

Chapter 182-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, COMPLEX REHABILITATION TECHNOLOGY, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

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WAC 182-543-0500 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—General. (1) The federal government considers durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, and medical supplies to be optional services under the medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The medicaid agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(2) The agency covers the DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter.

(3) The agency pays for DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies when they are:

(a) Covered;

(b) Within the scope of the client's medical program (see WAC 182-501-0060 and 182-501-0065);

(c) Medically necessary, as defined in WAC 182-500-0070;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), naturopathic physicians, or physician assistant certified (PAC) within the scope of his or her licensure, except for dual eligible medicare/medicaid clients when medicare is the primary payer and the agency is being billed for a co-pay and/or deductible only;

(e) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices;

(f) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices; and

(g) Provided and used within accepted medical or physical medicine community standards of practice.

(4) The agency requires prior authorization for covered DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The agency evaluates requests requiring prior authorization on a case-by-case basis to determine medical necessity, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-543-7000, 182-543-7100, and 182-543-7300 for specific details regarding authorization.

(5) The agency bases its determination about which DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 182-543-7100 for PA and WAC 182-543-7300 for EPA). The agency considers all of the following when establishing utilization criteria:

- (a) Cost;
- (b) The potential for utilization abuse;
- (c) A narrow therapeutic indication; and
- (d) Safety.

(6) The agency evaluates a request for any item listed as noncovered in this chapter under the provisions of WAC 182-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-543-0100 for EPSDT rules).

(7) The agency may terminate a provider's participation with the agency according to WAC 182-502-0030 and 182-502-0040.

(8) The agency evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under the provisions of WAC 182-501-0165.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-0500, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-0500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-0500, filed 6/29/11, effective 8/1/11.]

WAC 182-543-1000 DME and related supplies, complex rehabilitation technology, prosthetics, and orthotics, medical supplies and related services—Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

"By-report (BR)" - See WAC 182-500-0015.

"Complex needs patient" - An individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology (CRT)" - Wheelchairs and seating systems classified as durable medical equipment within the Medicare program that:

(1) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

(2) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(3) Require certain services necessary to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting.

"Date of delivery" - The date the client actually took physical possession of an item or equipment.

"Digitized speech" (also referred to as devices with whole message speech output) - Words or phrases that have been recorded by an individual other than the speech generating device (SGD) user for playback upon command of the SGD user.

"Disposable supplies" - Supplies which may be used once, or more than once, but are time limited.

"Durable medical equipment (DME)" - Equipment that:

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to a person in the absence of illness or injury; and
- (4) Is appropriate for use in the client's place of residence.

"EPSDT" - See WAC 182-500-0030.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Fee-for-service (FFS)" - See WAC 182-500-0035.

"Health care common procedure coding system (HCPCS)" - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"Home" - For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client receives care.

"House wheelchair" - A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Individually configured" - A device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

"Limitation extension" - A client-specific authorization by the agency for additional covered services beyond the set amount allowed under agency rules. See WAC 182-501-0169.

"Manual wheelchair" - See "Wheelchair - Manual."

"Medical supplies" - Supplies that are:

- (1) Primarily and customarily used to service a medical purpose; and
- (2) Generally not useful to a person in the absence of illness or injury.

"Medically necessary" - See WAC 182-500-0070.

"National provider indicator (NPI)" - See WAC 182-500-0075.

"Other durable medical equipment (other DME)" - All durable medical equipment, excluding wheelchairs and wheelchair-related items.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Personal or comfort item" - An item or service which primarily serves the comfort or convenience of the client or caregiver.

"Power-drive wheelchair" - See "Wheelchair - Power."

"Pricing cluster" - A group of manufacturers' list prices for brands/models of DME, medical supplies and nondurable medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by medicare.

"Prior authorization" - See WAC 182-500-0085.

"Prosthetic device" or **"prosthetic"** - See WAC 182-500-0085.

"Qualified complex rehabilitation technology supplier" - A company or entity that:

(1) Is accredited by a recognized accrediting organization as a supplier of CRT;

(2) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

(3) For each site that it operates, employs at least one CRT professional, certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of clients, and provide training in the use of the selected covered CRT items;

(4) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured CRT for the complex needs patient;

(5) Provides service and repairs by qualified technicians for all CRT products it sells; and

(6) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair of the delivered CRT.

"Resource-based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"Reusable supplies" - Supplies which are to be used more than once.

"Scooter" - A federally approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

"Specialty bed" - A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Synthesized speech" - Is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules, unlike prerecorded messages of

digitized speech. A SGD that has synthesized speech is not limited to prerecorded messages but rather can independently create messages as communication needs dictate.

"Three- or four-wheeled scooter" - A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

"Trendelenburg position" - A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" - See WAC 182-500-0110.

"Warranty-period" - A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

"Wheelchair - Manual" - A federally approved, non-motorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(1) Standard:

(a) Usually is not capable of being modified;

(b) Accommodates a person weighing up to two hundred fifty pounds; and

(c) Has a warranty period of at least one year.

(2) Lightweight:

(a) Composed of lightweight materials;

(b) Capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds; and

(d) Usually has a warranty period of at least three years.

(3) High-strength lightweight:

(a) Is usually made of a composite material;

(b) Is capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds;

(d) Has an extended warranty period of over three years;

and

(e) Accommodates the very active person.

(4) Hemi:

(a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(8) Heavy duty:

(a) Specifically manufactured to support a person weighing up to three hundred pounds; or

(b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(10) Custom heavy duty:

(a) Specifically manufactured to support a person weighing over three hundred pounds; or

(b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(11) Custom manufactured specially built:

(a) Ordered for a specific client from custom measurements; and

(b) Is assembled primarily at the manufacturer's factory. **"Wheelchair - Power"** - A federally approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(a) Alternative driving controls; and

(b) Power recline and tilt-in-space systems.

(2) Noncustom power: Does not need special positioning or controls and has a standard frame.

(3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-1000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-1000, filed 6/29/11, effective 8/1/11. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 02-16-054, § 388-543-1000, filed 8/1/02, effective 9/1/02; WSR 01-01-078, § 388-543-1000, filed 12/13/00, effective 1/13/01.]

WAC 182-543-1100 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Client eligibility.

(1) Refer to the table in WAC 182-501-0060 to see which Washington apple health (WAH) programs include DME and related services, complex rehabilitation technology (CRT), prosthetics and orthotics, medical supplies and related services in their benefit package.

(2) For clients eligible under an alien emergency medical (AEM) program, see WAC 182-507-0115.

(3) Clients who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for DME and related services, CRT, prosthetics and orthotics, medical supplies and related services.

(4) Clients who are enrolled in a agency-contracted managed care organization (MCO) must arrange for DME and related services, prosthetics and orthotics, medical supplies and related services directly through his or her agency-contracted MCO. The agency does not pay for medical equipment and/or services provided to a client who is enrolled in a agency-contracted MCO, but chose not to use one of the MCO's participating providers.

(5) For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(6) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for DME and related supplies, CRT, prosthetics, orthotics, medical sup-

plies, and related equipment when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-1100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-1100, filed 6/29/11, effective 8/1/11; WSR 07-17-062, § 388-543-1100, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-543-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. WSR 05-21-102, § 388-543-1100, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 34.05.-353. WSR 03-12-005, § 388-543-1100, filed 5/22/03, effective 6/22/03. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 02-16-054, § 388-543-1100, filed 8/1/02, effective 9/1/02; WSR 01-01-078, § 388-543-1100, filed 12/13/00, effective 1/13/01.]

