIONS

WAC

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WAC 182-500-0005 Medical definitions. Chapter 388-500 WAC contains definitions of words and phrases used in rules for medical assistance programs. When a term is not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the medical definitions found in the Taber's Cyclopedic Medical Dictionary will apply. For general terms not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the definitions in Webster's New World Dictionary apply. If a definition in this chapter conflicts with a definition in another chapter of Title 388 WAC, the definition in the specific WAC prevails.

[11-14-075, recodified as § 182-500-0005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. 11-14-053, § 388-500-0005, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-500-0005, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.-010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

WAC 182-500-0010 Medical assistance definition—
A. "Agency" means the Washington state health care authority, created pursuant to chapter 41.05 RCW.

"Allowable costs" are the documented costs as reported after any cost adjustment, cost disallowances, reclassifications, or reclassifications to nonallowable costs which are necessary, ordinary and related to the outpatient care of medical care clients are not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude which prudent and cost-conscious management would pay.

"Ancillary services" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to,

laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy.

"Apple health for kids" is the umbrella term for health care coverage for certain groups of children that is funded by the state and federal governments under Title XIX medicaid programs or Title XXI Children's Health Insurance Program, or solely through state funds (including the program formerly known as the children's health program). Funding for any given child depends on the program for which the child is determined to be eligible. Children who may be eligible for medical assistance but who are not included under the apple health for kids umbrella are described in WAC 388-505-0210.

"Authorization" means the agency's or the agency's designee's determination that criteria are met, as one of the preconditions to the agency's or the agency's designee's decision to provide payment for a specific service or device. (See also "expedited prior authorization" and "prior authorization.")

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WAC 182-500-0015 Medical assistance definitions—
B. "Benefit package" means the set of health care service categories included in a client's eligibility program. See the table in WAC 388-501-0060.

"Benefit period" means the time period used in determining whether medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for medicare payments.

"Blind" is a category of medical program eligibility that requires a central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or a field of vision limitation so the widest diameter of the visual field subtends an angle no greater than twenty degrees from central.

"By report (BR)" means a method of payment in which the agency or the agency's designee determines the amount it will pay for a service when the rate for that service is not included in the agency's or the agency's designee(s) published fee schedules. The provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

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WAC 182-500-0020 Medical assistance definitions—
C. "Carrier" means an organization that contracts with the federal government to process claims under medicare Part B.

"Categorically needy (CN) or categorically needy program (CNP)" is the state and federally funded health care program established under Title XIX of the Social Security Act for persons within medicaid-eligible categories, whose income and/or resources are at or below set standards.

"Categorically needy (CN) scope of care" is the range of health care services included within the scope of service categories described in WAC 388-501-0060 available to individuals eligible to receive benefits under a CN program. Some state-funded health care programs provide CN scope of care.

"Centers for Medicare and Medicaid Services (CMS)" means the agency within the federal department of health and human services (DHHS) with oversight responsibility for the medicare and medicaid programs.

"Children's health program or children's health care programs" See "Apple health for kids."

"Community spouse" See "spouse" in WAC 388-500-0100.

"Couple" See "spouse" in WAC 388-500-0100.

"Covered service" is a health care service contained within a "service category" that is included in a medical assistance benefits package described in WAC 388-501-0060. For conditions of payment, see WAC 388-501-0050(5). A noncovered service is a specific health care service (for example, cosmetic surgery), contained within a service category that is included in a medical assistance benefits package, for which the agency or the agency's designee requires an approved exception to rule (ETR) (see WAC 388-501-0160). A noncovered service is not an excluded service (see WAC 388-501-0060).

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WAC 182-500-0025 Medical assistance definitions—
D. "Delayed certification" means agency or the agency's designee approval of a person's eligibility for medical assistance made after the established application processing time limits.

"Dental consultant" means a dentist employed or contracted by the agency or the agency's designee.

"Department" means the state department of social and health services.

"Disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:

- (1) Can be expected to result in death;
- (2) Has lasted or can be expected to last for a continuous period of not less than twelve months; or
- (3) In the case of a child age seventeen or younger, means any physical or mental impairment of comparable severity.

