

# Chapter 182-502 WAC

## ADMINISTRATION OF MEDICAL PROGRAMS— PROVIDERS

**WAC**

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**PROVIDER TYPES**

**WAC 182-502-0002 Eligible provider types.** The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state department of social and health services to provide covered health care services to eligible clients. For

the purposes of this chapter, health care services includes treatment, equipment, related supplies and drugs.

- (1) Professionals:
  - (a) Advanced registered nurse practitioners;
  - (b) Anesthesiologists;
  - (c) Audiologists;
  - (d) Chemical dependency professionals:
    - (i) Mental health care providers; and
    - (ii) Peer counselors.
  - (e) Chiropractors;
  - (f) Dentists;
  - (g) Dental hygienists;
  - (h) Denturists;
  - (i) Dietitians or nutritionists;
  - (j) Hearing aid fitters/dispensers;
  - (k) Marriage and family therapists, only as provided in WAC 388-531-1400;
- (l) Mental health counselors, only as provided in WAC 388-531-1400;
- (m) Mental health care providers;
- (n) Midwives;
- (o) Nurse anesthetist;
- (p) Occupational therapists;
- (q) Ophthalmologists;
- (r) Opticians;
- (s) Optometrists;
- (t) Orthodontists;
- (u) Orthotist;
- (v) Osteopathic physicians;
- (w) Osteopathic physician assistants;
- (x) Peer counselors;
- (y) Podiatric physicians;
- (z) Pharmacists;
- (aa) Physicians;
- (bb) Physician assistants;
- (cc) Physical therapists;
- (dd) Prosthetist;
- (ee) Psychiatrists;
- (ff) Psychologists;
- (gg) Radiologists;
- (hh) Registered nurse delegators;
- (ii) Registered nurse first assistants;
- (jj) Respiratory therapists;
- (kk) Social workers, only as provided in WAC 388-531-1400; and

- (ll) Speech/language pathologists.
- (2) Agencies, centers and facilities:
  - (a) Adult day health centers;
  - (b) Ambulance services (ground and air);
  - (c) Ambulatory surgery centers (medicare-certified);
  - (d) Birthing centers (licensed by the department of health);

- (e) Blood banks;
- (f) Cardiac diagnostic centers;
- (g) Case management agencies;
- (h) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of alcohol and substance abuse (DASA), and contracted through either:
  - (i) A county under chapter 388-810 WAC; or
  - (ii) DASA to provide chemical dependency treatment services.
    - (i) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);
    - (j) Community AIDS services alternative agencies;
    - (k) Community mental health centers;
    - (l) Diagnostic centers;
    - (m) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;
    - (n) Family planning clinics;
    - (o) Federally qualified health centers (designated by the federal department of health and human services);
    - (p) Genetic counseling agencies;
    - (q) Health departments;
    - (r) Health maintenance organization (HMO)/managed care organization (MCO);
    - (s) HIV/AIDS case management;
    - (t) Home health agencies;
    - (u) Hospice agencies;
    - (v) Hospitals;
    - (w) Indian health service facilities/tribal 638 facilities;
    - (x) Tribal or urban Indian clinics;
    - (y) Inpatient psychiatric facilities;
    - (z) Intermediate care facilities for the mentally retarded (ICF-MR);
      - (aa) Kidney centers;
      - (bb) Laboratories (CLIA certified);
      - (cc) Maternity support services agencies; maternity case managers; infant case management, first steps providers;
      - (dd) Neuromuscular and neurodevelopmental centers;
      - (ee) Nurse services/delegation;
      - (ff) Nursing facilities (approved by the DSHS aging and disability services administration);
      - (gg) Pathology laboratories;
      - (hh) Pharmacies;
      - (ii) Private duty nursing agencies;
      - (jj) Radiology - Stand alone clinics;
      - (kk) Rural health clinics (medicare-certified);
      - (ll) School districts and educational service districts;
      - (mm) Sleep study centers; and
      - (nn) Washington state school districts and educational service districts.
- (3) Suppliers of:
  - (a) Durable and nondurable medical equipment and supplies;
  - (b) Infusion therapy equipment and supplies;
  - (c) Prosthetics/orthotics;
  - (d) Hearing aids; and
  - (e) Oxygen equipment and supplies.
- (4) Contractors:
  - (a) Transportation brokers;
  - (b) Spoken language interpreter services agencies;
  - (c) Independent sign language interpreters; and

- (d) Eyeglass and contact lens providers.

[11-14-075, recodified as § 182-502-0002, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0002, filed 5/9/11, effective 6/9/11.]

