

Chapter 182-531 WAC

PHYSICIAN-RELATED SERVICES

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WAC 182-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, apply to this chapter.

"Acquisition cost" - The cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" - Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" - A comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 182-550-2501).

"Add-on procedure(s)" - Secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" - The medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

"Advanced registered nurse practitioner (ARNP)" - A registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and disability services administration (ADSA)" - The administration that administers directly or contracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-71-0202.

"Allowed charges" - The maximum amount reimbursed for any procedure that is allowed by the agency.

"Anesthesia technical advisory group (ATAG)" - An advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" - Any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" - A number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" - Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" - Supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

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

"Call" - A face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" - A reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Center of excellence (COE)" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)", see WAC 182-500-0020.

"Certified registered nurse anesthetist (CRNA)" - An advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

"Children's health insurance plan (CHIP)", see chapter 182-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" - Regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" - Dollar amounts the agency uses to calculate the maximum allowable fee for physician-related services.

"Covered service" - A service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" - Physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Diagnosis code" - A set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Emergency medical condition(s)", see WAC 182-500-0030.

"Emergency services" - Medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" - The agency's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" - Procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" - The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the agency which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" - A term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 182-531-0550. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body, if such approval is required.

"Federally approved hemophilia treatment center" - A hemophilia treatment center (HTC) which:

(1) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

(2) Is qualified to participate in 340B discount purchasing as an HTC;

(3) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC web site;

(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and

(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

"Fee-for-service," see WAC 182-500-0035.

"Flat fee" - The maximum allowable fee established by the agency for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" - As defined by Medicare, means a Medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 182-531-1700.

"HCPCS Level II" - Health care common procedure coding system, a coding system established by Centers for Medicare and Medicaid Services (CMS) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" - The name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" - A group of health care providers involved in the care of a client.

"Hospice" - A medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD-9-CM," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"Informed consent" - That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
 (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" - An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)" - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumeric designations (coding).

"Investigational" - A term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" - Mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension," see WAC 182-501-0169.

"Maximum allowable fee" - The maximum dollar amount that the agency will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 182-500-0070.

"Medicare physician fee schedule data base (MPFSDB)" - The official CMS publication of the Medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" - The official CMS publication of the Medicare fees for physician services.

"Medicare clinical diagnostic laboratory fee schedule" - The fee schedule used by Medicare to reimburse for

clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" - A client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient," see WAC 182-500-0080.

"Peer-reviewed medical literature" - Medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" - A written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" - Physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "current procedural terminology (CPT)."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" - The diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the agency's fee schedules that is not routinely covered.

"Preventive" - Medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization," see WAC 182-500-0085.

"Professional component" - The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" - The probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" - Face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 182-500-0085.

"Radioallergosorbent test" or "RAST" - A blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RBRVS RVU" - A measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - Physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"Reimbursement" - Payment to a provider or other agency-approved entity who bills according to the provisions in WAC 182-502-0100.

"Reimbursement steering committee (RSC)" - An interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Relative value guide (RVG)" - A system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" - A unit which is based on the resources required to perform an individual service or intervention.

"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.

"RSC RVU" - A unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"RVU," see relative value unit.

"Stat laboratory charges" - Charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" - A tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by CMS to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" - An advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Technical component" - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 41.05.021, WSR 12-16-061, § 182-531-0050, filed 7/30/12, effective 11/1/12. WSR 11-14-075, recodified as § 182-531-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, WSR 10-19-057, § 388-531-0050, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.500, WSR 04-20-059, § 388-531-0050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, WSR 03-19-081, § 388-531-0050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, WSR 03-06-049, § 388-531-0050, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520, WSR 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1) The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 182-501-0060 and 182-501-0065; and

(b) Medically necessary as defined in WAC 182-500-0070.

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC 182-501-0065.

(3) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

(4) The agency covers the following physician-related services and health care professional services, subject to the conditions in subsections (1), (2), and (3) of this section:

(a) Allergen immunotherapy services;

(b) Anesthesia services;

(c) Dialysis and end stage renal disease services (refer to chapter 182-540 WAC);

(d) Emergency physician services;

(e) ENT (ear, nose, and throat) related services;

(f) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 182-534-0100);

(g) Reproductive health services (refer to chapter 182-532 WAC);

(h) Hospital inpatient services (refer to chapter 182-550 WAC);

(i) Maternity care, delivery, and newborn care services (refer to chapter 182-533 WAC);

(j) Office visits;

(k) Vision-related services (refer to chapter 182-544 WAC for vision hardware for clients twenty years of age and younger);

(l) Osteopathic treatment services;

(m) Pathology and laboratory services;

(n) Physiatry and other rehabilitation services (refer to chapter 182-550 WAC);

(o) Foot care and podiatry services (refer to WAC 182-531-1300);

(p) Primary care services;

(q) Psychiatric services, provided by a psychiatrist;

(r) Psychotherapy services for children as provided in WAC 182-531-1400;

(s) Pulmonary and respiratory services;

(t) Radiology services;

(u) Surgical services;

(v) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment;

(w) Oral health care services for emergency conditions for clients twenty-one years of age and older, except for clients of the division of developmental disabilities (refer to WAC 182-531-1025); and

(x) Other outpatient physician services.

(5) The agency covers physical examinations for medical assistance clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 182-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(6) By providing covered services to a client eligible for a medical assistance program, a provider who meets the requirements in WAC 182-502-0005(3) accepts the agency's rules and fees which includes federal and state law and regulations, billing instructions, and agency issuances.

[Statutory Authority: RCW 41.05.021, WSR 13-18-035, § 182-531-0100, filed 8/28/13, effective 9/28/13. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455.410, WSR 13-04-095, § 182-531-0100, filed 2/6/13, effective 3/9/13. Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act, WSR 12-18-062, § 182-531-0100, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-531-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, WSR 11-14-055, § 388-531-0100, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.09.521, WSR 08-12-030, § 388-531-0100, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, WSR 06-24-036, § 388-531-0100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, WSR 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) Except as provided in WAC 182-531-0100 and subsection (2) of this section, the medicaid agency does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Hysterectomy performed solely for the purpose of sterilization;

(e) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(f) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165;

(g) Hair transplantation;

(h) Marital counseling or sex therapy;

(i) More costly services when the medicaid agency determines that less costly, equally effective services are available;

(j) Vision-related services as follows:

(i) Services for cosmetic purposes only;

(ii) Group vision screening for eyeglasses; and

(iii) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens correction. This refractive surgery does not include intraocular lens implantation following cataract surgery.

(k) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 182-531-1750;

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(l) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(m) Physical examinations or routine checkups, except as provided in WAC 182-531-0100;

(n) Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300, as follows:

(i) Routine foot care, such as but not limited to:

(A) Treatment of tinea pedis;

(B) Cutting or removing warts, corns and calluses; and

(C) Trimming, cutting, clipping, or debriding of nails.

(ii) Nonroutine foot care, such as, but not limited to treatment of:

(A) Flat feet;

(B) High arches (cavus foot);

(C) Onychomycosis;

(D) Bunions and tailor's bunion (hallux valgus);

(E) Hallux malleus;

(F) Equinus deformity of foot, acquired;

(G) Cavovarus deformity, acquired;

(H) Adult acquired flatfoot (metatarsus adductus or pes planus);

(I) Hallux limitus.