Decisions on SSI-related disability are subject to the authority of federal statutes and rules codified at 42 U.S.C. Sec 1382c and 20 C.F.R., parts 404 and 416, as amended, and controlling federal court decisions, which define the old-age, survivors, and disability insurance (OASDI) and SSI disability

standard and determination process. See WAC 388-500-0015 for definition of "blind."

"Domestic partner" means an adult who meets the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who has been issued a certificate of state registered domestic partnership from the Washington secretary of state.

"Dual eligible client" means a client who has been found eligible as a categorically needy (CN) or medically needy (MN) medicaid client and is also a medicare beneficiary. This does not include a client who is only eligible for a medicare savings program as described in chapter 388-517 WAC.

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WAC 182-500-0030 Medical assistance definitions—

E. "Early and periodic screening, diagnosis and treatment (EPSDT)" is a comprehensive child health program that entitles infants, children, and youth to preventive care and treatment services. EPSDT is available to persons twenty years of age and younger who are eligible for any agency health care program. Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B. See also chapter 388-534 WAC.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement (EMER)" see WAC 388-865-0217(3).

"Evidence-based medicine (EBM)" means the application of a set of principles and a method for the review of well-designed studies and objective clinical data to determine the level of evidence that proves to the greatest extent possible, that a health care service is safe, effective, and beneficial when making:

- (1) Population-based health care coverage policies (WAC 388-501-0055 describes how the agency or the agency's designee determines coverage of services for its health care programs by using evidence and criteria based on health technology assessments); and
- (2) Individual medical necessity decisions (WAC 388-501-0165 describes how the agency or the agency's designee uses the best evidence available to determine if a service is medically necessary as defined in WAC 388-500-0030).

"Exception to rule" See WAC 388-501-0160.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected health care services in which providers use a set of numeric codes to indicate to the agency or the agency's designee which acceptable indications, conditions, or agency or agency's designee-defined criteria are applicable to a particular request for authorization. EPA is a form of "prior authorization."

"Extended care services" means nursing and rehabilitative care in a skilled nursing facility provided to a recently hospitalized medicare patient.

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WAC 182-500-0035 Medical assistance definitions—
F. "Fee-for-service (FSS)" - The general payment method the agency or agency's designee uses to pay for covered medical services provided to clients, except those services covered under the agency's prepaid managed care programs.

"Fiscal intermediary" means an organization having an agreement with the federal government to process medicare claims under Part A.

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WAC 182-500-0040 Medical assistance definitions—
G. "Grandfathered client" means a noninstitutionalized person who meets all current requirements for medicaid eligibility except the criteria for blindness or disability; and:

(1) Was eligible for medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973;

(2) Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the medicaid plan in December 1973; or

(3) Was an institutionalized person who:

(a) Was eligible for medicaid in December 1973, or any part of that month, as an inpatient of a medical institution or a resident of a facility that is known as an intermediate care facility that was participating in the medicaid program and for each consecutive month after December 1973; and

(b) Continues to meet the requirements for medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons and remains institutionalized.

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WAC 182-500-0045 Medical assistance definitions—
H. "Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the agency on a prepaid capitation risk basis.

"Health care professional" means a provider of health care services licensed or certified by the state in which they practice.

Health care service category" means a grouping of health care services listed in the table in WAC 388-501-0060. A health care service category is included or excluded depending on the client's medical assistance benefits package.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

(9/13/12)

"Hospital" means an entity that is licensed as an acute care hospital in accordance with applicable state laws and rules, or the applicable state laws and rules of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a medicare or state-certified distinct rehabilitation unit or a psychiatric hospital.

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WAC 182-500-0050 Medical assistance definitions—
I. "Ineligible spouse" see "spouse" in WAC 388-500-0100.

"Institution" means an entity that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Eligibility for medical assistance program may vary depending upon the type of institution in which an individual resides. For the purposes of medical assistance programs, "institution" includes all of the following:

(1) **"Institution for mental diseases (IMD)"**—A hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An IMD may include inpatient chemical dependency facilities of more than sixteen beds which provide residential treatment for alcohol and substance abuse.