WAC 182-543-2000 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service basis as follows:

(a) DME providers who are enrolled with medicare for DME and related repair services;

(b) Qualified CRT suppliers who are enrolled with medicare for DME and related repair services;

(c) Medical equipment dealers who are enrolled with medicare, pharmacies who are enrolled with medicare, and home health agencies under their national provider indicator (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Physicians who provide medical equipment and supplies in the office. The agency may pay separately for medical supplies, subject to the provisions in the agency's resource-based relative value scale fee schedule; and

(f) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(2) Providers and suppliers of DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related items must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Have the proper business license and be certified, licensed and/or bonded if required, to perform the services billed to the agency;

(c) Have a valid prescription;

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at: <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>;

(B) Be written by a physician, advanced registered nurse practitioner (ARNP), naturopathic physician, or physician's assistant certified (PAC);

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual eligible medicare/medicaid clients when medicare is the primary payer and the agency is being billed for the co-pay and/or deductible only, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Furnish only new equipment to clients that includes full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Furnish documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

(g) Bill the agency using only the allowed procedure codes listed in the agency's published DME and related supplies, prosthetics and orthotics, medical supplies and related items billing instructions.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2000, filed 3/25/14, effective 4/25/14. 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. WSR 12-15-015, § 182-543-2000, filed 7/10/12, effective 9/1/12. WSR 11-14-075, recodified as § 182-543-2000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2000, filed 6/29/11, effective 8/1/11; WSR 07-17-062, § 388-543-2000, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]

WAC 182-543-2100 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Requests to include new equipment/supplies/technology. (1) An interested party may request the medicaid agency to include new equipment/supplies in the agency's durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related services billing instructions.

(2) The request should include credible evidence, including but not limited to:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (included FDA approval, if required);

(d) Proof of certification from the Centers for Medicare and Medicaid Services (CMS), if applicable; and

(e) Any additional information the requester feels would aid the agency in its determination.

(3) Requests should be sent to the DME Program Management Unit, P.O. Box 45505, Olympia WA 98504-5506.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-2100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2100, filed 6/29/11, effective 8/1/11. Statutory Authority: RCW 74.04.050, 74.04.057,

(9/24/14)

74.08.090, and Public Law 104-191. WSR 03-19-083, § 388-543-2100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.-530. WSR 01-01-078, § 388-543-2100, filed 12/13/00, effective 1/13/01.]

WAC 182-543-2200 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Proof of delivery.

(1) When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the medicaid agency requests that information. All of the following apply:

(a) The agency requires a delivery slip as proof of delivery. The proof of delivery slip must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For durable medical equipment (DME) and complex rehabilitation technology (CRT) that may require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or the client's authorized representative; or

(ii) For nondurable medical supplies for which the agency has established a monthly maximum, on or after the date the item was received by the client or the client's authorized representative.

(2) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must furnish proof of delivery that the client received the equipment and/or supply, when the agency requests that information.

(a) If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery. The tracking slip must include:

(i) The client's name or a reference to the client's package(s);

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) If the provider/supplier does the delivering, the delivery slip is the proof of delivery. The delivery slip must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand name(s) of the items being shipped; and

(iv) For DME and CRT that may require future repairs, the serial number.

(c) When billing the agency:

(i) Use the shipping date as the date of service on the claim if the provider uses a delivery/shipping service; or

(ii) Use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery.

(3) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(4) Providers must obtain prior authorization when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

(5) The agency does not pay for DME and related supplies, CRT, prosthetics and orthotics, medical supplies and related items furnished to the agency's clients when:

(a) The medical professional who provides medical justification to the agency for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of DME and related supplies, CRT, prosthetics and orthotics, medical supplies, and related items.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2200, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-2200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2200, filed 6/29/11, effective 8/1/11. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 02-16-054, § 388-543-2200, filed 8/1/02, effective 9/1/02; WSR 01-01-078, § 388-543-2200, filed 12/13/00, effective 1/13/01.]

WAC 182-543-2250 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Rental or purchase.

(1) The medicaid agency bases its decision to rent or purchase durable medical equipment (DME) on the length of time the client needs the equipment.

(2) A provider must not bill the agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(3) The agency purchases new DME equipment and complex rehabilitation technology (CRT) only.

(a) A new DME item that is placed with a client initially as a rental item is considered a new item by the agency at the time of purchase.

(b) A used DME item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the agency.

(4) The agency requires a dispensing provider to ensure the DME rented to a client is:

(a) In good working order; and

(b) Comparable to equipment the provider rents to individuals with similar medical equipment needs who are either private pay or who have other third-party coverage.

(5) The agency's minimum rental period for covered DME is one day.

(6) The agency authorizes rental equipment for a specific period of time. The provider must request authorization from the agency for any extension of the rental period.

(7) The agency's reimbursement amount for rented DME includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(8) The agency considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.

(9) DME and related supplies, CRT, prosthetics, and orthotics purchased by the agency for a client are the client's property.

(10) The agency rents, but does not purchase, certain DME for clients. This includes, but is not limited to, the following:

(a) Bilirubin lights for newborns at home with jaundice; and

(b) Electric hospital-grade breast pumps.

(11) The agency stops paying for any rented equipment effective the date of a client's death. The agency prorates monthly rentals as appropriate.

(12) For a client who is eligible for both medicare and medicaid, the agency pays only the client's coinsurance and deductibles. The agency discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:

(a) The reimbursement amount reaches medicare's reimbursement cap for the equipment; or

(b) Medicare considers the equipment purchased.

(13) The agency does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2250, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-2250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2250, filed 6/29/11, effective 8/1/11.]

WAC 182-543-3000 Covered—Hospital beds, mattresses, and related equipment.

(1) Hospital beds.

(a) The medicaid agency covers, with prior authorization, one hospital bed in a ten-year period, per client, with the following limitations:

(i) A manual hospital bed as the primary option when the client has full-time caregivers; or

(ii) A semi-electric hospital bed only when:

(A) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(B) The client's medical condition requires immediate position changes;

(C) The client is able to operate the controls independently; and

(D) The client needs to be in the Trendelenburg position.

(b) The agency bases the decision to rent or purchase a manual or semi-electric hospital bed on the length of time the client needs the bed.

(c) Rental - The agency pays up to eleven months continuous rental of a hospital bed in a twelve-month period as follows:

(i) A manual hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

(A) Has a length of need/life expectancy that is twelve months or less;

(B) Has a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file);

(C) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and these have been determined to not be effective in meeting the client's positioning needs (nature of ineffectiveness must be documented in the client's file);

(D) Has a medical condition that necessitates upper body positioning at no less than a thirty-degree angle the majority of time the client is in the bed;

(E) Does not have full-time caregivers; and

(F) Does not also have a rental wheelchair.

(ii) A semi-electric hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

(A) Has a length of need/life expectancy that is twelve months or less;

(B) Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and these have been determined to be ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file);

(C) Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation;

(D) Must be able to independently and safely operate the bed controls; and

(E) Does not have a rental wheelchair.