(iii) Any other service performed in the absence of localized illness, injury, or symptoms involving the foot;

(o) Except as provided in WAC 182-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services.

(p) Nonmedical equipment;

(q) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas;

(r) Bilateral cochlear implantation; and

(s) Routine or nonemergency medical and surgical dental services provided by a doctor of dental medicine or dental surgery for clients twenty one years of age and older, except for clients of the developmental disabilities administration in the department of social and health services.

(2) The medicaid agency covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 41.05.021, 74.09.520, 74.09.657, 74.09.659, and 74.09.800, WSR 13-16-008, § 182-531-0150, filed 7/25/13, effective 9/1/13. WSR 11-14-075, recodified as § 182-531-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, WSR 11-14-055, § 388-531-0150, filed 6/29/11, effective 7/30/11; WSR 10-19-057, § 388-531-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520, WSR 05-12-022, § 388-531-0150, filed 5/20/05, effective 6/20/05; WSR 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0200 Physician-related and health care professional services requiring prior authorization.

(1) The medicaid agency requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 182-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in the medicaid agency's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to the medicaid agency showing how the authorization number was created.

(c) Selected nonemergency admissions to contract hospitals require EPA. These are identified in the medicaid agency billing instructions.

(d) Procedures allowing expedited prior authorization include, but are not limited to, the following:

(i) Reduction mammoplasties/mastectomy for gynecomastia;

(ii) Strabismus surgery for clients eighteen years of age and older;

(iii) Meningococcal vaccine;

(iv) Placement of drug eluting stent and device;

(v) Cochlear implants for clients twenty years of age and younger;

(vi) Hyperbaric oxygen therapy;

(vii) Visual exam/refraction for clients twenty-one years of age and older;

(viii) Blepharoplasties; and

(ix) Neuropsychological testing for clients sixteen years of age and older.

(3) The medicaid agency evaluates new technologies under the procedures in WAC 182-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R)**;

(c) Unilateral cochlear implants for clients twenty years of age and younger (refer to WAC 182-531-0375);

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of the medicaid agency's published limits;

(f) Panniculectomy;

(g) Bariatric surgery (see WAC 182-531-1600); and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(i) Osseointegrated/bone anchored hearing aids (BAHA) for clients twenty years of age and younger;

(j) Removal or repair of previously implanted BAHA or cochlear device for clients twenty one years of age and older when medically necessary.

(5) All hysterectomies performed for medical reasons may require prior authorization, as explained in subsection (2) of this section.

(a) Hysterectomies may be performed without prior authorization in either of the following circumstances:

(i) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(ii) A hysterectomy is needed due to trauma.

(b) The agency reimburses all attending providers for a hysterectomy procedure only when the provider submits an accurately completed agency-approved consent form with the claim for reimbursement.

(6) The medicaid agency may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(7) Children six years of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 41.05.021, 74.09.520, 74.09.657, 74.09.659, and 74.09.800. WSR 13-16-008, § 182-531-0200, filed 7/25/13, effective 9/1/13. WSR 11-14-075, recodified as § 182-531-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-0200, filed 6/29/11, effective 7/30/11; WSR 10-19-057, § 388-531-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-531-0200, filed 5/20/05, effective 6/20/05; WSR 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0250 Who can provide and bill for physician-related and health care professional services.

(1) The following enrolled providers are eligible to provide and bill for physician-related and health care professional services which they provide to eligible clients:

(a) Advanced registered nurse practitioners (ARNP);

(b) Federally qualified health centers (FQHCs);

(c) Health departments;

(d) Hospitals currently licensed by the department of health;

(e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;

(f) Licensed marriage and family therapists, only as provided in WAC 388-531-1400;

(g) Licensed mental health counselors, only as provided in WAC 388-531-1400;

(h) Licensed radiology facilities;

(i) Licensed social workers, only as provided in WAC 388-531-1400 and 388-531-1600;

(j) Medicare-certified ambulatory surgery centers;

(k) Medicare-certified rural health clinics;

(l) Providers who have a signed agreement with the department to provide screening services to eligible persons in the EPSDT program;

(m) Registered nurse first assistants (RNFA); and

(n) Persons currently licensed by the state of Washington department of health to practice any of the following:

(i) Dentistry (refer to chapter 388-535 WAC);

(ii) Medicine and osteopathy;

(iii) Nursing;

(iv) Optometry; or

(v) Podiatry.

(2) The department does not pay for services performed by any of the following practitioners:

(a) Acupuncturists;

(b) Christian Science practitioners or theological healers;

(c) Counselors, except as provided in WAC 388-531-1400;

(d) Herbalists;

(e) Homeopaths;

(f) Massage therapists as licensed by the Washington state department of health;

(g) Naturopaths;

(h) Sanipractors;

(i) Social workers, except those who have a master's degree in social work (MSW), and:

- (i) Are employed by an FQHC;
- (ii) Who have prior authorization to evaluate a client for bariatric surgery; or
- (iii) As provided in WAC 388-531-1400.

(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0002; or

(k) Any other licensed practitioners providing services which the practitioner is not:

- (i) Licensed to provide; and
- (ii) Trained to provide.

(3) The department pays practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:

- (a) The EPSDT program;
- (b) A medicaid program for qualified medicare beneficiaries (QMB); or
- (c) A waiver program.

[WSR 11-14-075, recodified as § 182-531-0250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-0250, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.09.521. WSR 08-12-030, § 388-531-0250, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-531-0250, filed 5/20/05, effective 6/20/05; WSR 01-01-012, § 388-531-0250, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0300 Anesthesia providers and covered physician-related services. The department bases coverage of anesthesia services on medicare policies and the following rules:

(1) The department reimburses providers for covered anesthesia services performed by:

- (a) Anesthesiologists;
- (b) **Certified registered nurse anesthetists (CRNAs);**
- (c) Oral surgeons with a special agreement with the department to provide anesthesia services; and
- (d) Other providers who have a special agreement with the department to provide anesthesia services.

(2) The department covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

- (a) Computerized tomography (CT);
- (b) Dental procedures;
- (c) Electroconvulsive therapy; and
- (d) Magnetic resonance imaging (MRI).

(3) The department covers anesthesia services provided for any of the following:

- (a) Dental restorations and/or extractions;
- (b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;
- (c) Pain management per subsection (5) of this section;
- (d) Radiological services as listed in WAC 388-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

- (a) Perform a preanesthetic examination and evaluation;
- (b) Prescribe the anesthesia plan;
- (c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The department does not allow the anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The department requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the department reimburses the base anesthesia units (BAU) for the major procedure only.

(b) The department does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, the department reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, the department limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) The department pays CRNAs or anesthesiologists for pain management services.

(b) The department allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The department does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[WSR 11-14-075, recodified as § 182-531-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) The department reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) The department calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: $(BAU \times fifteen) + time \times (conversion\ factor\ divided\ by\ fifteen) = reimbursement$.