**WAC 182-502-0003 Noneligible provider types.** The department does not enroll licensed or unlicensed health care practitioners not specifically listed in WAC 388-502-0002, including, but not limited to:

- (1) Acupuncturists;
- (2) Counselors, except as provided in WAC 388-531-1400;
- (3) Sanipractors;
- (4) Naturopaths;
- (5) Homeopaths;
- (6) Herbalists;
- (7) Massage therapists;
- (8) Social workers, except as provided in WAC 388-531-1400 and 388-537-0350;
- (9) Christian science practitioners, theological healers, and spiritual healers;
- (10) Chemical dependency professional trainee (CDPT); and
- (11) Mental health trainee (MHT).

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## ENROLLMENT

**WAC 182-502-0005 Core provider agreement (CPA).** (1) The agency only pays claims submitted by or on behalf of a health care professional, health care entity, supplier or contractor of service that has an approved core provider agreement (CPA) with the agency or is a performing provider on an approved CPA with the agency.

(2) Performing providers of services to a medical assistance client must be enrolled under the billing providers' CPA.

(3) Any ordering, prescribing, or referring providers must be enrolled in the agency's claims payment system in order for any services or supplies ordered, prescribed, or referred by them to be paid. The national provider identifier (NPI) of any referring, prescribing, or ordering provider must be included on the claim form.

(4) For services provided out-of-state, refer to WAC 182-501-0180, 182-501-0182, and 182-501-0184.

(5) The agency does not pay for services provided to clients during the CPA application process, regardless of whether the agency later approves or denies the CPA application, except as provided in subsection (6) of this section.

(6) Enrollment of a provider applicant is effective on the date the agency approves the provider application.

(a) A provider applicant may ask for an effective date earlier than the agency's approval of the provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

(i) Earlier than the effective date of any required license or certification; or

(ii) More than three hundred sixty-five days prior to the agency's approval of the provider application.

(b) The chief medical officer or designee may approve exceptions as follows:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need as determined by the agency's chief medical officer or designee.

(c) For federally qualified health centers (FQHCs), see WAC 182-548-1200. For rural health clinics (RHCs), see WAC 182-549-1200.

(d) Exceptions granted under this subsection (6) do not supersede or otherwise change the agency's timely billing requirements under WAC 182-502-0150.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455 subpart E Provider Screening and Enrollment requirements. 12-12-032, § 182-502-0005, filed 5/29/12, effective 7/1/12. 11-14-075, recodified as § 182-502-0005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0005, filed 5/9/11, effective 6/9/11.]

**WAC 182-502-0010 When the medicaid agency enrolls.** (1) Nothing in this chapter obligates the agency to enroll any eligible health care professional, health care entity, supplier or contractor of service who requests enrollment.

(2) To enroll as a provider with the medicaid agency, a health care professional, health care entity, supplier or contractor of service must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules. Persons or entities outside of Washington state, see WAC 182-502-0120;

(b) Be enrolled with medicare, when required in specific program rules;

(c) Have current professional liability coverage, individually or as a member of a group;

(d) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(e) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(f) Sign, without modification, a core provider agreement (CPA) and debarment form (09-048) or a contract with the agency. (Note: Section 13 of the CPA, 09-048 (REV. 08/2005), is hereby rescinded. The medicaid agency and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.);

(g) Agree to accept the payment from the medicaid agency as payment in full (in accordance with 42 C.F.R. § 447.15 acceptance of state payment as payment in full and WAC 182-502-0160 billing a client);

(h) Fully disclose ownership and control information requested by the agency. If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and obtain a

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CPA number to be used for submitting claims as the billing provider. All owners must be identified and fully disclosed in the application; and

(i) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5.

[Statutory Authority: RCW 41.05.021 and Affordable Care Act (ACA) - 76 Fed. Reg. 5862, 42 C.F.R. Parts 405, 424, 447, 455, 457, and 498. 12-15-015, § 182-502-0010, filed 7/10/12, effective 9/1/12. 11-14-075, recodified as § 182-502-0010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0010, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.09.521. 08-12-030, § 388-502-0010, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.080, 74.09.120. 03-14-106, § 388-502-0010, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

**WAC 182-502-0012 When the department does not enroll.** (1) The department does not enroll a health care professional, health care entity, supplier or contractor of service for reasons which include, but are not limited to, the following:

(a) The department determines that:

(i) There is a quality of care issue with significant risk factors that may endanger client health and/or safety (see WAC 388-502-0030 (1)(a)); or

(ii) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 388-502-0030 (1)(b)).