(d) Purchase - The agency pays, with prior authorization, for the initial purchase of a semi-electric hospital bed with mattress, with or without bed rails, when the following criteria are met:

(i) The client:

(A) Has a length of need/life expectancy that is twelve months or more;

(B) Has tried positioning devices such as pillows, bolsters, foam wedges, and/or rolled up blankets/towels in own bed, and these have been determined to be ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file);

(C) Must be able to independently and safely operate the bed controls; and

(D) Is diagnosed:

(I) With quadriplegia;

(II) With tetraplegia;

(III) With duchenne muscular dystrophy;

(IV) With amyotrophic lateral sclerosis (ALS), often referred to as "Lou Gehrig's Disease";

(V) As ventilator-dependent; or

(VI) With COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate change of upper body positioning of more than thirty degrees.

(ii) Requests for prior authorization must be submitted in writing to the agency and be accompanied by:

(A) A completed General Information for Authorization form (HCA 13-835) and Hospital Bed Evaluation form (HCA 13-747). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(B) Documentation of the client's life expectancy, in months and/or years, the client's diagnosis, the client's date of delivery and serial number of the hospital bed; and

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(C) Be accompanied by written documentation, from the client or caregiver, indicating the client has not been previously provided a hospital bed, purchase or rental.

(2) Mattresses and related equipment - The agency pays, with prior authorization, for the following:

(a) Pressure pad, alternating with pump - One in a five-year period;

(b) Dry pressure mattress - One in a five-year period;

(c) Gel or gel-like pressure pad for mattress - One in a five-year period;

(d) Gel pressure mattress - One in a five-year period;

(e) Water pressure pad for mattress - One in a five-year period;

(f) Dry pressure pad for mattress - One in a five-year period;

(g) Mattress, inner spring - One in a five-year period; and

(h) Mattress, foam rubber - One in a five-year period.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3000, filed 6/29/11, effective 8/1/11. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 01-01-078, § 388-543-3000, filed 12/13/00, effective 1/13/01.]

WAC 182-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards. The medicaid agency covers the purchase of the following with the stated limitations, without prior authorization:

(1) Patient lift, hydraulic, with seat or sling - One per client in a five-year period.

(2) Traction equipment - One per client in a five-year period.

(3) Trapeze bars - One per client in a five-year period. The agency requires prior authorization for rental.

(4) Fracture frames - One per client in a five-year period. The agency requires prior authorization for rental.

(5) Transfer board or devices - One per client in a five-year period.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3100, filed 6/29/11, effective 8/1/11.]

WAC 182-543-3200 Covered—Positioning devices. The medicaid agency covers, without prior authorization, positioning devices with the following limitations:

(1) Positioning system/supine board (small or large), including padding, straps, adjustable armrests, footboard, and support blocks - One per client in a five-year period.

(2) Prone stander (infant, child, youth, or adult size) - One per client in a five-year period. The prone stander must be prescribed by a physician and the client must not be residing in a skilled nursing facility.

(3) Adjustable standing frame (for child/adult who is thirty to sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - One per client in a five-year period.

(4) Positioning car seats - One per client, eight years of age and older or four feet nine inches or taller, in a five-year period.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3200, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3200, filed 6/29/11, effective 8/1/11.]

WAC 182-543-3300 Covered—Osteogenesis electrical stimulator (bone growth stimulator). (1) The medicaid agency covers, with prior authorization, noninvasive osteogenesis electrical stimulators, limited to one per client, in a five-year period.

(2) The agency pays for the purchase of nonspinal bone growth stimulators, only when:

(a) The stimulators have pulsed electromagnetic field (PEMF) simulation; and

(b) The client meets one or more of the following clinical criteria:

(i) Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) where three months have elapsed since the date of injury without healing; or

(ii) Has a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery.

(3) The agency pays for the purchase of spinal bone growth stimulators, when:

(a) Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon; and

(b) The client meets one or more of the following clinical criteria:

(i) Has a failed spinal fusion where a minimum of nine months have elapsed since the last surgery; or

(ii) Is post-op from a multilevel spinal fusion surgery; or

(iii) Is post-op from spinal fusion surgery and there is a history of a previously failed spinal fusion.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3300, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3300, filed 6/29/11, effective 8/1/11.]

WAC 182-543-3400 Covered—Communication devices/speech generating devices (SGD). (1) The medicaid agency covers:

(a) One artificial larynx, any type, without prior authorization, per client in a five-year period; and

(b) One speech generating device (SGD), with prior authorization, per client every two years.

(2) The agency pays only for those approved SGDs that have:

(a) Digitized speech output, using prerecorded messages;

(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or

(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

(3) The agency requires prior authorization for SGDs and reviews requests on a case-by-case basis. Requests to the agency for prior authorization must meet all of the following:

(a) The client must have a severe expressive speech impairment and the client's medical condition warrants the use of a device to replace verbal communication (e.g., to communicate medical information); and

(b) The request must be in writing and be accompanied by:

(i) A completed General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization); and

(ii) A completed Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices (15-310) form. The agency requires, at a minimum, the following information:

(A) A detailed description of the client's therapeutic history;

(B) A written assessment by a licensed SLP; and

(C) Documentation of all of the following:

(I) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;

(II) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and

(III) The client's treatment plan includes a training schedule for the selected device.

(iii) A copy of the prescription for the SGD from the client's treating physician written on an agency Prescription Form (HCA 13-794) (see WAC 182-543-2000(2)).

(4) The agency may require trial-use rental of a SGD. The agency applies the rental costs for the trial-use to the purchase price.

(5) The agency pays for the repair or modification of an SGD when all of the following are met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new SGD and the provider has submitted supporting documentation; and

(c) The repair has a warranty for a minimum of ninety days.

(6) The agency does not pay for devices requested for the purpose of education.

(7) The agency pays for replacement batteries for a SGD in accordance with WAC 182-543-5500(3). The agency does not pay for back-up batteries for an SGD.

(8) Clients who are eligible for both medicare and medicaid must apply first to medicare for an SGD. If medicare denies the request and the client requests an SGD from the agency, the agency evaluates the request according to the rules of this section.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3400, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3400, filed 6/29/11, effective 8/1/11.]

WAC 182-543-3500 Covered—Ambulatory aids (canes, crutches, walkers, related supplies). (1) The medicaid agency covers the purchase of the following ambulatory aids with stated limitations, without prior authorization:

(a) Canes - One per client in a five-year period.

(b) Crutches - One per client in a five-year period.

(c) Walkers - One per client in a five-year period.

(2) The agency pays for replacement underarm pads for crutches and replacement handgrips and tips for canes, crutches, and walkers. Prior authorization is not required.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-3500, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-3500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-3500, filed 6/29/11, effective 8/1/11.]

WAC 182-543-4000 Covered—Wheelchairs—General. (1) The medicaid agency covers, with prior authorization, manual and power-drive wheelchairs for clients who reside at home. For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(2) For manual or power-drive wheelchairs for clients who reside at home, requests for prior authorization must include all of the following completed forms:

(a) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) A Prescription Form (HCA 13-794); and

(c) Medical Necessity for Wheelchair Purchase (for home clients only) form (HCA 13-727) from the client's physician or therapist. The date on this form (HCA 13-727) must not be prior to the date on the Prescription Form (HCA 13-794).

(3) The agency does not pay for manual or power-drive wheelchairs that have been delivered to a client without prior authorization from the agency.

(4) When the agency determines that a wheelchair is medically necessary, according to the process found in WAC 182-501-0165, the agency rents or purchases a wheelchair for clients who live at home. For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-4000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-4000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-4000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-4100 Covered—Wheelchairs—Manual. The medicaid agency covers the rental or purchase of a manual wheelchair for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(1) The agency determines the type of manual wheelchair for a home client as follows:

(a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

(b) A standard lightweight wheelchair if the client's medical condition is such that the client:

(i) Cannot self-propel a standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.

