**WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.**

**GENERAL PAYMENT METHODOLOGY**

(1) The medicaid agency bases the payment methodology for most physician-related services on medicare's RBRVS. The agency obtains information used to update the agency's RBRVS from the MPFSPS.

(2) The agency updates and revises the following RBRVS areas each January prior to the agency's annual update.

(3) The agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels. Then,

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, the agency establishes maximum allowable fees, also known as "flat" fees.

(i) The agency does not use the conversion factor for these codes.

(ii) The agency updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at the medicare Part B drug file price or POS AAC when there is no Part B rate. (See WAC 182-530-1050 for explanation of POS AAC.) When the provider receives immunization materials from the department of health, the agency pays only a flat fee for administering the immunization.

(B) A cast material maximum allowable fee is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only

to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, the agency reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) The agency reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The technical advisory group reviews RBRVS changes.

(6) The agency also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as the agency's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the agency applies the increase after calculating budget-neutral fees. The agency pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The agency does not allow separate reimbursement for bundled services. However, the agency allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

**CPT/HCFA MODIFIERS**

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for the agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-21-040, § 182-531-1850, filed 10/12/17, effective 11/12/17; WSR 17-04-039, § 182-531-1850, filed 1/25/17, effective 2/25/17. WSR 11-14-075, recodified as § 182-531-1850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]