(b) The health care professional, health care entity, supplier or contractor of service:

(i) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(ii) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(iii) Has been disciplined based on allegation of sexual misconduct or admitted to sexual misconduct;

(iv) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(v) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(vi) Is noncompliant with the department of health's or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(vii) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(viii) Fails a background check performed by the department. See WAC 388-502-0014 and 388-502-0016; or

(ix) Does not have sufficient liability insurance according to WAC 388-502-0016 for the scope of practice.

(2) The department may not pay for any health care service, drug, supply or equipment prescribed or ordered by a health care professional, health care entity, supplier or con-

tractor of service whose application for a core provider agreement (CPA) has been denied or terminated.

(3) The department may not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service who does not have a current CPA with the department when the department determines there is a potential danger to a client's health and/or safety.

(4) Nothing in this chapter precludes the department from entering into other forms of written agreements with a health care professional, health care entity, supplier or contractor of service.

(5) If the department denies an enrollment application, the applicant does not have any dispute rights within the department.

[11-14-075, recodified as § 182-502-0012, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0012, filed 5/9/11, effective 6/9/11.]

**WAC 182-502-0014 Review and consideration of an applicant's history.** (1) The department may consider enrolling a health care professional, health care entity, supplier or contractor of service for reasons which include, but are not limited to, the following:

(a) The department determines that:

(i) There is not a quality of care issue with significant risk factors that endanger client health and/or safety;

(ii) There are not risk factors that affect the credibility, honesty, or veracity of the applicant; and

(iii) The applicant is not likely to repeat the violation that led to a restriction or sanction.

(b) The health care professional, health care entity, supplier or contractor of service has:

(i) Been excluded from participation in medicare, medicaid, or any other federally funded health care program but is not currently excluded; or

(ii) A history of probation, suspension, termination, revocation, or a surrendered professional license, certification, accreditation, or registration as defined under chapter 18.130 RCW but currently has an active license, certification, accreditation, or registration; or

(iii) A restricted or limited professional license, certification, accreditation, or registration as defined under RCW 18.130.160; or

(iv) A history of denial, limitation, suspension or termination of participation or privileges by any health care institution, plan, facility, clinic, or state agency for quality of care issues or inappropriate billing practices and the quality of care issue or inappropriate billing practices have been corrected to the department's satisfaction.

(2) The department may conduct a background check on any applicant applying for a core provider agreement (CPA).

(3) The department's response to a review of a request for enrollment is based on the information available to the department at the time of application.

[11-14-075, recodified as § 182-502-0014, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0014, filed 5/9/11, effective 6/9/11.]

## PROVIDER REQUIREMENTS

**WAC 182-502-0016 Continuing requirements.** (1) To continue to provide services for eligible clients and be paid for those services, a provider must:

(a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(b) Provide all services according to federal and state laws and rules, department billing instructions, numbered memoranda issued by the department, and other written directives from the department;

(c) Inform the department of any changes to the provider's application or contract, including but not limited to, changes in:

(i) Ownership (see WAC 388-502-0018);

(ii) Address or telephone number;

(iii) Professional practicing under the billing provider number; or

(iv) Business name.

(d) Retain a current professional state license, registration, certification and/or applicable business license for the service being provided, and update the department of all changes;

(e) Inform the department in writing within seven calendar days of changes applicable to the provider's clinical privileges;

(f) Inform the department in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s), including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Screen employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5.

(h) Report immediately to the department any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 388-502-0010 (2)(j);

(i) Pass a background check, when the department requires such information to fully evaluate a provider;

(j) Maintain professional and general liability coverage requirements, if not covered under agency, center or facility, in the amounts identified by the department;

(k) Not surrender, voluntarily or involuntarily, his or her professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct; and

(l) Furnish documentation or other assurances as determined by the department in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.

(2) A provider may contact the department with questions regarding its programs. However, the department's response is based solely on the information provided to the department's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs.

(3) The department may refer the provider to the appropriate state health professions quality assurance commission.

[11-14-075, recodified as § 182-502-0016, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0016, filed 5/9/11, effective 6/9/11.]

**WAC 182-502-0018 Change of ownership.** (1) A provider must notify the department in writing within seven calendar days of ownership or control changes of any kind. An entity is considered to have an ownership or control interest in another entity if it has direct or indirect ownership of five percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or who directly or indirectly conducts day-to-day operations of the entity. The department determines whether a new core provider agreement (CPA) must be completed for the new entity.

(2) When a provider obtains a new federal tax identification (ID) following a change of ownership, the department terminates the provider's CPA as of the date of the change in federal tax ID. The provider may reapply for a new CPA.

(3) All new ownership enrollments are subject to the requirements in WAC 388-502-0010. In addition to those requirements, the applicant must:

- (a) Complete a change of ownership form;
- (b) Provide the department with a copy of the contract of sale identifying previous and current owners; and
- (c) Provide the department with a list of all provider numbers affected by the change of ownership.