(3) The department obtains BAU values from the relative value guide (RVG), and updates them annually. The department and/or the anesthesia technical advisory group (ATAG) members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) The department determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

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

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

(5) The department calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) The department changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as the department's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as the department's annual update, the department applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, the department uses the BAU of the major procedure to determine anesthesia **allowed charges**. The department reimburses for add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[WSR 11-14-075, recodified as § 182-531-0350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0375 Audiology services. (1) The department covers, with prior authorization, the implantation of a unilateral cochlear device for clients twenty years of age and younger with the following limitations:

(a) The client meets one of the following:

(i) Has a diagnosis of profound to severe bilateral, sensorineural hearing loss;

(ii) Has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to forty percent correct in the best-aided condition on recorded open-set sentence recognition tests);

(iii) Has the cognitive ability to use auditory clues;

(iv) Is willing to undergo an extensive rehabilitation program;

(v) Has an accessible cochlear lumen that is structurally suitable for cochlear implantation;

(vi) Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; or

(vii) Has no other contraindications to surgery; and

(b) The procedure is performed in an inpatient hospital setting or outpatient hospital setting.

(2) The department covers osseointegrated bone anchored hearing aids (BAHA) for clients twenty years of age and younger with prior authorization.

(3) The department covers replacement parts for BAHA and cochlear devices for clients twenty years of age and younger only. See WAC 388-547-0800.

(4) The department considers requests for removal or repair of previously implanted bone anchored hearing aids (BAHA) and cochlear devices for clients twenty one years of age and older only when medically necessary. Prior authorization from the department is required.

(5) For audiology, the department limits:

(a) Caloric vestibular testing to four units for each ear; and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

[WSR 11-14-075, recodified as § 182-531-0375, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-0375, filed 6/29/11, effective 7/30/11.]

WAC 182-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC 388-501-0100, for noncovered services as defined in WAC 388-501-0050 or for services excluded from the client's benefits package as defined under WAC 388-501-0060. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

[WSR 11-14-075, recodified as § 182-531-0400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-0400, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0400, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0450 Critical care—Physician-related services. (1) The department reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) The department reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing the department.

(3) The department limits payment for critical care services to a maximum of three hours per day, per client.

(4) The department does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[WSR 11-14-075, recodified as § 182-531-0450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0450, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

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WAC 182-531-0500 Emergency physician-related services. (1) The department reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) The department reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on **call** to cover the hospital emergency department.

(3) The department pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit [to] the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

(4) The department does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[WSR 11-14-075, recodified as § 182-531-0500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0500, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0550 Experimental and investigational services. (1) When the department makes a determination as to whether a proposed service is experimental or investigational, the department follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. The department also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and preclinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

[Ch. 182-531 WAC p. 9]

(3) The department applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) The department does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

- (a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;
- (b) Designated by the department's medical director to issue such approvals; and
- (c) Available to consult with the client's treating physician by telephone.

[WSR 11-14-075, recodified as § 182-531-0550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0550, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0600 HIV/AIDS counseling and testing as physician-related services. The department covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[WSR 11-14-075, recodified as § 182-531-0600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0600, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0650 Hospital physician-related services not requiring authorization when provided in department-approved centers of excellence or hospitals authorized to provide the specific services. The department covers the following services without prior authorization when provided in department-approved centers of excellence. The department issues periodic publications listing centers of excellence. These services include the following:

- (1) All transplant procedures specified in WAC 388-550-1900;
- (2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;
- (3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. The department allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300.

[WSR 11-14-075, recodified as § 182-531-0650, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0650, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 05-12-022, § 388-531-0650, filed 5/20/05, effective 6/20/05; WSR 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0700 Inpatient chronic pain management physician-related services. (1) The department covers inpatient chronic pain management services only when the services are obtained through a department-approved chronic pain facility.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

- (a) The client has had chronic pain for at least three months, that has not improved with conservative treatment, including tests and therapies;
- (b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and
- (c) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

(3) For chronic pain management, the department limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.

(4) The department reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[WSR 11-14-075, recodified as § 182-531-0700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0700, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0750 Inpatient hospital physician-related services. (1) The department separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) The department reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement**, the department does not reimburse separately.

(3) The department reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[WSR 11-14-075, recodified as § 182-531-0750, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0750, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0800 Laboratory and pathology physician-related services. (1) The department reimburses providers for laboratory services only when:

- (a) The provider is certified according to Title XVII of the Social Security Act (medicare), if required; and
- (b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The department includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) The department reimburses only one blood drawing fee per client, per day. The department allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) The department reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) The department reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the department reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

- (i) A clinic;
- (ii) A hospital laboratory;
- (iii) An independent laboratory; or
- (iv) A physician's office.

(6) The department allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The department reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The department reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) The department does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) The department does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) The department may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill the department directly. The department does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[WSR 11-14-075, recodified as § 182-531-0800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0800, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-

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090, 74.09.520. WSR 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0850 Laboratory and pathology physician-related services reimbursement. (1) The department pays for clinical diagnostic laboratory procedures based on the **medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. The department obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) The department updates budget-neutral fees each July by:

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

(b) Determining in total the ratio of current department fees to existing medicare fees. Then,

(c) Determining new department fees by adjusting the new medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new department fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) The department calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing **RSC** fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or "**flat fees**" for procedure codes that have no applicable MCDLF or RSC fees. The department updates flat fee reimbursement only when authorized by the legislature.

(d) The department reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) The department increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as the department's annual update, the department applies the increase after calculating budget-neutral fees.

[WSR 11-14-075, recodified as § 182-531-0850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0900 Neonatal intensive care unit (NICU) physician-related services. (1) The department pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) The department reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to **prolonged services** and newborn resuscitation when the provider is present at the delivery.

[WSR 11-14-075, recodified as § 182-531-0900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0900, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

WAC 182-531-0950 Office and other outpatient physician-related services. (l) The department reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (l) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, the department reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) The department may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) The department does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) The department does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; the department does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, the department reimburses a minimum E&M service.

(8) The department reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. The department reimburses a separate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) The department reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) The department does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. The department does pay separately for the administration of these injections when they

are provided on the same day as an E&M service. The department does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. The department reimburses separately for the drug(s).

(b) The department does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, the department pays an administrative fee. The department reimburses separately for the drug.

(c) The department reimburses injectable drugs at **acquisition cost**. The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by the department. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing the department for the following drugs:

(i) Classified drugs where the billed charge to the department is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to the department is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) The department reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, the department reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) The department covers the antigen, the antigen preparation, and an administration fee.

(e) The department reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) The department reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) The department reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

- (ii) The dosage and strength used; and
- (iii) The national drug code (NCD) [NDC].

(12) Notwithstanding the provisions of this section, the department reserves the option of determining drug pricing for any particular drug based on the best evidence available to the department, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) The department may request an invoice as necessary.

[WSR 11-14-075, recodified as § 182-531-0950, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0950, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1000 Ophthalmic services. Refer to chapter 388-544 WAC for vision-related hardware coverage for clients twenty years of age and younger.

(1) The department covers, without prior authorization, eye examinations, refraction and fitting services with the following limitations:

- (a) Once every twenty-four months for asymptomatic clients twenty-one years of age and older;
- (b) Once every twelve months for asymptomatic clients twenty years of age and younger; or
- (c) Once every twelve months, regardless of age, for asymptomatic clients of the division of developmental disabilities.

(2) The department covers additional examinations and refraction services outside the limitations described in subsection (1) of this section when:

- (a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;
- (b) The client is on medication that affects vision; or
- (c) The service is necessary due to lost or broken eyeglasses/contacts. In this case:
 - (i) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.
 - (ii) Providers must follow the department's expedited prior authorization process to receive payment for clients twenty-one years of age or older. Providers must also document the following in the client's file:
 - (A) The eyeglasses or contacts are lost or broken; and
 - (B) The last examination was at least eighteen months ago.