(c) A high-strength, lightweight wheelchair for a client:

(i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

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(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing three hundred pounds or over; or

(ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing three hundred pounds or over; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self-propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the categories of wheelchairs listed in this section.

(h) Pediatric wheelchairs/positioning strollers having a narrower seat and shorter depths more suited to pediatric patients, usually adaptable to modifications for a growing child.

(2) The agency pays for both a manual wheelchair and a power-drive wheelchair only for noninstitutionalized clients in limited circumstances. See WAC 182-543-4200(5).

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-4100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-4100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-4100, filed 6/29/11, effective 8/1/11.]

WAC 182-543-4200 Covered—Wheelchairs—Power-drive. (1) The medicaid agency covers power-drive wheelchairs when the prescribing physician certifies that the following clinical criteria are met:

(a) The client can independently and safely operate a power-drive wheelchair;

(b) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(c) A power-drive wheelchair will:

(i) Provide the client the only means of independent mobility; or

(ii) Enable a child to achieve age-appropriate independence and developmental milestones.

(2) The following additional information is required for a three or four-wheeled power-drive scooter/power-operated vehicle (POV):

(a) The prescribing physician certifies that the client's condition is stable; and

(b) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(3) When the agency approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria in subsection (5) of this section.

(4) The agency pays to maintain only the client's primary wheelchair, unless the conditions of subsection (6) of this section apply.

(5) The agency pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients only when one of the following circumstances applies:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The agency requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

(6) When the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the circumstances in subsection (5) of this section, the agency pays to maintain both wheelchairs.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-4200, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-4200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-4200, filed 6/29/11, effective 8/1/11.]

WAC 182-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs. (1) The agency covers, with prior authorization, wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. To receive payment, providers must submit the following to the agency:

(a) A completed General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) A completed Prescription Form (HCA 13-794);

(c) A completed Medical Necessity for Wheelchair Purchase (for home clients only) form (HCA 13-727). The date on this form (HCA 13-727) must not be dated prior to the date on the Prescription Form (HCA 13-794);

(d) The make, model, and serial number of the wheelchair to be modified;

(e) The modification requested; and

(f) Any specific information regarding the client's medical condition that necessitates the modification.

(2) The agency pays for transit option restraints only when used for client-owned vehicles.

(3) The agency covers, with prior authorization, wheelchair repairs. To receive payment, providers must submit the following to the agency:

(a) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000);

(b) A completed Medical Necessity for Wheelchair Purchase form (for home clients only) (HCA 13-727);

(c) The make, model, and serial number of the wheelchair to be repaired; and

(d) The repair requested.

(4) Prior authorization is required for the repair and modification of client-owned equipment.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-4300, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-4300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-4300, filed 6/29/11, effective 8/1/11.]

WAC 182-543-4400 Covered—Complex rehabilitation technology. (1) The agency covers, with prior authorization, individually configured, complex rehabilitation technology (CRT) products.

(2) CRT must be supplied by a CRT supplier with the appropriate taxonomy number to bill for the items.

(3) Each site that a company operates must employ at least one CRT professional who has been certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(4) The client must be evaluated by a licensed health care provider who performs specialty evaluations within their scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.

(a) At the evaluation, a CRT professional must also be present from the company ordering the equipment; or

(b) The CRT provider must be present at the evaluation to:

(i) Assist in selection of the appropriate CRT item(s); and

(ii) Provide training in the use of the selected items.

(5) The CRT provider must:

(a) Provide service and repairs by qualified technicians for all CRT products it sells; and

(b) Provide written information to the client at the time of delivery as to how the client may receive services and repairs.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-4400, filed 3/25/14, effective 4/25/14.]

WAC 182-543-5000 Covered—Prosthetics/orthotics. (1) The agency covers, without prior authorization, the following prosthetics and orthotics, with stated limitations:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - One every five years.

(b) Preparatory, above knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, molded to model - One per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - One per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - One per twelve-month period, per limb.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - One per twelve-month period, per limb.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(2) The agency pays only licensed prosthetic and orthotic providers to supply prosthetics and orthotics. This requirement does not apply to the following:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out-of-state providers, who must meet the licensure requirements of that state.

(3) The agency pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), that meet the definition of prosthetic or orthotic as defined in WAC 182-543-1000 and are prescribed per WAC 182-543-1100 and 182-543-1200.

(4) The agency pays for repair or modification of a client's current prosthesis. To receive payment, all of the following must be met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has submitted supporting documentation; and

(c) The repair is warranted for a minimum of ninety days.

(5) The agency requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, the agency requires the client's caregiver to be responsible. The agency requires prior authorization for extensive maintenance to a prosthetic or orthotic.

(6) For prosthetics dispensed for purely cosmetic reasons, see WAC 182-543-6000, Noncovered-DME.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-5000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-5000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-5000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-5500 Covered—Medical supplies and related services. The agency covers, without prior authorization unless otherwise specified, the following medical supplies and related services:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - One pint per month;

(b) Alcohol wipes (box of two hundred) - One box per month;

(c) Betadine or pHisoHex solution - One pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - One box per month;

(2) Bandages, dressings, and tapes;

(3) Batteries - Replacement batteries:

(a) The agency pays for the purchase of replacement batteries for wheelchairs with prior authorization.

(b) The agency does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. See WAC 182-543-3400 for speech generating devices and chapter 182-548 WAC for ventilators.

(4) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - One in a three-month period;

(b) Spring-powered device for lancet - One in a six-month period;

(c) Diabetic test strips as follows:

(i) For clients, twenty years of age and younger, as follows:

(A) Insulin dependent, three hundred test strips and three hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, per month.

(ii) For clients, twenty-one years of age and older:

(A) Insulin dependent, one hundred test strips and one hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, every three months.

(iii) For pregnant women with gestational diabetes, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to sixty days postpartum.

(d) See WAC 182-543-5500(12) for blood glucose monitors.

(5) Braces, belts, and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - Two per twelve-month period;

(b) Ankle, elbow, or wrist brace - Two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - One per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - One per twelve-month period.

(6) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - One per twelve-month period;

(b) Synthetic or lamb's wool sheepskin pad - One per twelve-month period;

(c) Heel or elbow protectors - Four per twelve-month period.

(7) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - Four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - Ten per month.

(c) Adhesive remover or solvent - Three ounces per month.

(d) Adhesive remover wipes, fifty per box - One box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - Sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - Ten per month.

(g) Continent plug for continent stoma - Thirty per month.

(h) Continent device for continent stoma - One per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - Twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - Twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(m) Irrigation bag - Two every six months.

(n) Irrigation cone and catheter, including brush - Two every six months.

(o) Irrigation supply, sleeve - One per month.

(p) Ostomy belt (adjustable) for appliance - Two every six months.

(q) Ostomy convex insert - Ten per month.

(r) Ostomy ring - Ten per month.

(s) Stoma cap - Thirty per month.

(t) Ostomy faceplate - Ten per month. The agency does not pay for either of the following when billed in combination with an ostomy faceplate:

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(8) Syringes and needles;

(9) Urological supplies - Diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a top sheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the back sheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a back sheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The agency pays for urological products when they are used alone. The following are examples of products which the agency does not pay for when used in combination with each other:

- (i) Disposable diapers;
- (ii) Disposable pull-up pants and briefs;
- (iii) Disposable liners, shields, guards, pads, and undergarments;
- (iv) Rented reusable diapers (e.g., from a diaper service); and
- (v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) The agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use. Example: pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

(h) Purchased disposable diapers (any size) are limited to two hundred per month for clients three years of age and older.