[11-14-075, recodified as § 182-502-0018, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0018, filed 5/9/11, effective 6/9/11.]

**WAC 182-502-0020 Health care record requirements.** This section applies to providers, as defined under WAC 388-500-0005 and under WAC 388-538-050. Providers must:

(1) Maintain documentation in the client's medical or health care records to verify the level, type, and extent of services provided to each client to fully justify the services and billing, including, but not limited to:

- (a) Client's name and date of birth;
- (b) Dates of services;
- (c) Name and title of person performing the service;
- (d) Chief complaint or reason for each visit;
- (e) Pertinent past and present medical history;
- (f) Pertinent findings on examination at each visit;

(g) Medication(s) or treatment prescribed and/or administered;

(h) Name and title of individual prescribing or administering medication(s);

(i) Equipment and/or supplies prescribed or provided;

(j) Name and title of individual prescribing or providing equipment and/or supplies;

(k) Detailed description of treatment provided;

(l) Subjective and objective findings;

(m) Clinical assessment and diagnosis;

(n) Recommendations for additional treatments, procedures, or consultations;

(o) Radiographs (X rays), diagnostic tests and results;

(p) Plan of treatment and/or care, and outcome;

(q) Specific claims and payments received for services;

(r) Correspondence pertaining to client dismissal or termination of health care practitioner/patient relationship;

(s) Advance directives, when required under WAC 388-501-0125;

(t) Patient treatment agreements (examples: Opioid agreement, medication and treatment compliance agreements); and

(u) Informed consent documentation.

(2) Keep legible, accurate, and complete charts and records;

(3) Meet any additional record requirements of the department of health (DOH);

(4) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(5) Make charts and records available to the department, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. The department does not separately reimburse for copying of health care records, reports, client charts and/or radiographs, and related copying expenses; and

(6) Permit the department access to its physical facilities and its records to enable the department to conduct audits, inspections or reviews without prior announcement.

[11-14-075, recodified as § 182-502-0020, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0020, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

**WAC 182-502-0025 Electronic health records (EHR) incentive program.** The purpose of this section is to establish the medicaid electronic health records (EHR) incentive program in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA). The medicaid EHR incentive program promotes the adoption and meaningful use of certified EHR technology by offering financial incentives to eligible professionals and hospitals. This program is administered by the department.

(1) The department provides incentive payments to eligible providers and hospitals that adopt and meaningfully use certified EHR technology in accordance with the provisions

of 42 C.F.R. Parts 412, 413, 422, and any other federal regulations that apply.

(2) Providers and hospitals eligible to participate in EHR incentive program are identified in 42 C.F.R. Part 495.304 and other applicable rules.

(3) As authorized by 42 C.F.R. Parts 412, 413, 422, chapters 43.20B and 74.09 RCW, and any other federal or state rules that apply, the department monitors and reviews all providers and hospitals participating in the EHR incentive program. By the same authority, the department reviews all practices, documentation, and/or data related to EHR technology to determine whether professionals and hospitals participating in the EHR incentive program are eligible and complying with state and federal rules and regulations.

(4) The department may determine that a participating professional or hospital has not met the eligibility or performance requirements to receive an EHR incentive payment, or should receive an incentive payment in an amount less than the amount anticipated by the provider or hospital. Areas of possible dispute in the EHR incentive program include, at a minimum, any of the following:

(a) Patient volume thresholds and calculations, as outlined in 42 C.F.R. Part 495.304 and 495.306.

(b) Eligibility criteria and payment limitations, as outlined in 42 C.F.R. Part 495.10, 495.304, 495.306, and 495.310.

(c) Attestations and compliance demonstrations including, at a minimum:

(i) Attestations that certified EHR technology has been adopted, implemented, or upgraded; and

(ii) Demonstrations of meaningful use, as outlined in 42 C.F.R. Part 495.6, 495.8, 495.306, 495.310, and in any future published federal regulations and requirements, as applicable.

(d) The payment process and incentive payment amounts, as outlined in 42 C.F.R. Part 495.310, 495.312, and 495.314.

(e) Additional issues regarding EHR incentive program eligibility, participation, documentation, and compliance as outlined in 42 C.F.R. Parts 412, 413, 422 et al. and in any future published federal regulations and requirements, as applicable.

(5) All matters of dispute are subject to the administrative procedure act (APA) appeal process per chapter 34.05 RCW. A provider who disagrees with a department action under this section may request a hearing. The hearing request must:

(a) Be in writing;

(b) Be received by the agency, at the address identified in the notice of action, within twenty-eight days of the date of the notice of action by certified mail (return receipt); and

(c) State the reason(s) why the provider thinks the action is incorrect.