(3) The department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:

- (a) The extent of the testing;
 - (b) Why the testing was reasonable and necessary for the client; and
 - (c) The medical basis for the frequency of testing.
- (4) The department covers orthoptics and vision training therapy. Providers must obtain prior authorization from the department.

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(5) The department covers ocular prosthetics for clients when provided by any of the following:

- (a) An ophthalmologist;
- (b) An ocularist; or
- (c) An optometrist who specializes in prosthetics.

(6) The department covers cataract surgery, without prior authorization when the following clinical criteria are met:

- (a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- (b) One or more of the following conditions:
 - (i) Dislocated or subluxated lens;
 - (ii) Intraocular foreign body;
 - (iii) Ocular trauma;
 - (iv) Phacogenic glaucoma;
 - (v) Phacogenic uveitis;
 - (vi) Phacoanaphylactic endophthalmitis; or
 - (vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.

(7) The department covers strabismus surgery as follows:

(a) For clients seventeen years of age and younger. The provider must clearly document the need in the client's record. The department does not require authorization for clients seventeen years of age and younger; and

(b) For clients eighteen years of age and older, when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

- (i) The client has double vision; and
- (ii) The surgery is not being performed for cosmetic reasons.

(8) The department covers blepharoplasty or blepharoptosis surgery for clients when all of the clinical criteria are met. To receive payment, providers must follow the department's expedited prior authorization process. The clinical criteria are:

- (a) The client's excess upper eyelid skin is blocking the superior visual field; and
- (b) The blocked vision is within ten degrees of central fixation using a central visual field test.

[WSR 11-14-075, recodified as § 182-531-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-1000, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1000, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1025 Oral health care services provided by dentists for clients age twenty-one and older—General. This section does not apply to clients of the division of developmental disabilities. Refer to WAC 388-535-1099.

(1) Clients age twenty-one and older are eligible for the oral health care services listed in this section, subject to coverage limitations. The department pays for oral health care services provided by a dentist to clients age twenty-one and older when the services provided:

- (a) Are within the scope of the eligible client's medical care program;
- (b) Are medically necessary as defined in WAC 388-500-0005;

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(c) Are emergency services and meet the criteria of coverage for emergency oral health care benefit listed in subsection (7) of this section;

(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

(e) Meet the department's prior authorization requirements, if there are any;

(f) Are within prevailing standard of care accepted practice standards;

(g) Are consistent with a diagnosis of teeth, mouth and jaw disease or condition;

(h) Are reasonable in amount and duration of care, treatment, or service;

(i) Are billed using only the allowed procedure codes listed in the department's published billing instructions and fee schedules; and

(j) Are documented with a comprehensive description of the client's presenting symptoms, diagnosis and services provided, in the client's record, including the following, if applicable:

(i) Client's blood pressure, when appropriate;

(ii) A surgical narrative;

(iii) A copy of the post-operative instructions; and

(iv) A copy of all pre- and post-operative prescriptions.

(2) An appropriate consent form, if required, signed and dated by the client or the client's legal representative must be in the client's record.

(3) An anesthesiologist providing oral health care under this section must have a current provider's permit on file with the department.

(4) A health care provider providing oral or parenteral conscious sedation, or general anesthesia, must meet:

(a) The provider's professional organization guidelines;

(b) The department of health (DOH) requirements in chapter 246-817 WAC; and

(c) Any applicable DOH medical, dental, and nursing anesthesia regulations.

(5) Department-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery (see WAC 388-535-1070(3)) must use only the current dental terminology (CDT) codes to bill claims for services that are listed in this section.

(6) Oral health care services must be provided in a clinic setting, with the exception of trauma related services.

(7) Emergency oral health care benefit.

(a) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, are considered a physician service, are included in the emergency oral health care benefit when the services are done on an emergency basis. All services are subject to prior authorization when indicated.

(b) The following set of services are covered under the emergency oral health care benefit when provided by a dentist to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pre-transplant protocol:

(i) One emergency examination, per presenting problem, performed as a limited oral evaluation to:

(A) Evaluate the client's symptom of pain;

(B) Make a diagnosis; and

(C) Develop or implement a treatment plan, including a referral to another health care professional, such as an oral surgeon; or

(D) A second evaluation if the treatment initiated is conservative, such as prescribed antibiotics, and a subsequent visit is necessary for definitive treatment, such as tooth extraction. The treatment plan must be documented in the client's record.

(ii) Diagnostic radiographs (X rays).

(A) Radiographs include:

(I) Periapical; and

(II) Panoramic films, limited to one every three years.

(B) Radiographs must:

(I) Be required to make the diagnosis;

(II) Support medical necessity;

(III) Be of diagnostic quality, dated and labeled with the client's name;

(IV) Be retained by the provider as part of the client's record. The retained radiograph must be the original.

(C) Duplicate radiographs must be submitted with prior authorization requests or when the department requests a copy of the client's dental record.

(iii) Pulpal debridement. One gross pulpal debridement per client, per tooth, within a twelve-month period.

(iv) Extractions and surgical extractions for symptomatic teeth, limited to:

(A) Extraction of a nearly erupted or fully erupted tooth or exposed root;

(B) Surgical removal of an erupted tooth only;

(C) Surgical removal of residual tooth roots; and

(D) Extraction of an impacted wisdom tooth when the tooth is not erupted.

(v) Palliative (emergency) treatment for the treatment of dental pain, one per client, per six-month period, during a limited oral evaluation appointment.

(vi) Local anesthesia and regional blocks as part of the global fee for any procedure being provided to a client.

(vii) Inhalation of nitrous oxide, once per day.

(viii) House or extended care facility visits, for emergency care as defined in this section.

(ix) Emergency office visits after regularly scheduled hours. The department limits coverage to one emergency visit per day, per provider.

(x) Therapeutic drug injections including drugs and/or medications (pharmaceuticals) only when used with general anesthesia.

(xi) Treatment of post-surgical complications, such as dry socket.

(c) Emergency health care benefit services provided by dentists specialized in oral maxillofacial surgery. Services that are covered under the emergency oral health care benefit to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pre-transplant protocol:

(i) May be provided by dentists specialized in oral maxillofacial surgery; and

(ii) Are billed using only the allowed procedure codes listed in the department's published billing instructions and fee schedules.

(8) Prior Authorization for oral health care services provided by dentists for clients age twenty-one and older.

(a) The department uses the determination process described in WAC 388-501-0165 for covered oral health care services for clients age twenty-one and older for an emergency condition that requires prior authorization.

(b) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on the DSHS 13-835 general information for authorization form which may be obtained at <http://dshs.wa.gov/msa/forms/eforms.html>.

(c) The department may request additional information as follows:

- (i) Additional radiographs (X rays);
- (ii) Study models;
- (iii) Photographs; and
- (iv) Any other information as determined by the department.

(d) The department may require second opinions and/or consultations before authorizing any procedure.

(e) When the department authorizes an oral health care service for a client, that authorization indicates only that the specific service is medically necessary and an emergency, it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible and the service is covered in the client's health care benefit package on the date of service.