(2) **"Intermediate care facility for the mentally retarded (ICF/MR)"**—An institution or distinct part of an institution that is:

(a) Defined in 42 C.F.R. 440.150;

(b) Certified to provide ICF/MR services under 42 C.F.R. 483, Subpart I; and

(c) Primarily for the diagnosis, treatment, or rehabilitation for persons with mental retardation or a related condition (see WAC 388-823-0700 for information about what qualifies as a "related condition").

(3) **"Medical institution"**—An entity that is organized to provide medical care, including nursing and convalescent care. The terms "medical facility" and "medical institution" are sometimes used interchangeably throughout Title 388 WAC.

(a) To meet the definition of medical institution, the entity must:

(i) Be licensed as a medical institution under state law;

(ii) Provide medical care, with the necessary professional personnel, equipment, and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards; and

(iii) Include adequate physician and nursing care.

(b) Medical institutions include all of the following:

(i) **"Hospice care center"**—An entity licensed by the department of health (DOH) to provide hospice services. Hospice care centers must be medicare-certified, and approved by the agency or the agency's designee to be considered a medical institution.

(ii) **"Hospital"**—Defined in WAC 388-500-0045.

(iii) **"Nursing facility (NF)"**—An entity certified to provide skilled nursing care and long-term care services to medicare recipients under Section 1919(a) of the Social Security

Act. Nursing facilities that may become certified include nursing homes licensed under chapter 18.51 RCW, and nursing facility units within hospitals licensed by the department of health (DOH) under chapter 70.41 RCW. This includes the nursing facility section of a state veteran's facility.

(iv) "Psychiatric hospital"—An institution, or a psychiatric unit located in a hospital, licensed as a hospital in accordance with applicable Washington state laws and rules, that is primarily engaged to provide psychiatric services for the diagnosis and treatment of mentally ill persons under the supervision of a physician.

(v) "Psychiatric residential treatment facility (PRTF)"—A nonhospital residential treatment center licensed by department of health, and certified by the agency or the agency's designee to provide psychiatric inpatient services to medic-aid-eligible individuals twenty-one years of age and younger. A PRTF must be accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) or any other accrediting organization with comparable standards recognized by Washington state. A PRTF must meet the requirements in 42 C.F.R. 483, Subpart G, regarding the use of restraint and seclusion.

(vi) "Residential habilitation center (RHC)"—A residence operated by the state under chapter 71A.20 RCW that serves individuals who have exceptional care and treatment needs due to their developmental disabilities by providing residential care designed to develop individual capacities to their optimum. RHCs provide residential care and may be certified to provide ICF/MR services and/or nursing facility services.

(c) Medical institutions do not include entities licensed by the agency or the agency's designee as adult family homes (AFHs) and boarding homes. AFHs and boarding homes include assisted living facilities, adult residential centers, enhanced adult residential centers, and developmental disability group homes.

(4) "**Public institution**" means an entity that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(a) Public institutions include all of the following:

(i) Correctional facility—An entity such as a state penitentiary or county jail, (includes placement in a work release program or outside of the institution, including home detention).

(ii) Eastern and Western State mental hospitals. (Medicaid coverage for these institutions is limited to individuals age twenty-one and younger, and individuals age sixty-five and older.)

(iii) Certain facilities administered by Washington state's department of veteran's affairs (see (b) of this subsection for facilities that are not considered public institutions).

(b) Public institutions do not include intermediate care facilities, entities that meet the definition of medical institution (such as Harborview Medical Center and University of Washington Medical Center), or facilities in Retsil, Orting, and Spokane that are administered by the department of veteran's affairs and licensed as nursing facilities.

"**Institution for mental diseases (IMD)**" see "institution" in this section.

"**Institutionalized spouse**" see "spouse" in WAC 388-500-0100.

"**Intermediate care facility for the mentally retarded (ICF/MR)**" see "institution" in this section.

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WAC 182-500-0065 Medical assistance definitions—
L. "Limitation extension" see WAC 388-501-0169.

"**Limited casualty program (LCP)**" means the medically needy (MN) program.

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WAC 182-500-0070 Medical assistance definitions—
M. "Medicaid" is the federal aid Title XIX program of the Social Security Act under which medical care is provided to eligible persons.