[11-14-075, recodified as § 182-502-0025, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 11-13-053, § 388-502-0025, filed 6/10/11, effective 7/11/11.]

### TERMINATION OF PROVIDER

**WAC 182-502-0030 Termination of a provider agreement—For cause.** (1) The department may immedi-

ately terminate a provider's core provider agreement (CPA) for any one or more of the following reasons, each of which constitutes cause:

(a) Provider exhibits significant risk factors that endanger client health and/or safety. These factors include, but are not limited to:

(i) Moral turpitude;

(ii) Sexual misconduct as defined in WAC 246-934-100 or in profession specific rules of the department of health (DOH);

(iii) A statement of allegations or statement of charges by DOH;

(iv) Restrictions placed by DOH on provider's current practice such as chaperone required for rendering treatment, preceptor required to review practice, or prescriptive limitations;

(v) Limitations, restrictions, or loss of hospital privileges or participation in any health care plan and/or failure to disclose the reasons to the department;

(vi) Negligence, incompetence, inadequate or inappropriate treatment, or lack of appropriate follow-up treatment;

(vii) Patient drug mismanagement and/or failure to identify substance abuse/addiction or failure to refer the patient for substance abuse treatment once abuse/addiction is identified;

(viii) Use of health care providers or health care staff who are unlicensed to practice or who provide health care services which are outside their recognized scope of practice or the standard of practice in the state of Washington;

(ix) Failure of the health care provider to comply with the requirements of WAC 388-502-0016;

(x) Failure of the health care practitioner with an alcohol or chemical dependency to furnish documentation or other assurances as determined by the department to adequately safeguard the health and safety of medical assistance clients that the provider:

(A) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(B) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.

(xi) Infection control deficiencies;

(xii) Failure to maintain adequate professional malpractice coverage;

(xiii) Medical malpractice claims or professional liability claims that constitute a pattern of questionable or inadequate treatment, or contain any gross or flagrant incident of malpractice; or

(xiv) Any other act which the department determines is contrary to the health and safety of its clients.

(b) Provider exhibits significant risk factors that affect the provider's credibility or honesty. These factors include, but are not limited to:

(i) Failure to meet the requirements in WAC 388-502-0010 and WAC 388-502-0020;

(ii) Dishonesty or other unprofessional conduct;

(iii) Investigatory (e.g. audit), civil, or criminal finding of fraudulent or abusive billing practices;

(iv) Exclusion from participation in medicare, medicaid, or any other federally-funded health care program;

(v) Any conviction, no contest plea, or guilty plea relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(vi) Any conviction, no contest plea, or guilty plea of a criminal offense;

(vii) Failure to comply with a DOH request for information or an on-going DOH investigation;

(viii) Noncompliance with a DOH or other state health care agency's stipulation to disposition, agreed order, final order, or other similar licensure restriction;

(ix) Misrepresentation or failure to disclose information on the enrollment application for a core provider agreement (CPA), failure to supply requested information, or failure to update CPA as required;

(x) Failure to comply with a department request for information;

(xi) Failure to cooperate with a department investigation, audit or review;

(xii) Providing health care services which are outside the provider's recognized scope of practice or the standard of practice in the state of Washington;

(xiii) Unnecessary medical/dental or other health care procedures;

(xiv) Discriminating in the furnishing of health care services, supplies, or equipment as prohibited by 42 U.S.C. § 2000d; and

(xv) Any other dishonest or discreditable act which the department determines is contrary to the interest of the department or its clients.

(2) If a provider is terminated for cause, the department pays for authorized services provided up to the date of termination only.

(3) If the department terminates a provider who is also a full or partial owner of a group practice, the department also terminates all providers linked to the group practice. The remaining practitioners in the group practice may reapply for participation with the department subject to WAC 388-502-0010(2).

(4) A provider who is terminated for cause may dispute a department decision under the process in WAC 388-502-0050.

[11-14-075, recodified as § 182-502-0030, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0030, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530, 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

**WAC 182-502-0040 Termination of a provider agreement—For convenience.** (1) Either the department or the provider may terminate the provider's participation with the department for convenience with thirty calendar days written notice served upon the other party in a manner which provides proof of receipt or proof of valid attempt to deliver.

(2) Terminations for convenience are not eligible for the dispute resolution process described in WAC 388-502-0050.

(3) If a provider is terminated for convenience, the department pays for authorized services provided up to the date of termination only.

[11-14-075, recodified as § 182-502-0040, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0040, filed 5/9/11, effective 6/9/11.]