(f) The department denies a request for an oral health care service when the requested service:

- (i) Is not covered in the client's health care benefit package;
- (ii) Is covered by another department program;
- (iii) Is covered by an agency or other entity outside the department; or
- (iv) Fails to meet the clinical criteria, limitations, or restrictions in this section.

(9) Refer to chapter 388-535 WAC and WAC 388-531-1850 and 388-531-1900 for the payment methodologies used for the services listed in this section.

[WSR 11-14-075, recodified as § 182-531-1025, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-1025, filed 6/29/11, effective 7/30/11.]

WAC 182-531-1050 Osteopathic manipulative treatment. (1) The department reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) The department reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) The department allows an osteopathic physician to bill the department for an evaluation and management (E&M) service in addition to the OMT when one of the following apply:

- (a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;
- (b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

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(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) The department limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) The department does not reimburse for physical therapy services performed by osteopathic physicians.

[WSR 11-14-075, recodified as § 182-531-1050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1050, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1100 Out-of-state physician services.

(1) The department covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.

(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. The department considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[WSR 11-14-075, recodified as § 182-531-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1150 Physician care plan oversight services. (1) The department covers **physician care plan oversight services** only when:

- (a) A physician provides the service; and
- (b) The client is served by a home health agency, a nursing facility, or a **hospice**.

(2) The department reimburses for physician care plan oversight services when both of the following apply:

(a) The facility/agency has established a plan of care; and

(b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.

(3) The department reimburses only one physician per client, per month, for physician care plan oversight services.

(4) The department reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[WSR 11-14-075, recodified as § 182-531-1150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1200 Physician office medical supplies. (1) Refer to RBRVS billing instructions for a list of:

- (a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and

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(b) Supplies that can be billed separately and that the department considers nonroutine to office or outpatient procedures.

(2) The department reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to the department upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) The department reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[WSR 11-14-075, recodified as § 182-531-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1250 Physician standby services. (1)

The department reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) The department does not reimburse physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than thirty minutes; or

(c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. The department reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. The department rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[WSR 11-14-075, recodified as § 182-531-1250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1250, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1300 Foot care services for clients twenty-one years of age and older. (1) This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients twenty-one years of age and older.

(2) The department covers the foot care services listed in this section when those services are provided by any of the following health care providers and billed to the department using procedure codes and diagnosis codes that are within their scope of practice:

(a) Physicians or physician's assistants-certified (PA-C);

(b) Osteopathic physicians, surgeons, or physician's assistant-certified (PA-C);

(c) Podiatric physicians and surgeons; or

(d) Advanced registered nurse practitioners (ARNP).

(3) The department covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the department covers treatment if the criteria in subsection (4) of this section are met.

(4) The department pays for:

(a) Treatment of the following conditions of the lower extremities only when there is an acute condition, an exacerbation of a chronic condition, or presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain resulting in the inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified:

(i) Acute inflammatory processes such as, but not limited to tendonitis;

(ii) Circulatory compromise such as, but are not limited to:

(A) Lymphedema;

(B) Raynaud's disease;

(C) Thromboangiitis obliterans; and

(D) Phlebitis.

(iii) Injuries, fractures, sprains, and dislocations;

(iv) Gout;

(v) Lacerations, ulcerations, wounds, blisters;

(vi) Neuropathies (e.g., reflex sympathetic dystrophy, secondary to diabetes, charcot arthropathy);

(vii) Osteomyelitis;

(viii) Post-op complications;

(ix) Warts, corns, or calluses in the presence of an acute condition such as infection and pain effecting the client's ability to ambulate as a result of the warts, corns, or calluses and meets the criteria in subsection (4) of this section;

(x) Soft tissue conditions, such as, but are not limited to:

(A) Rashes;

(B) Infections (fungal, bacterial);

(C) Gangrene;

(D) Cellulitis of lower extremities;

(E) Soft tissue tumors; and

(F) Neuroma.

(xi) Nail bed infections (paronychia); and

(xii) Tarsal tunnel syndrome.

(b) Trimming and/or debridement of nails to treat, as applicable, conditions from the list in subsection (4)(a) of this section. The department pays for one treatment in a sixty-day period. The department covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) A surgical procedure to treat one of the conditions in subsection (4) of this section performed on the lower extremities, and performed by a qualified provider;

(d) Impression casting to treat one of the conditions in subsection (4) of this section. The department includes ninety-day follow-up care in the reimbursement;

(e) Custom fitted and/or custom molded orthotic devices to treat one of the conditions in subsection (4) of this section.

(i) The department's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) The department includes an evaluation and management (E&M) fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(5) The department does not pay for:

(a) The following radiology services:

(i) Bilateral X rays for a unilateral condition; or

(ii) X rays in excess of three views; or

(iii) X rays that are ordered before the client is examined.

(b) Podiatric physicians or surgeons for X rays for any part of the body other than the foot or ankle.

[WSR 11-14-075, recodified as § 182-531-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-1300, filed 6/29/11, effective 7/30/11; WSR 10-19-057, § 388-531-1300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1350 Prolonged physician-related service. (1) The department reimburses prolonged services based on established medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician and the client; and

(b) Be provided with other services.

(2) The department allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[WSR 11-14-075, recodified as § 182-531-1350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1400 Psychiatric physician-related services and other professional mental health services. (1) The mental health services covered in the medical benefits described in this section are separate from the mental health services covered by the mental health managed care system administered under the authority of the mental health division pursuant to chapter 388-865 WAC. The department covers outpatient mental health services with the following limitations:

(a) For clients eighteen years of age and younger:

(i) The department pays for only one hour per day, per client, up to a total of twenty hours per calendar year, including the psychiatric diagnostic evaluation and family therapy visits that are medically necessary to the client's treatment;

(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric advanced registered nurse practitioners (ARNP) in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and

(iii) The mental health services must be provided in an outpatient setting by a psychiatrist, psychologist, psychiatric

ARNP, social worker, marriage and family therapist, or mental health counselor who must:

(A) Be licensed, in good standing and without restriction, by the department of health under their appropriate licensure; and

(B) Have a minimum of two years experience in the diagnosis and treatment of clients eighteen years of age and younger and their families, including a minimum one year under the supervision of a mental health professional trained in child and family mental health. A licensed psychiatrist may provide these services and bill the department without meeting this requirement.

(b) For clients nineteen years of age and older:

(i) The department pays for only one hour per day, per client, up to a total of twelve hours per calendar year, including family or group therapy visits;

(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric ARNPs in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and

(iii) The mental health services must be provided by a psychiatrist in an outpatient setting.

(2) The department covers inpatient mental health services with the following limitations:

(a) Must be provided by a psychiatrist;

(b) Only the total time spent on direct psychiatric client care during each visit; and

(c) One hospital call per day for direct psychiatric client care, including making rounds. Making rounds is considered direct client care and includes any one of the following:

(i) Individual psychotherapy up to one hour;

(ii) Family/group therapy; or

(iii) Electroconvulsive therapy.

(3) With the exception of medication management, the department covers other mental health services described in this section with the limitation of one per client, per day regardless of location or provider type.

(4) The department pays psychiatrists when the client receives a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) The department covers psychiatric diagnostic interview evaluations at the limit of one per provider, per calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the department.

(6) The department does not cover psychiatric sleep therapy.

(7) The department covers electroconvulsive therapy and narcosynthesis only when performed by a psychiatrist.

(8) The department pays psychiatric ARNPs only for mental health medication management and diagnostic interview evaluations provided to clients nineteen years of age and older.