"**Medical assistance**" for the purposes of chapters 388-500 through 388-561 WAC, means the various health care programs administered by the agency or the agency's designee that provide federally funded and/or state-funded health care benefits to eligible clients.

"**Medical assistance administration (MAA)**" is the former organization within the department of social and health services authorized to administer the federally funded and/or state-funded health care programs that are now administered by the agency, formerly the medicaid purchasing administration (MPA), of the health and recovery services administration (HRSA).

"**Medical care services (MCS)**" means the limited scope of care medical program financed by state funds for clients who meet the incapacity criteria defined in chapter 182-508 WAC or who are eligible for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program.

"**Medical consultant**" means a physician employed or contracted by the agency or the agency's designee.

"**Medical facility**" means a medical institution or clinic that provides health care services.

"**Medical institution**" See "institution" in WAC 182-500-0050.

"**Medically necessary**" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

"**Medically needy (MN) or medically needy program (MNP)**" is the state- and federally funded health care program available to specific groups of persons who would be eligible as categorically needy (CN), except their monthly income is above the CN standard. Some long-term care clients with income and/or resources above the CN standard may also qualify for MN.

"Medicare" is the federal government health insurance program for certain aged or disabled persons under Titles II and XVIII of the Social Security Act. Medicare has four parts:

(1) **"Part A"** - Covers medicare inpatient hospital services, post-hospital skilled nursing facility care, home health services, and hospice care.

(2) **"Part B"** - The supplementary medical insurance benefit (SMIB) that covers medicare doctors' services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of medicare.

(3) **"Part C"** - Covers medicare benefits for clients enrolled in a medicare advantage plan.

(4) **"Part D"** - The medicare prescription drug insurance benefit.

"Medicare assignment" means the process by which a provider agrees to provide services to a medicare beneficiary and accept medicare's payment for the services.

"Medicare cost-sharing" means out-of-pocket medical expenses related to services provided by medicare. For medical assistance clients who are enrolled in medicare, cost-sharing may include Part A and Part B premiums, co-insurance, deductibles, and copayments for medicare services. See chapter 182-517 WAC for more information.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-500-0070, filed 9/13/12, effective 10/14/12. 11-14-075, recodified as § 182-500-0070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp. sess. c 15. 11-14-053, § 388-500-0070, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0075 Medical assistance definitions—
N. "National correct coding initiative (NCCI)" is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

"National provider indicator (NPI)" is a federal system for uniquely identifying all providers of health care services, supplies, and equipment.

"NCCI edit" is a software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency or the agency's designee's fee schedules, billing instructions, and other publications. The agency or the agency's designee has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards or agency or agency's designee policy.

"Nonapplying spouse" see "spouse" in WAC 388-500-0100.

"Noncovered service" see "covered service" in WAC 388-500-0020.

"Nursing facility" see "institution" in WAC 388-500-0050.

(9/13/12)

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WAC 182-500-0080 Medical assistance definitions—
O. "Outpatient" means a patient receiving care in a hospital outpatient setting or a hospital emergency department, or away from a hospital such as in a physician's office or clinic, the patient's own home, or a nursing facility.

"Overhead costs" means those costs that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Overhead costs that are allocated must be clearly distinguished from other functions and identified as a benefit to a direct service.

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WAC 182-500-0085 Medical assistance definitions—
P. "Patient transportation" means client transportation to and/or from covered health care services under federal and state health care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Prior authorization" is the requirement that a provider must request, on behalf of a client and when required by rule, the agency's or the agency's designee's approval to render a health care service or write a prescription in advance of the client receiving the health care service or prescribed drug, device, or drug-related supply. The agency's or the agency's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body.

"Provider" means an institution, agency, or person that is licensed, certified, accredited, or registered according to Washington state laws and rules, and:

(1) Has signed a core provider agreement or signed a contract with the agency or the agency's designee, and is authorized to provide health care, goods, and/or services to medical assistance clients; or

(2) Has authorization from a managed care organization (MCO) that contracts with the agency or the agency's designee to provide health care, goods, and/or services to eligible medical assistance clients enrolled in the MCO plan.

"Public institution" see "institution" in WAC 388-500-0050.