(8/31/12)

## INFORMAL DISPUTE RESOLUTION PROCESS

**WAC 182-502-0050 Provider dispute of a department action.** The process described in this section applies only when department rules allow a provider to dispute a department decision under this section.

(1) In order for the department to review a decision previously made by the department, a provider must submit the request to review the decision:

(a) Within twenty-eight calendar days of the date on the department's decision notice;

(b) To the address listed in the decision notice; and

(c) In a manner that provides proof of receipt.

(2) A provider's dispute request must:

(a) Be in writing;

(b) Specify the department decision that the provider is disputing;

(c) State the basis for disputing the department's decision; and

(d) Include documentation to support the provider's position.

(3) The department may request additional information or documentation. The provider must submit the additional information or documentation to the department within twenty-eight calendar days of the date on the department's request.

(4) The department closes the dispute without issuing a decision and with no right to further review under subsection (6) of this section when the provider:

(a) Fails to comply with any requirement of subsections (2), (3), and (4) of this section;

(b) Fails to cooperate with, or unduly delays, the dispute process; or

(c) Withdraws the dispute request in writing.

(5) The department will send the provider a written notice of dispute closure or written dispute decision.

(6) The provider may request the deputy assistant secretary of the medicaid purchasing administration (MPA) or designee to review the written dispute decision according to the process in WAC 388-502-0270.

(7) This section does not apply to disputes regarding overpayment. For disputes regarding overpayment, see WAC 388-502-0230.

[11-14-075, recodified as § 182-502-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0050, filed 5/9/11, effective 6/9/11.]

## REAPPLYING FOR PARTICIPATION

**WAC 182-502-0060 Reapplying for participation.** (1) Providers who are denied enrollment or removed from participation are not eligible to reapply for participation with the department for five years from the date of denial or termination.

(2) Providers who are denied enrollment or removed from participation due to sexual misconduct as defined in chapter 246-16 WAC or in profession-specific rules of the department of health (DOH) are not eligible to be enrolled for participation with the department.

(3) Providers who are denied enrollment or removed from participation more than once are not eligible to reapply for participation with the department.

[11-14-075, recodified as § 182-502-0060, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0060, filed 5/9/11, effective 6/9/11.]

### PAYMENT

#### **WAC 182-502-0100 General conditions of payment.**

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 388-502-0150;

(e) The provider bills according to department rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The department does not reimburse providers for medical services identified by the department as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (co-pays) (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(c) Emergency medical expense requirements (EMER) (see WAC 388-550-1050 and 388-865-0217); and

(d) Spenddown (see WAC 388-519-0110).

(4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and medical assistance before the department makes any payment.

(5) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(6) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

(a) The department considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the department.

(7) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

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(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[11-14-075, recodified as § 182-502-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 11-11-014, § 388-502-0100, filed 5/9/11, effective 6/9/11; 10-19-057, § 388-502-0100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-502-0100, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

**WAC 182-502-0110 Conditions of payment—Medicare deductible and coinsurance.** (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the medicare DRG as payment in full until the medicaid outlier threshold is reached. After the medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If medicare and medicaid cover the service, the department pays only the deductible and/or coinsurance up to medicare or medicaid's allowed amount, whichever is less. If only medicare and not medicaid covers the service, the department pays only the deductible and/or coinsurance up to medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for medicaid covered services when the client exhausts medicare benefits.

[11-14-075, recodified as § 182-502-0110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

**WAC 182-502-0120 Payment for health care services provided outside the state of Washington.** (1) The department pays for health care services provided outside the state of Washington only when the service meets the provisions set forth in WAC 388-501-0180, 388-501-0182, 388-501-0184, and specific program WAC.

(2) With the exception of hospital services and nursing facilities, the department pays the provider of service in designated bordering cities as if the care was provided within the state of Washington (see WAC 388-501-0175).

(8/31/12)

(3) With the exception of designated bordering cities, the department does not pay for health care services provided to clients in medical care services (MCS) programs outside the state of Washington (see WAC 388-556-0500).

(4) With the exception of hospital services (see subsection (5) of this section), the department pays for health care services provided outside the state of Washington at the lower of:

(a) The billed amount; or

(b) The rate established by the Washington state medical assistance programs.

(5) The department pays for hospital services provided in designated bordering cities and outside the state of Washington in accordance with the provisions of WAC 388-550-3900, 388-550-4000, 388-550-4800 and 388-550-6700.

(6) The department pays nursing facilities located outside the state of Washington when approved by the aging and disability services administration (ADSA) at the lower of the billed amount or the adjusted statewide average reimbursement rate for in-state nursing facility care, only in the following limited circumstances:

(a) Emergency situations; or

(b) When the client intends to return to Washington state and the out-of-state stay is for:

(i) Thirty days or less; or

(ii) More than thirty days if approved by ADSA.