(9) The department covers interactive, face-to-face visits at the limit of one per client, per day, in an outpatient setting. Interactive, face-to-face visits may be billed only for clients age twenty and younger.

(10) The client or licensed health care provider may request a limitation extension only when the client exceeds the total hour limit described in subsection (1) of this section, and for no other limitation of service in this section. The department will evaluate these requests in accordance with WAC 388-501-0169.

(11) DSHS providers must comply with chapter 388-865 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the mental health division or the appropriate regional support network (RSN).

(12) Accepting payment under more than one contract or agreement with the department for the same service for the same client constitutes duplication of payment. If a client is provided services under multiple contracts or agreements, each provider must maintain documentation identifying the type of service provided and the contract or agreement under which it is provided to ensure it is not a duplication of service.

[WSR 11-14-075, recodified as § 182-531-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.521. WSR 08-12-030, § 388-531-1400, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1400, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1450 Radiology physician-related services. (1) The department reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) The department does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) The department reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by the department, and reimbursement is at acquisition cost.

(4) The department reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) The department reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The department reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) The department reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contrast [contrast] media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[WSR 11-14-075, recodified as § 182-531-1450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1450, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.-090, 74.09.520. WSR 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1500 Sleep studies. (1) Purpose. For the purposes of this section, sleep studies include polysomnography (PSG) and multiple sleep latency testing (MSLT). The medicaid agency covers attended, full-channel, PSG and MSLT when:

(a) Ordered by the client's physician;

(b) Performed in an agency-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital; and

(c) Results are used to:

(i) Establish a diagnosis of narcolepsy or sleep apnea; or

(ii) Evaluate a client's response to therapy, such as continuous positive airway pressure (CPAP).

(2) Definitions. The following definitions, those found in chapter 182-500 WAC, and definitions found in other sections of this chapter, apply to this section:

(a) "American Academy of Sleep Medicine" or "AASM" - The only professional society dedicated exclusively to the medical subspecialty of sleep medicine. AASM sets standards and promotes excellence in health care, education, and research. Members specialize in studying, diagnosing, and treating disorders of sleep and daytime alertness such as insomnia, narcolepsy, and obstructive sleep apnea.

(b) "Continuous positive airway pressure" or "CPAP" - See WAC 182-552-0005.

(c) "Core provider agreement" or "CPA" - The basic contract the agency holds with providers serving medical assistance clients.

(d) "Multiple sleep latency test" or "MSLT" - A sleep disorder diagnostic tool used to measure the time elapsed from the start of a daytime nap period to the first signs of sleep, called sleep latency. The MSLT is used extensively to test for narcolepsy, to distinguish between physical tiredness and true excessive daytime sleepiness, or to assess whether treatments for breathing disorders are working.

(e) "Obstructive sleep apnea" or "OSA" - See WAC 182-552-0005.

(f) "Polysomnogram" - The test results from a polysomnography.

(g) "Polysomnography" - A multiparametric test that electronically transmits and records specific physical activi-

ties while a person sleeps. The recordings become data that are analyzed by a qualified sleep specialist to determine whether or not a person has a sleep disorder.

(h) "PSG" - The abbreviation for both "polysomnography" and "polysomnogram."

(i) "Registered polysomnographic technologist" or "RPSGT" - A sleep technologist credentialed by the board of registered polysomnographic technologists to assist sleep specialists in the clinical assessment, physiological monitoring and testing, diagnosis, management, and prevention of sleep-related disorders with the use of various diagnostic and therapeutic tools. These tools include, but are not limited to, polysomnograph, positive airway pressure devices, oximeter, capnograph, actigraph, nocturnal oxygen, screening devices, and questionnaires. To become certified as a registered polysomnographic technologist, a sleep technologist must have the necessary clinical experience, hold CPR certification or its equivalent, adhere to the board of registered polysomnographic technologists standards of conduct, and pass the registered polysomnographic technologist examination for polysomnographic technologists.

(3) Client eligibility. Clients in the following agency programs are eligible to receive sleep studies as described in this section:

(a) Categorically needy (CN);

(b) Apple health for kids and other children's medical assistance programs as defined in WAC 182-505-0210;

(c) Medical care services as described in WAC 182-508-0005 (within Washington state or border areas only);

(d) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (within Washington state or border areas only); and

(e) Medically needy (MN) only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis, and treatment program as described in chapter 182-534 WAC; or

(ii) Receiving home health care services as described in chapter 182-551 WAC, subchapter II.

(4) Provider requirements. To be paid for providing sleep studies as described in this section to eligible clients, the facility must:

(a) Be a sleep study COE. Refer to subsection (5) of this section for information on becoming an agency-approved sleep study COE;

(b) Be currently accredited by AASM and continuously meet the accreditation standards of AASM;

(c) Have at least one physician on staff who is board certified in sleep medicine; and

(d) Have at least one registered polysomnographic technologist (RPSGT) in the sleep lab when studies are being performed.

(5) Documentation.

(a) To become an agency-approved COE, a sleep center must send the following documentation to the Health Care Authority, c/o Provider Enrollment, P.O. Box 45510, Olympia, WA 98504-5510:

(i) A completed CPA; and

(ii) Copies of the following:

(A) The sleep center's current accreditation certificate by AASM;

(B) Either of the following certifications for at least one physician on staff:

(I) Current certification in sleep medicine by the American Board of Sleep Medicine (ABSM); or

(II) Current subspecialty certification in sleep medicine by a member of the American Board of Medical Specialties (ABMS); and

(C) The certification of an RPSGT who is employed by the sleep center.

(b) Sleep centers must request reaccreditation from AASM in time to avoid expiration of COE status with the agency.

(c) At least one physician on staff at the sleep center must be board certified in sleep medicine. If the only physician on staff who is board certified in sleep medicine resigns, the sleep center must ensure another physician on staff at the sleep center obtains board certification or another board-certified physician is hired. The sleep center must then send provider enrollment a copy of the physician's board certification.

(d) If a certified medical director leaves a COE, the COE status does not transfer with the medical director to another sleep center.

(e) The COE must maintain a record of the physician's order for the sleep study.

(6) Coverage.

(a) The agency covers only medically necessary sleep studies. The need for the sleep study must be confirmed by medical evidence (e.g., physician examination and laboratory tests).

(b) For clients twenty-one years of age and older, the agency covers:

(i) Full-night, in-laboratory PSG for either of the following:

(A) Confirmation of obstructive sleep apnea (OSA) in an individual with signs or symptoms consistent with OSA (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.); or

(B) Titration of positive airway pressure therapy when initial PSG confirms the diagnosis of OSA, and positive airway pressure is ordered; or

(ii) Split-night, in-laboratory PSG in which the initial diagnostic portion of the PSG is followed by positive airway pressure titration when the PSG meets either of the following criteria:

(A) The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to fifteen events per hour with a minimum of thirty events; or

(B) The AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with a minimum of ten events with documentation of either of the following:

(I) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or

(II) Hypertension, ischemic heart disease, or history of stroke.