(i) Reusable cloth diapers (any size) are limited to:

- (i) Purchased - Thirty-six per year; and
- (ii) Rented - Two hundred per month.

(j) Disposable briefs and pull-up pants (any size) are limited to:

- (i) Two hundred per month for a client age three to eighteen years of age; and
- (ii) One hundred fifty per month for a client nineteen years of age and older.

(k) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

- (i) Purchased - Four per year.
- (ii) Rented - One hundred fifty per month.

(l) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - One hundred eighty per month.

(ii) Purchased, reusable (large) - Forty-two per year.

(iii) Rented, reusable (large) - Ninety per month.

(10) Urological supplies - Urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - Two per month. The agency does not pay for these when billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adaptor; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - Two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adaptor, for use with urinary leg bag or urostomy pouch. The agency does not pay for these when billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - Two per twelve-month period.

(e) Indwelling catheters (any type) - Three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - One hundred and twenty per month. The agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - Three per month. The agency does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter, individual indwelling catheters, and/or individual lubricant packets.

(g) Intermittent urinary catheter - One hundred twenty per month. The agency does not pay for these when billed in combination with an insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston). The agency does not pay for these when billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - Thirty per month. The agency does not pay for these when billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - Thirty per month. The agency does not pay for these when billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric), replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - Sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - Two per month. The agency does not pay for these when billed in combination with a latex urinary leg bag, urinary suspensory without leg bag, extension drainage tubing, or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - Two per month.

(o) Urinary leg bag, vinyl, with or without tube - Two per month. The agency does not pay for these when billed in combination with drainage bag and without catheter.

(p) Urinary leg bag, latex - One per month. The agency does not pay for these when billed in combination with or without catheter.

(11) Miscellaneous supplies:

(a) Bilirubin light therapy supplies when provided with a bilirubin light which the agency prior authorized - Five days supply.

(b) Continuous passive motion (CPM) softgoods kit - One, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - One box of twenty.

(d) Eye patch (adhesive wound cover) - One box of twenty.

(e) Nontoxic gel (e.g., LiceOff TM) for use with lice combs - One bottle per twelve-month period.

(f) Nonsterile gloves - Two hundred, per client, per month.

(i) For clients residing in an assisted living facility, the agency pays, with prior authorization, for additional nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of four hundred per client, per month.

(ii) Prior authorization requests must include a completed:

(A) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000 Authorization); and

(B) Limitation Extension Request Incontinent Supplies and Gloves form (HCA 13-870).

(g) Sterile gloves - Thirty pair, per client, per month.

(12) Miscellaneous DME:

(a) Bilirubin light or light pad - Five days rental per twelve-month period for at-home newborns with jaundice.

(b) Blood glucose monitor (specialized or home) - One in a three-year period. See WAC 182-543-5500(4) for blood monitoring/testing supplies. The agency does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC 182-553-500 home infusion therapy/parenteral nutrition program.

(c) Continuous passive motion (CPM) machine - Up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - Two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - Two per twelve-month period.

(f) Pneumatic compressor - One in a five-year period.

(g) Positioning car seat - One in a five-year period.

[Statutory Authority: RCW 41.05.021, WSR 12-07-022, § 182-543-5500, filed 3/12/12, effective 4/12/12, WSR 11-14-075, recodified as § 182-543-5500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050, WSR 11-14-052, § 388-543-5500, filed 6/29/11, effective 8/1/11.]

WAC 182-543-5700 Covered—DME and related supplies and complex rehabilitation technology for clients in skilled nursing facilities. (1) The agency's skilled nursing facility per diem rate, established in chapters 74.46 RCW, 388-96, and 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this section.

(2) The agency pays for the following covered DME and related supplies and complex rehabilitation technology (CRT) outside of the skilled nursing facility per diem rate, subject to the limitations in this section:

(a) Manual or power-drive wheelchairs (including CRT);

(b) Speech generating devices (SGD); and

(c) Specialty beds.

(3) The agency pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization, according to the requirements in WAC 182-543-4100, 182-543-4200, and 182-543-4300. Requests for prior authorization must:

(a) Be for the exclusive full-time use of a skilled nursing facility resident;

(b) Not be included in the skilled nursing facility's per diem rate;

(c) Include a completed General Information for Authorization form (HCA 13-835);

(d) Include a copy of the telephone order, signed by the physician, for the wheelchair assessment;

(e) Include a completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729).

(4) The agency pays for wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges, with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A copy of the telephone order, signed by the physician for the wheelchair accessories and modifications;

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The date on this form (HCA 13-729) must not be prior to the date on the telephone order. The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(c) The make, model, and serial number of the wheelchair to be modified;

(d) The modification requested; and

(e) Specific information regarding the client's medical condition that necessitates modification.

(5) The agency pays for wheelchair repairs, with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) The make, model, and serial number of the wheelchair to be repaired; and

(c) The repair requested.

(6) Prior authorization is required for the repair and modification of client-owned equipment.

(7) The skilled nursing facility must provide a house wheelchair as part of the per diem rate, when the client resides in a skilled nursing facility.

(8) When the client is eligible for both Medicare and Medicaid and is residing in a skilled nursing facility in lieu of hospitalization, the agency does not reimburse for DME and related supplies, CRT, prosthetics, orthotics, medical supplies, related services, or related repairs or labor charges under fee-for-service (FFS).

(9) The agency pays for the purchase and repair of a speech generating device (SGD), with prior authorization. The agency pays for replacement batteries for SGDs in accordance with WAC 182-543-5500(3).

(10) The agency pays for the purchase or rental of a specialty bed (a heavy duty bariatric bed is not a specialty bed), with prior authorization, when:

(a) The specialty bed is intended to help the client heal; and

(b) The client's nutrition and laboratory values are within normal limits.

(11) The agency considers decubitus care products to be included in the skilled nursing facility per diem rate and does not reimburse for these separately.

(12) See WAC 182-543-9200 for reimbursement for wheelchairs and WAC 182-543-9250 for reimbursement for CRT.

(13) The agency pays for the following medical supplies for a client in a skilled nursing facility outside the skilled nursing facility per diem rate:

(a) Medical supplies or services that replace all or part of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to, the following:

(i) Colostomy and other ostomy bags and necessary supplies (see WAC 388-97-1060(3)); and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies.

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony.

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks post-surgery.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-5700, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-5700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-5700, filed 6/29/11, effective 8/1/11.]

WAC 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered. The medicaid agency pays for DME and related supplies, medical supplies and related services only when listed as covered in this chapter. The agency evaluates a request for any durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies listed as noncovered in this chapter under the provisions of WAC 182-501-0160. In addition to the noncovered services found in WAC 182-501-0070, the agency does not cover:

(1) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the agency for the client contributes to an increased utility bill;

(2) Instructional materials such as pamphlets and video tapes;

(3) Hairpieces or wigs;

(4) Material or services covered under manufacturers' warranties;

(5) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(6) Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;

(7) Prosthetic devices dispensed for cosmetic reasons;

(8) Home improvements and structural modifications, including but not limited to the following:

(a) Automatic door openers for the house or garage;

(b) Electrical rewiring for any reason;

(c) Elevator systems and elevators;

(d) Installation of, or customization of existing, bathtubs or shower stalls;

(e) Lifts or ramps for the home;

(f) Overhead ceiling track lifts;

(g) Saunas;

(h) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(i) Swimming pools; and

(j) Whirlpool systems, such as jacuzzis, hot tubs, or spas.