(7) To receive payment from the department, an out-of-state provider must:

(a) Have a signed agreement with the department;

(b) Meet the functionally equivalent licensing requirements of the state or province in which care is rendered;

(c) Meet the conditions in WAC 388-502-0100 and 388-502-0150;

(d) Satisfy all medicaid conditions of participation;

(e) Accept the department's payment as payment in full according to 42 C.F.R. 447.15; and

(f) If a Canadian provider, bill at the U.S. exchange rate in effect at the time the service was provided.

(8) For covered services for eligible clients, the department reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX medicaid program.

[11-14-075, recodified as § 182-502-0120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0120, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.-057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-502-0120, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

### INTEREST PENALTIES

#### **WAC 182-502-0130 Interest penalties—Providers.**

(1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[11-14-075, recodified as § 182-502-0130, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

### TIME LIMITS FOR BILLING

**WAC 182-502-0150 Time limits for providers to bill the department.** Providers must bill the department for covered services provided to eligible clients as follows:

(1) The department requires providers to submit initial claims and adjust prior claims in a timely manner. The department has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims and claims for major trauma services, see subsections (7) and (8) of this section;

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to the department as described in the department's current published billing instructions.

(3) Providers must submit the initial claim to the department and have a transaction control number (TCN) assigned by the department within three hundred sixty-five calendar days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) The department may grant exceptions to the time limit of three hundred sixty-five calendar days for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retro-active period; or

(b) The provider proves to the department's satisfaction that there are other extenuating circumstances.

(5) The department requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to the department's billing limits.

(6) When a client is covered by both medicare and medicaid, the provider must bill medicare for the service before billing the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, the department requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, with a timely TCN. This applies to any claim, other than a prescription drug claim or a claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. The department does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(8) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) The department allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within fifteen months of the date the service was provided to the client. After fifteen months, the department does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for

hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

[11-14-075, recodified as § 182-502-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-502-0150, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

## BILLING A CLIENT

**WAC 182-502-0160 Billing a client.** (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 182-500-0085) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a medicaid agency-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050 (4)(a) and 182-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable medicaid agency or agency-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the agency or agency-contracted MCO for medical assistance services furnished to clients. See 42 C.F.R. § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of

payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the agency or the client's MCO.

(c) A covered service when the agency or its designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC 182-501-0050(9), or a noncovered service, defined in WAC 182-501-0050(10) and 182-501-0070. The client and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at <http://hrsa.dshs.wa.gov/mpforms.shtml>. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service other than a nonformulary drug and that the client may choose not to do so;

(viii) Specify that the client and their prescriber may request a nonformulary justification (NFJ) in accordance with WAC 182-530-2300 for a nonformulary drug and that the client may choose not to do so;

(ix) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(x) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the

requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(xi) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 or the NFJ process as described in WAC 182-530-2300 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR or NFJ and has chosen not to pursue an ETR as described in WAC 182-501-0160 or the NFJ process as described in WAC 182-530-2300;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for agency or the agency's designee review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency or its designee). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is under the agency's or an agency-contracted MCO's patient review and coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or health care facilities other than those to whom the client is assigned or referred under the PRC program;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 182-530-7700 (2)(a)(iii) are met;

(f) The services provided to a TAKE CHARGE or family planning only client are not within the scope of the client's benefit package;

(g) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the agency or its designee after being informed by the provider that he or she is not contracted with the agency or its designee and that the services offered will not be paid by the client's health care program; and

(i) An agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

(7) Under chapter 182-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on health care expenses to become eligible for coverage under the medically needy program. An individual must incur health care expenses greater than or equal to the amount that he or she must spend down. The provider is prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the agency for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the agency or its designee or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the agency or its designee makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 182-500-0025; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 C.F.R. § 435.914(a) and defined in WAC 182-500-0095.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the agency or its designee for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

[Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act. 12-18-062, § 182-502-0160, filed 8/31/12, effective 10/1/12. 11-14-075, recodified as § 182-502-0160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0160, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.15. 10-10-022, § 388-502-0160, filed 4/26/10, effective 5/27/10. Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090. 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

## PROVIDER REPORTS

**WAC 182-502-0210 Statistical data-provider reports.** (1) At the request of the department, all providers enrolled with department programs must submit full reports, as specified by the department, of goods and services furnished to eligible medical assistance clients. The department furnishes the provider with a standardized format to report these data.

(2) The department analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to the department's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with the department, and any other interested organizations or individuals.