(c) For clients younger than twenty-one years of age, the agency considers any of the following indications as medically necessary criteria for a sleep study:

(i) OSA suspected based on clinical assessment;

(ii) Obesity, Trisomy 21, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidosis (MPS), prior to adenotonsillectomy in a child;

(iii) Residual symptoms of OSA following mild preoperative OSA;

(iv) Residual symptoms of OSA in a child with preoperative evidence of moderate to severe OSA, obesity, craniofacial anomalies that obstruct the upper airway, or neurologic disorder following adenotonsillectomy;

(v) Titration of positive airway pressure in a child with OSA;

(vi) Suspected congenital central alveolar hypoventilation syndrome or sleep related hypoventilation due to neuromuscular disorder or chest wall deformities;

(vii) Primary apnea of infancy;

(viii) Evidence of a sleep-related breathing disorder in an infant who has experienced an apparent life threatening event;

(ix) Child being considered for adenotonsillectomy to treat OSA; or

(x) Clinical suspicion of an accompanying sleep-related breathing disorder in a child with chronic asthma, cystic fibrosis, pulmonary hypertension, bronchopulmonary dysplasia, or chest wall abnormality.

(7) Noncoverage. The agency does not cover sleep studies:

(a) When the sleep study is an unattended home study;

(b) When documentation for a repeat study does not indicate medical necessity (e.g., no new clinical documentation indicating the need for a repeat study); or

(c) For the following indications, except when an underlying physiology exists (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.):

(i) Chronic insomnia; and

(ii) Snoring.

[Statutory Authority: RCW 41.05.021, WSR 13-07-029, § 182-531-1500, filed 3/13/13, effective 4/13/13. WSR 11-14-075, recodified as § 182-531-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, WSR 10-19-057, § 388-531-1500, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520, WSR 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing.

Hysterectomy results in sterilization and is not covered by the medicaid agency solely for that purpose. (See WAC 182-531-0150 and 182-531-0200 for more information about hysterectomies.)

STERILIZATION

(2) The medicaid agency covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time an agency-approved consent form is signed;

(b) The client is a mentally competent individual;

(c) The client participates in a medical assistance program (see WAC 182-501-0060);

(d) The client has voluntarily given **informed consent**; and

(e) The date the client signed a sterilization consent is at least thirty days and not more than one hundred eighty days before the date of the sterilization procedure.

(3) Any medicaid provider who is licensed to do sterilizations within their scope of practice may provide vasectomies and tubal ligations to any medicaid client. (See subsections (10), (11), and (12) of this section for additional qualifications of providers performing hysteroscopic sterilizations.)

(4) The medicaid agency requires at least a seventy-two hour waiting period rather than the usual thirty-day waiting period for sterilization in either of the following circumstances:

(a) At the time of a premature delivery when the client gave consent at least thirty days before the expected date of delivery. (The expected date of delivery must be documented on the consent form.)

(b) For emergency abdominal surgery. (The nature of the emergency must be described on the consent form.)

(5) The medicaid agency waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(6) The medicaid agency does not accept informed consent obtained when the client is:

(a) In labor or childbirth;

(b) In the process of seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances, including pain medications for labor and delivery, that affects the client's state of awareness.

(7) The medicaid agency has certain consent requirements that the provider must meet before the agency reimburses sterilization of an institutionalized client or a client with mental incompetence. The agency requires both of the following:

(a) A court order, which includes both a statement that the client is to be sterilized, and the name of the client's legal guardian who will be giving consent for the sterilization; and

(b) A sterilization consent form signed by the legal guardian, sent to the agency at least thirty days before the procedure.

(8) The medicaid agency reimburses epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with or immediately following a delivery.

(a) For reimbursement, anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session.

(b) If the sterilization and delivery are performed during different operative sessions, the anesthesia time is calculated separately.

(9) The medicaid agency reimburses all attending providers for the sterilization procedure only when the provider submits an agency-approved and complete consent form with the claim for reimbursement. (See subsections (10), (11), and (12) of this section for additional coverage criteria for hysteroscopic sterilizations.)

(a) The physician must complete and sign the physician statement on the consent form within thirty days of the sterilization procedure.

(b) The agency reimburses attending providers after the procedure is completed.

HYSTEROSCOPIC STERILIZATIONS

(10) The medicaid agency pays for hysteroscopic sterilizations when the following additional criteria are met:

(a) A device covered by the agency is used.

(b) The procedure is predominately performed in a clinical setting, such as a physician's office, without general anesthesia and without the use of a surgical suite; and is covered according to the corresponding agency fee schedule.

(c) If determining that it is medically necessary to perform the procedure in an inpatient rather than outpatient setting, a provider must submit clinical notes with the claim, documenting the medical necessity.

(d) The client provides informed consent for the procedure.

(e) The hysteroscopic sterilization is performed by an approved provider who:

(i) Has a core provider agreement with the agency;

(ii) Is nationally board certified in obstetrics and gynecology (OB-GYN);

(iii) Is privileged at a licensed hospital to do hysteroscopies;

(iv) Has successfully completed the manufacturer's training for the device covered by the agency;

(v) Has successfully performed a minimum of twenty hysteroscopies; and

(vi) Has established screening and follow-up protocols for clients being considered for hysteroscopic sterilization.

(11) To become approved for hysteroscopic sterilizations, interested providers must send the medicaid agency-approved vendor, identified in the agency's billing instructions, the following:

(a) Documentation of successful completion of the manufacturer's training;

(b) Documentation demonstrating privilege at a licensed hospital to perform hysteroscopies;

(c) Documentation attesting to having successfully performed twenty or more hysteroscopies;

(d) Evidence of valid National Board Certification; and

(e) Office protocols for screening and follow-up.

(12) The provider will not be paid to perform the hysteroscopic procedure until the medicaid agency sends written approval to the provider.

[Statutory Authority: RCW 41.05.021, 74.09.520, 74.09.657, 74.09.659, and 74.09.800. WSR 13-16-008, § 182-531-1550, filed 7/25/13, effective 9/1/13. WSR 11-14-075, recodified as § 182-531-1550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-24-071, § 388-531-1550, filed 11/30/10, effective 1/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

(2/26/14)

WAC 182-531-1600 Bariatric surgery. (1) The agency covers medically necessary bariatric surgery for eligible clients.

(2) Bariatric surgery must be performed in a hospital with a bariatric surgery program, and the hospital must be:

(a) Located in the state of Washington or approved border cities (see WAC 182-501-0175); and

(b) Meet the requirements of WAC 182-550-2301.

(3) If bariatric surgery is requested or prescribed under the EPSDT program, the agency evaluates it as a covered service under EPSDT's standard of coverage that requires the service to be:

(a) Medically necessary;

(b) Safe and effective; and

(c) Not experimental.

(4) The agency authorizes payment for bariatric surgery and bariatric surgery-related services in three stages:

(a) Stage one - Initial assessment of client;

(b) Stage two - Evaluations for bariatric surgery and successful completion of a weight loss regimen; and

(c) Stage three - Bariatric surgery.

Stage one - Initial assessment

(5) Any agency-enrolled provider who is licensed to practice medicine in the state of Washington may examine a client requesting bariatric surgery to ascertain if the client meets the criteria listed in subsection (6) of this section.

(6) The client meets the preliminary conditions of stage one when:

(a) The client is:

(i) Twenty-one through fifty-nine years of age; or

(ii) Eighteen through twenty years old for laparoscopic adjustable gastric banding (LAGB) only;

(b) The client has a body mass index (BMI) of thirty-five or greater;

(c) The client is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery);

(d) The client is diagnosed with one of the following:

(i) Diabetes mellitus;

(ii) Degenerative joint disease of a major weight bearing joint(s) (the client must be a candidate for joint replacement surgery if weight loss is achieved); or

(iii) Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality; and

(e) The client has an absence of other medical conditions such as multiple sclerosis (MS) that would increase the client's risk of surgical mortality or morbidity from bariatric surgery.