(9) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(a) Back-packs, pouches, bags, baskets, or other carrying containers;

(b) Bedboards/conversion kits, and blanket lifters (e.g., for feet);

(c) Car seats for children seven years of age and younger or less than four feet nine inches tall, except for prior authorized positioning car seats under WAC 182-543-3200;

(d) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(e) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(f) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(i) Devices intended for amplifying voices (e.g., microphones);

(ii) Interactive communications computer programs used between patients and health care providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services;

(iii) Two-way radios;

(iv) Rental of related equipment or services; and

(v) Devices requested for the purpose of education.

(g) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads, and light boxes;

(h) Ergonomic equipment;

(i) DME that is used in a clinical setting;

(j) Exercise classes or equipment such as exercise mats, exercise balls, bicycles, tricycles, stair steppers, weights, or trampolines;

(k) Generators;

(l) Computer software other than speech generating software, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(m) Computer utility bills, telephone bills, internet service bills, or technical support for computers or electronic notebooks;

(n) Any communication device that is useful to someone without severe speech impairment (including but not limited to cellular telephone and associated hardware, walkie-talkie, two-way radio, pager, or electronic notebook);

(o) Racing strollers/wheelchairs and purely recreational equipment;

(p) Room fresheners/deodorizers;

(q) Bidet or hygiene systems, "sharps" containers, paraffin bath units, and shampoo rings;

(r) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(s) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(t) Wheeled reclining chairs, lounge and/or lift chairs (including but not limited to geri-chair, posture guard, or lazy boy).

(10) Blood pressure monitoring:

(a) Sphygmomanometer/blood pressure apparatus with cuff and stethoscope;

(b) Blood pressure cuff only; and

- (c) Automatic blood pressure monitor.
- (11) Transcutaneous electrical nerve stimulation (TENS) devices and supplies, including battery chargers;
- (12) Functional electrical stimulation (FES) bike;
- (13) Wearable defibrillators;
- (14) Disinfectant spray;
- (15) Periwash;
- (16) Bathroom equipment used inside or outside of the physical space of a bathroom:
 - (a) Bath stools;
 - (b) Bathtub wall rail (grab bars);
 - (c) Bed pans;
 - (d) Bedside commode chair;
 - (e) Control unit for electronic bowel irrigation/evacuation system;
 - (f) Disposable pack for use with electronic bowel system;
 - (g) Potty chairs;
 - (h) Raised toilet seat;
 - (i) Safety equipment (including but not limited to belt, harness or vest);
 - (j) Shower chairs;
 - (k) Shower/commode chairs;
 - (l) Sitz type bath or equipment;
 - (m) Standard and heavy duty bath chairs;
 - (n) Toilet rail;
 - (o) Transfer bench for tub or toilet;
 - (p) Urinal male/female.
- (17) Personal and/or comfort items, including but not limited to the following:
 - (a) Bathroom and hygiene items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;
 - (b) Full electric beds;
 - (c) Bedding items, such as mattress pads, blankets, mattress covers/bags, pillows, pillow cases/covers, sheets, and bumper pads;
 - (d) Bedside items, such as bed trays, carafes, and over-the-bed tables;
 - (e) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, socks, custom vascular supports (CVS), surgical stockings, gradient compression stockings, and custom compression garments;
 - (f) Clothing protectors, surgical masks, and other protective cloth furniture coverings;
 - (g) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;
 - (h) Diverter valves and handheld showers for bathtub;
 - (i) Eating/feeding utensils;
 - (j) Emesis basins, enema bags, and diaper wipes;
 - (k) Health club memberships;
 - (l) Hot or cold temperature food and drink containers/holders;
 - (m) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;
 - (n) Impotence devices;
 - (o) Insect repellants;
 - (p) Massage equipment;

- (q) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 182-530 WAC;
- (r) Medicine cabinet and first-aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;
- (s) Page turners;
- (t) Radio and television;
- (u) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services;
- (v) Toothettes and toothbrushes, waterpics, and periodontal devices whether manual, battery-operated, or electric;
- (18) Certain wheelchair features and options including, but not limited to, the following:
 - (a) Attendant controls (remote control devices);
 - (b) Canopies, including those used for strollers and other equipment;
 - (c) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);
 - (d) Decals;
 - (e) Hub Lock brake;
 - (f) Identification devices (such as labels, license plates, or name plates);
 - (g) Lighting systems;
 - (h) Replacement key or extra key;
 - (i) Speed conversion kits; and
 - (j) Trays for clients in a skilled nursing facility.
- (19) New DME, supplies, or related technology that the agency has not evaluated for coverage. See WAC 182-543-2100.

[Statutory Authority: RCW 41.05.021, and 41.05.160. WSR 14-20-041, § 182-543-6000, filed 9/24/14, effective 10/25/14. Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-6000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-6000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-6000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-7000 Authorization. (1) The medicaid agency requires providers to obtain authorization for covered durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related equipment as required in this chapter, in chapters 182-501 and 182-502 WAC, and in published billing instructions and/or provider notices or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the agency as specified in the agency's published billing instructions (see WAC 182-543-7100). All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. The agency's electronic forms are available online at: <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>.

(b) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the agency's published billing instructions. The appropriate EPA number must be used when the provider bills the agency (see WAC 182-543-7200).

(2) When a service requires authorization, the provider must properly request authorization in accordance with the agency's rules, billing instructions, and provider notices.

(3) The agency's authorization of service(s) does not necessarily guarantee payment.

(4) When authorization is not properly requested, the agency rejects and returns the request to the provider for further action. The agency does not consider the rejection of the request to be a denial of service.

(5) Authorization requirements in this chapter are not a denial of service to the client.

(6) The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100 (1)(c).

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-7000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-7000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-7000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-7100 Prior authorization. (1) The medicaid agency requires providers to obtain prior authorization for certain items and services before delivering that item or service to the client, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. The item or service must also be delivered to the client before the provider bills the agency.

(2) All prior authorization requests must be accompanied by a completed General Information for Authorization form (HCA 13-835), in addition to any program specific agency forms as required within this chapter. Agency forms are available online at <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>.

(3) When the agency receives the initial request for prior authorization, the prescription(s) for those items or services must not be older than three months from the date the agency receives the request.

(4) The agency requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

- (a) The manufacturer's name;
- (b) The equipment model and serial number;
- (c) A detailed description of the item; and
- (d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(5) For prior authorization requests, the agency requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. The agency does not accept general standards of care or industry standards for generalized equipment as justification.

(6) The agency considers requests for new durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related equipment that do not have assigned health care common procedure coding system (HCPCS) codes and are not listed in the agency's published issuances, including billing instructions or provider notices. These items require

prior authorization. The provider must furnish all of the following information to the agency to establish medical necessity:

(a) A detailed description of the item(s) or service(s) to be provided;

(b) The cost or charge for the item(s);

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item(s) being provided; and

(d) A detailed explanation of how the requested item(s) differs from an already existing code description.

(7) The agency does not pay for the purchase, rental, or repair of medical equipment that duplicates equipment that the client already owns, rents, or that the agency has authorized for the client. If the provider believes the purchase, rental, or repair of medical equipment is not duplicative, the provider must request prior authorization and submit the following to the agency:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet the client's medical needs.

(c) Upon request, documentation showing how the client's condition met the criteria for PA or EPA.