[11-14-075, recodified as § 182-502-0210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0210, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.035. 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

## APPEAL—RATE REIMBURSEMENT

**WAC 182-502-0220 Administrative appeal contractor/provider rate reimbursement.** (1) Any enrolled

contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the department reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with the department.

(a) The appeal must include all of the following:

- (i) A statement of the specific issue being appealed;
- (ii) Supporting documentation; and
- (iii) A request for the department to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, the department may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, the department may do one or both of the following:

- (i) Request additional information; and/or
- (ii) Conduct an audit of the documentation provided.

(d) The department issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When the department requests additional information, the contractor/provider has forty-five calendar days from the date of the department's request to submit the additional information.

(ii) The department issues a decision within thirty calendar days of receipt of the completed information.

(e) The department may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from the department. The department does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) The department may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that the department grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with the department. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to the department within thirty calendar days after the contractor/provider receives the rate review decision. The department does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) The department conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(f) The department considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[11-14-075, recodified as § 182-502-0220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 10-19-057, § 388-502-0220, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.730, 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

## PROVIDER PAYMENT REVIEWS AND DISPUTE RIGHTS

**WAC 182-502-0230 Provider payment reviews and dispute rights.** (1) As authorized by chapters 43.20B and 74.09 RCW, the department monitors and reviews all providers who furnish health care services to eligible clients. For the purposes of this section, health care services includes treatment, equipment, related supplies, and drugs. The department may review all documentation and/or data related to payments made to providers for health care services for eligible clients and determine whether the providers are complying with the rules and regulations of the program(s). Examples of provider reviews are:

(a) A review of all records and/or payments for medical assistance clients;

(b) A random sampling of billing and/or records for medical assistance clients; and/or

(c) A review focused on selected records for medical assistance clients.

(2) The department may determine that a provider's billing does not comply with program rules and regulations. As a result of that determination, the department may take any of the following actions, or others as appropriate:

(a) Conduct prepay reviews of all claims the provider submits to the department;

(b) Refer the provider to the department's auditors (see chapter 388-502A WAC);

(c) Refer the provider to the Washington state medicaid fraud control unit;

(d) Refer the provider to the appropriate state health professions quality assurance commission;

(e) Terminate the provider's participation in medical assistance programs (see WAC 388-502-0030);

(f) Assess a civil penalty against the provider, per RCW 74.09.210; and

(g) Recover any moneys that the provider received as a result of overpayments as authorized under chapter 43.20B RCW.

(3) A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s) per RCW 43.20B.675.

(a) The request for hearing must be in writing; and

(i) Must be received by the department within twenty-eight days of the date of the notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:

Office of Financial Recovery  
P.O. Box 9501  
Olympia, WA 98507-5501; and

(ii) State the reason(s) why the provider thinks the action(s) are incorrect.

(b) The office of administrative hearings schedules and conducts the hearing under the Washington Administrative Procedure Act, chapter 34.05 RCW, and chapter 388-02 WAC. The department offers a prehearing/alternative dispute conference prior to the hearing.

(c) The office of financial recovery collects any amount the provider is ordered to repay.

[11-14-075, recodified as § 182-502-0230, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. 11-11-017, § 388-502-0230, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220. 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

**WAC 182-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements.** (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[11-14-075, recodified as § 182-502-0260, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.290. 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

**WAC 182-502-0270 Review of department's provider dispute decision.** (1) This section applies only when department rules allow review of a department dispute decision under this section. The deputy assistant secretary of the health and recovery services administration (HRSA) or designee conducts the review.

(2) Providers and former providers may request a review of a department dispute decision. The request must be in writing and sent to: HRSA, Attn: Deputy Assistant Secretary, PO Box 45504, Olympia, WA 98504-5504. The department must receive the written dispute review request within twenty-eight calendar days of the date on the department's written dispute decision.

(3) When the department receives a timely dispute review request, the deputy or designee may schedule a dispute review conference. "Dispute review conference" means an informal conference for the purpose of resolving disagreements between the department and a provider or former provider who is dissatisfied with a department decision. The dispute review conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW. If the deputy or designee chooses to schedule a dispute review conference, the deputy or designee will conduct the conference within ninety calendar days of the dispute review request unless the deputy or designee and the party requesting review agree to an extension.

(4) The deputy or designee will issue a dispute review decision to the provider or former provider requesting review within thirty calendar days of receiving the dispute review request or within thirty calendar days of the dispute review conference, whichever is later, unless both parties agree to an extension.

(5) The deputy review is the final level of department review for disputes to which this section applies.

[11-14-075, recodified as § 182-502-0270, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 08-12-012, § 388-502-0270, filed 5/27/08, effective 6/27/08.]