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WAC 182-500-0095 Medical assistance definitions—
R. "Regional support network (RSN)" means a single or multiple-county authority or other entity operating as a pre-paid health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health services system in a defined geographic area.

"Retroactive period" means approval of medical coverage for any or all of the retroactive period. A client may be eligible only in the retroactive period or may have both current eligibility and a separate retroactive period of eligibility approved.

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WAC 182-500-0100 Medical assistance definitions—
S. "Spendedown" is a term used in the medically needy (MN) program and means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the agency. See WAC 388-519-0110.

"Spouse" means, for the purposes of medicaid, a person who is a husband or wife legally married to a person of the opposite sex. Washington state recognizes other states' determinations of legal and common-law marriages between two persons of the opposite gender.

(1) **"Community spouse"** means a person who:

(a) Does not reside in a medical institution; and

(b) Is legally married to a client who resides in a medical institution or receives services from a home and community-based waiver program. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

(2) **"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, who lives with the SSI-eligible person, and is also eligible for SSI.

(3) **"Essential spouse"** means a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) for a client in December 1973, who continues to live in the home and remains married to the client.

(4) **"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person, and who has not applied or is not eligible to receive SSI.

(5) **"Institutionalized spouse"** means a legally married person who has attained institutional status as described in chapter 388-513 WAC, and receives services in a medical institution or from a home or community-based waiver program described in chapter 388-515 WAC. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

(6) **"Nonapplying spouse"** means an SSI-related person's husband or wife, who has not applied for medical assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"State supplemental payment (SSP)" is a state-funded cash benefit for certain individuals who are either recipients of the Title XVI supplemental security income (SSI) program or who are clients of the division of developmental disabili-

ties. The SSP allotment for Washington state is a fixed amount of twenty-eight million nine hundred thousand dollars and must be shared between all individuals who fall into one of the groups listed below. The amount of the SSP may vary each year depending on the number of individuals who qualify. The following groups are eligible for an SSP:

(1) **Mandatory SSP group—SSP made to a mandatory income level client (MIL)** who was grandfathered into the SSI program. To be eligible in this group, an individual must have been receiving cash assistance in December 1973 under the department of social and health services former old age assistance program or aid to the blind and disability assistance. Individuals in this group receive an SSP to bring their income to the level they received prior to the implementation of the SSI program in 1973.

(2) **Optional SSP group—SSP made to any of the following:**

(a) An individual who receives SSI and has an ineligible spouse.

(b) An individual who receives SSI based on meeting the age criteria of sixty-five or older.

(c) An individual who receives SSI based on blindness.

(d) An individual who has been determined eligible for SSP by the division of developmental disabilities.

(e) An individual who is eligible for SSI as a foster child as described in WAC 388-474-0012.

"Supplemental security income (SSI) program (Title XVI)" is the federal grant program for aged, blind, and disabled persons, established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

[11-14-075, recodified as § 182-500-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. 11-14-053, § 388-500-0100, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0105 Medical assistance definitions—
T. "Third party" means an entity other than the agency or the agency's designee that is or may be liable to pay all or part of the cost of health care for a medical assistance client.

"Third party liability (TPL)" means the legal responsibility of an identified third party or parties to pay all or part of the cost of health care for a medical assistance client. A medical assistance client's obligation to help establish TPL is described in WAC 388-505-0540.

"Title XIX" is the portion of the federal Social Security Act, 42 U.S.C. 1396, that authorizes funding to states for medical assistance programs. Title XIX is also called medicaid.

"Title XXI" is the portion of the federal Social Security Act, 42 U.S.C. 1397 et seq, that authorizes funding to states for the children's health insurance program. Title XXI is also called CHIP.

"Transfer of assets" means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(1) An intentional act that changes ownership or title; or

(2) A failure to act that results in a change of ownership or title.

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WAC 182-500-0110 Medical assistance definitions—

U. "Urgent care" means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day or the following day.

"Usual and customary charge" means the amount a provider typically charges to fifty percent or more of patients who are not medical assistance clients.

[11-14-075, recodified as § 182-500-0110, filed 6/30/11, effective 7/1/11.
Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. 11-14-053, § 388-500-0110, filed 6/29/11, effective 7/30/11.]