(8) A provider may resubmit a request for prior authorization for an item or service that the agency has denied. The agency requires the provider to include new documentation that is relevant to the request.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-7100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-7100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-7100, filed 6/29/11, effective 8/1/11.]

WAC 182-543-7200 Limitation extension (LE). (1)

The medicaid agency limits the amount, frequency, or duration of certain covered medical supplies and equipment (MSE), durable medical equipment (DME), and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization.

(2) Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

(3) The agency requires a provider to request prior authorization for a limitation extension (LE) in order to exceed the stated limits for nondurable medical equipment and medical supplies. All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. Agency forms are available online at <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>.

(4) The agency evaluates such requests for LE under the provisions of WAC 182-501-0169.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-7200, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-7200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-7200, filed 6/29/11, effective 8/1/11.]

WAC 182-543-7300 Expedited prior authorization (EPA). (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected durable medical equipment (DME) procedure codes.

(2) The medicaid agency requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in the agency published DME-related billing instructions. The authorization number must be used when the provider bills the agency.

(3) Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for EPA.

(4) A written or telephone request for prior authorization is required when a situation does not meet the EPA criteria for selected DME procedure codes.

(5) The agency may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-7300, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-7300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-7300, filed 6/29/11, effective 8/1/11.]

WAC 182-543-8000 DME—Billing general. (1) A provider must not bill the medicaid agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(2) The agency does not pay a durable medical equipment (DME) provider for medical supplies used in conjunction with a physician office visit. The agency pays the office physician for these supplies when appropriate. Refer to the agency's physician-related services/health care professional services billing instructions.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-8000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-8000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-8000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-8100 DME—Billing for managed care clients. If a fee-for-service (FFS) client enrolls in a medicaid agency-contracted managed care organization (MCO), the following apply:

(1) The agency stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.

(2) The plan determines the client's continuing need for the equipment and is responsible for paying the provider.

(3) A client may become an MCO enrollee before the agency completes the purchase of prescribed medical equipment. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase:

(a) The agency rescinds the agency's authorization with the vendor until the MCO's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.

(4) If a client is disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment:

(a) The agency rescinds the MCO's authorization with the vendor until the client's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The agency's applicable reimbursement policies apply to the purchase or rental of the equipment.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-8100, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-8100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-8100, filed 6/29/11, effective 8/1/11.]

WAC 182-543-8200 Billing for clients eligible for medicare and medicaid. If a client is eligible for both medicare and medicaid, the following apply:

(1) The medicaid agency requires a provider to accept medicare assignment before any medicaid reimbursement;

(2) In accordance with WAC 182-502-0110(3):

(a) If the service provided is covered by medicare and medicaid, the agency pays only the deductible and/or coinsurance up to medicare's or medicaid's allowed amount, whichever is less.

(b) If the service provided is covered by medicare but is not covered by the agency, the agency pays only the deductible and/or coinsurance up to medicare's allowed amount.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-8200, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-8200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-8200, filed 6/29/11, effective 8/1/11.]

WAC 182-543-9000 DME and related supplies, complex rehabilitation, prosthetics, orthotics, medical supplies and related services—General reimbursement. (1) The medicaid agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for durable medical equipment (DME), supplies, repairs, and related services provided on a fee-for-service (FFS) basis as follows:

(a) To agency-enrolled DME providers, qualified complex rehabilitation technology (CRT) suppliers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the agency's current DME billing instructions; and

(b) In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignment.

(2) The agency sets, evaluates, and updates the maximum allowable fees for DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related services at least once yearly using available published information, including but not limited to:

- (a) Commercial data bases;
- (b) Manufacturers' catalogs;
- (c) Medicare fee schedules; and
- (d) Wholesale prices.

(3) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

(4) The agency updates the maximum allowable fees for DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related services at least once per year, unless otherwise directed by the legislature or deemed necessary by the agency.

(5) The agency's maximum payment for DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related services is the lesser of either of the following:

- (a) Providers' usual and customary charges; or
- (b) Established rates, except as provided in WAC 182-543-8200.

(6) The agency is the payor of last resort for clients with medicare or third-party insurance.

(7) The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted managed care plan, but who did not use one of the plan's participating providers.

(8) The agency's reimbursement rate for purchased or rented covered DME and related supplies, prosthetics, orthotics, medical supplies and related services includes all of the following:

- (a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery or are covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;
- (b) Any pick-up and/or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);
- (c) Telephone calls;
- (d) Shipping, handling, and/or postage;
- (e) Routine maintenance of DME that includes testing, cleaning, regulating, and assessing the client's equipment;
- (f) Fitting and/or set-up; and
- (g) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(9) DME, supplies, repairs, and related services supplied to eligible clients under the following reimbursement methodologies are included in those methodologies and are not reimbursed under fee-for-service:

- (a) Hospice providers' per diem reimbursement;
- (b) Hospitals' diagnosis-related group (DRG) reimbursement;
- (c) Managed care plans' capitation rate;
- (d) Skilled nursing facilities' per diem rate; and
- (e) Professional services' resource-based relative value system reimbursement (RBRVS) rate.

(10) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the equipment, and warranty period, available to the agency upon request.

(11) The dispensing provider who furnishes the equipment, supply or device to a client is responsible for any costs

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incurred to have a different provider repair the equipment when:

- (a) Any equipment that the agency considers purchased requires repair during the applicable warranty period;
- (b) The provider refuses or is unable to fulfill the warranty; and
- (c) The equipment, supply or device continues to be medically necessary.

(12) If the rental equipment, supply or device must be replaced during the warranty period, the agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment, supply or device delivered to the client if:

- (a) The provider is unwilling or unable to fulfill the warranty; and
- (b) The equipment, supply or device continues to be medically necessary.

(13) See WAC 182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400 for other reimbursement methodologies.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-9000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-9000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9000, filed 6/29/11, effective 8/1/11.]

WAC 182-543-9100 Reimbursement method—Other DME. (1) The agency sets, evaluates and updates the maximum allowable fees for purchased other durable medical equipment (DME) at least once yearly using one or more of the following:

(a) The current medicare rate, as established by the federal Centers for Medicare and Medicaid Services (CMS), for a new purchase if a medicare rate is available;

- (b) A pricing cluster; or
- (c) On a by report basis.

(2) Establishing reimbursement rates for purchased other DME based on pricing clusters.

(a) A pricing cluster is based on a specific health care common procedure coding system (HCPCS) code.

(b) The agency's pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster. The agency considers all of the following when establishing the pricing cluster:

- (i) A client's medical needs;
- (ii) Product quality;
- (iii) Introduction, substitution or discontinuation of certain brands/models; and/or
- (iv) Cost.

(c) When establishing the fee for other DME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices for all brands/models as noted in subsection (2)(b) of this section.

(3) The agency evaluates a by report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate for these items at eighty percent of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of July 31st of the base year or one

hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(4) Monthly rental reimbursement rates for other DME. The agency's maximum allowable fee for monthly rental is established using one of the following:

(a) For items with a monthly rental rate on the current medicare fee schedule as established by CMS, the agency equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;

(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule as established by CMS, the agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by CMS, the agency considers the maximum allowable monthly reimbursement rate as by report. The agency calculates the monthly reimbursement rate for these items at one-tenth of eighty percent of the manufacturer's list or MSRP.

(5) Daily rental reimbursement rates for other DME. The agency's maximum allowable fee for daily rental is established using one of the following:

(a) For items with a daily rental rate on the current medicare fee schedule as established by CMS, the agency equates its maximum allowable fee for daily rental to the current medicare daily rental rate;

(b) For items that have a new purchase rate but no daily rental rate on the current medicare fee schedule as established by CMS, the agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by CMS, the agency considers the maximum allowable daily reimbursement rate as by report. The agency calculates the daily reimbursement rate at one-three-hundredth of eighty percent of the manufacturer's list or MSRP as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(6) The agency does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both medicare and medicaid, and is staying in a skilled nursing facility in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(7) The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(8) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the agency may pay the provider an amount it considers

appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

(9) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-9100, filed 3/25/14, effective 4/25/14. Statutory Authority: RCW 41.05.021. WSR 12-16-059, § 182-543-9100, filed 7/30/12, effective 8/30/12; WSR 12-07-022, § 182-543-9100, filed 3/12/12, effective 4/12/12. WSR 11-14-075, recodified as § 182-543-9100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9100, filed 6/29/11, effective 8/1/11.]

WAC 182-543-9200 Reimbursement method—Wheelchairs. (1) The agency reimburses a DME provider for purchased wheelchairs based on the assigned health care common procedure coding system (HCPCS) code. The agency requires providers to make sure the specific brand and model of wheelchairs dispensed are coded according to the Centers for Medicare and Medicaid Services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates and updates the maximum allowable fees at least once yearly for wheelchair purchases and wheelchair rentals using the lesser of the following:

(a) The current medicare fees;

(b) A pricing cluster; or

(c) On a by-report (BR) basis.

(3) Establishing reimbursement rates for purchased wheelchairs based on pricing clusters.

(a) A pricing cluster is based on a specific health care common procedure coding system (HCPCS) code.

(b) The agency's pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster. The agency considers all of the following when establishing a pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Introduction, substitution or discontinuation of certain brands/models; and

(iv) Cost.

(c) When establishing the fee for wheelchair items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices for all brands/models as noted in (b) of this subsection.

(4) The agency evaluates a BR item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate for these items at a percentage of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of January 31st of the base year, or a percentage of the wholesale acquisition cost (AC). The agency uses the following percentages:

(a) For basic standard wheelchairs, sixty-five percent of MSRP or one hundred forty percent of AC;

(b) For parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(c) For seat and back cushions, eighty percent of MSRP or one hundred forty percent of AC.

(5) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-9200, filed 3/25/14, effective 4/25/14. Statutory Authority: RCW 41.05.021. WSR 12-16-059, § 182-543-9200, filed 7/30/12, effective 8/30/12; WSR 12-07-022, § 182-543-9200, filed 3/12/12, effective 4/12/12. WSR 11-14-075, recodified as § 182-543-9200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9200, filed 6/29/11, effective 8/1/11.]

WAC 182-543-9250 Reimbursement method—Complex rehabilitation technology. (1) The agency reimburses a complex rehabilitation technology (CRT) provider for purchased CRT products based on the assigned health care common procedure coding system (HCPCS) code. The agency requires providers to make sure the specific brand and model of CRT products dispensed are coded according to the Centers for Medicare and Medicaid Services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates, and updates the maximum allowable fees at least once yearly for CRT products using the lesser of the following:

- (a) The current medicare fees;
- (b) A pricing cluster; or
- (c) On a by-report basis.

(3) To establish a rate based on a pricing cluster, the agency uses the following methodology:

- (a) The pricing cluster is based on a specific HCPCS code;
- (b) The pricing cluster includes all brands/models for which the agency obtains pricing information;
- (c) The agency may limit the number of brands/models included in the pricing cluster based on the following:
 - (i) Product quality;
 - (ii) Introduction, substitution or discontinuation of certain brands/models; and
 - (iii) Cost, when there are equally effective substantially less costly alternatives available.
- (d) When establishing the fee for CRT products in a pricing cluster, the maximum allowable fee is the median cost of all manufacturers' list prices for all brands/models in the cluster.

(4) The agency evaluates by-report (BR) items, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate for these items at a percentage of the manufacturer's suggested retail price (MSRP) as of January 31st of the base year, or a percentage of the wholesale acquisition cost (AC) from the manufacturer's invoice. The agency uses the following percentages:

- (a) For add-on CRT accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;
- (b) For up-charge modifications, seating systems, back and seat cushions, eighty percent of MSRP or one hundred forty percent of AC;
- (c) For CRT manual wheelchair base, eighty percent of MSRP or one hundred forty percent of AC; and
- (d) For CRT power-drive wheelchair base, eighty-five percent of MSRP or one hundred forty percent of AC.

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(5) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary to:

- (a) Assure that payments are sufficient to enlist providers and maintain access to care and services; or
- (b) Comply with legislative budget directives specifically reducing available funds for optional programs as an alternative to eliminating the optional program.

[Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-9250, filed 3/25/14, effective 4/25/14.]

WAC 182-543-9300 Reimbursement method—Prosthetics and orthotics. (1) The agency sets, evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once yearly as follows:

(a) For items with a rate on the current medicare fee schedule, as established by the federal Centers for Medicare and Medicaid Services (CMS), the agency equates its maximum allowable fee to the current medicare rate; and

(b) For those items not included in the medicare fee schedule, as established by CMS, the rate is considered by report. The agency evaluates a by report item, procedure, or service based upon medical necessity criteria, appropriateness, and reimbursement value on a case-by-case basis. The agency calculates the reimbursement for these items at eighty-five percent of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(2) The agency follows health care common procedure coding system (HCPCS) guidelines for product classification and code assignment.

(3) The agency's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds, fitting, shipping, handling or any other administrative expenses related to provision of the prosthetic or orthotic to the client.

(4) The agency's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

(5) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

[Statutory Authority: RCW 41.05.021. WSR 12-16-059, § 182-543-9300, filed 7/30/12, effective 8/30/12; WSR 12-07-022, § 182-543-9300, filed 3/12/12, effective 4/12/12. WSR 11-14-075, recodified as § 182-543-9300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9300, filed 6/29/11, effective 8/1/11.]

WAC 182-543-9400 Reimbursement method—Medical supplies and related services. (1) The agency sets, evaluates and updates the maximum allowable fees for medical supplies and nondurable medical equipment (DME) items at least once yearly using one or more of the following:

- (a) The current medicare rate, as established by the federal Centers for Medicare and Medicaid Services (CMS), if a medicare rate is available;
- (b) A pricing cluster;
- (c) Based on input from stakeholders or other relevant sources that the agency determines to be reliable and appropriate; or

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(d) On a by report basis.

(2) Establishing reimbursement rates for medical supplies and non-DME items based on pricing clusters.

(a) A pricing cluster is based on a specific health care common procedure coding system (HCPCS) code.

(b) The agency's pricing cluster is made up of all the brands for which the agency obtains pricing information. However, the agency may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the agency. The agency considers all of the following when establishing the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Cost; and

(iv) Available alternatives.

(c) When establishing the fee for medical supplies or other non-DME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list or manufacturers' suggested retail prices (MSRP).

(3) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate at eighty-five percent of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(4) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

(5) For clients residing in skilled nursing facilities, see WAC 182-543-5700.

[Statutory Authority: RCW 41.05.021. WSR 12-16-059, § 182-543-9400, filed 7/30/12, effective 8/30/12; WSR 12-07-022, § 182-543-9400, filed 3/12/12, effective 4/12/12. WSR 11-14-075, recodified as § 182-543-9400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9400, filed 6/29/11, effective 8/1/11.]