(7) If a client meets the criteria in subsection (6) of this section, the provider must request prior authorization from the agency before referring the client to stage two of the bariatric surgery authorization process. The provider must attach a medical report to the request for prior authorization with supporting documentation that the client meets the stage one criteria in subsections (5) and (6) of this section.

(8) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restric-

tions when medically necessary, under the provisions of WAC 182-501-0165 and 182-501-0169.

Stage two - Evaluations for bariatric surgery and successful completion of a weight loss regimen

(9) After receiving prior authorization from the agency to begin stage two of the bariatric surgery authorization process, the client must:

(a) Undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. Upon completion, the results of the evaluation must be forwarded to the agency. The comprehensive psychosocial evaluation must include:

(i) An assessment of the client's mental status or illness to:

(A) Evaluate the client for the presence of substance abuse problems or psychiatric illness which would preclude the client from participating in presurgical dietary requirements or postsurgical lifestyle changes; and

(B) If applicable, document that the client has been successfully treated for psychiatric illness and has been stabilized for at least six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.

(ii) An assessment and certification of the client's ability to comply with the postoperative requirements such as life-long required dietary changes and regular follow-up.

(b) Undergo an internal medicine evaluation performed by an internist to assess the client's preoperative condition and mortality risk. Upon completion, the internist must forward the results of the evaluation to the agency.

(c) Undergo a surgical evaluation by the surgeon who will perform the bariatric surgery (see subsection (13) of this section for surgeon requirements). Upon completion, the surgeon must forward the results of the surgical evaluation to the agency and to the licensed medical provider who is supervising the client's weight loss regimen (refer to WAC 182-531-1600 (9)(d)(ii)).

(d) Under the supervision of a licensed medical provider, the client must participate in a weight loss regimen prior to surgery. The client must, within one hundred and eighty days from the date of the agency's stage one authorization, lose at least five percent of his or her initial body weight. If the client does not meet this weight loss requirement within one hundred and eighty days from the date of the agency's initial authorization, the agency will cancel the authorization. The client or the client's provider must reapply for prior authorization from the agency to restart stage two. For the purpose of this section, "initial body weight" means the client's weight at the first evaluation appointment.

(i) The purpose of the weight loss regimen is to help the client achieve the required five percent loss of initial body weight prior to surgery and to demonstrate the client's ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery.

(ii) The weight loss regimen must:

(A) Be supervised by a licensed medical provider who has a core provider agreement with the agency;

(B) Include monthly visits to the medical provider;

(C) Include counseling twice a month by a registered dietician referred to by the treating provider or surgeon; and

(D) Be at least six months in duration.

(iii) Documentation of the following requirements must be retained in the client's medical file. Copies of the documentation must be forwarded to the agency upon completion of stage two. The agency will evaluate the documentation and authorize the client for bariatric surgery if the stage two requirements were successfully completed.

(A) The provider must document the client's compliance in keeping scheduled appointments and the client's progress toward weight loss by serial weight recordings. The client must lose at least five percent of his or her initial body weight and must maintain the five percent weight loss until surgery;

(B) For diabetic clients, the provider must document the efforts in diabetic control or stabilization;

(C) The registered dietician must document the client's compliance (or noncompliance) in keeping scheduled appointments, and the client's weight loss progress;

(D) The client must keep a journal of active participation in the medically structured weight loss regimen including the activities under (d)(iii)(A), (d)(iii)(B) if appropriate, and (d)(iii)(C) of this subsection.

(10) If the client fails to complete all of the requirements of subsection (9) of this section, the agency will not authorize stage three - Bariatric surgery.

(11) If the client is unable to meet all of the stage two criteria, the client or the client's provider must reapply for prior authorization from the agency to reenter stage two.

Stage three - Bariatric surgery

(12) The agency may withdraw authorization of payment for bariatric surgery at any time up to the actual surgery if the agency determines that the client is not complying with the requirements of this section.

(13) A surgeon who performs bariatric surgery for medical assistance clients must:

(a) Have a signed core provider agreement with the agency;

(b) Have a valid medical license in the state of Washington; and

(c) Be affiliated with a bariatric surgery program that meets the requirements of WAC 182-550-2301.

(14) For hospital requirements for stage three - Bariatric surgery, see WAC 182-550-2301.

[Statutory Authority: RCW 41.05.021. WSR 13-14-016, § 182-531-1600, filed 6/21/13, effective 7/22/13. WSR 11-14-075, recodified as § 182-531-1600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-531-1600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-12-022, § 388-531-1600, filed 5/20/05, effective 6/20/05; WSR 01-01-012, § 388-531-1600, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1625 Outpatient hemophilia treatment requirements—Center of excellence. A hemophilia treatment center of excellence (COE) uses a comprehensive care model to provide care for persons with bleeding disorders. The comprehensive care model includes specialized prevention, diagnostic, and treatment programs designed to provide family-centered education, state-of-the-art treatment, research, and support services for individuals and families living with bleeding disorders.

(1) The agency pays for hemophilia and von Willebrand related products for administration in the home only when provided through a qualified hemophilia treatment COE.

(2) To become a qualified hemophilia treatment COE, a hemophilia center must meet all of the following:

(a) Have a current core provider agreement in accordance with WAC 182-502-0005;

(b) Be a federally approved hemophilia treatment center (HTC) as defined in WAC 182-531-0050 and meet or exceed all Medical and Scientific Advisory Council (MASAC) standards of care and delivery of services;

(c) Participate in the public health service 340B provider drug discount program and be listed in the medicaid exclusion files maintained by the federal Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA);

(d) Submit a written request to the agency to be a qualified hemophilia treatment center of excellence and include proof of the following:

(i) U.S. Center for Disease Control (CDC) and prevention surveillance site identification number; and

(ii) Listing in the hemophilia treatment center (HTC) directory.

(e) Receive written approval including conditions of payment and billing procedures from the agency.

(3) To continue as a qualified hemophilia treatment COE, the HTC must annually submit to the agency:

(a) Copies of grant documents and reports submitted to the maternal and child health bureau/human resources and services administration/department of health and human services or to their designated subcontractors; and

(b) Proof of continued federal funding by the National Hemophilia Program and listing with the regional hemophilia network and the CDC.

(4) Services rendered by a hemophilia treatment COE may be subject to the agency's limitations and authorization requirements.

[Statutory Authority: RCW 41.05.021. WSR 12-16-061, § 182-531-1625, filed 7/30/12, effective 11/1/12.]

WAC 182-531-1650 Substance abuse detoxification physician-related services. (1) The department covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in a department-enrolled hospital-based detoxification center.

(2) The department covers treatment in programs certified under chapter 388-805 WAC or its successor.

(3) The department covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[WSR 11-14-075, recodified as § 182-531-1650, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1650, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-081, § 388-531-1650, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

(2/26/14)

WAC 182-531-1700 Surgical physician-related services. (1) The department's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) The department's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) The department's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, the department does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) The department's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of the department's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of the department's allowed fee for each procedure.

(6) The department allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) The department's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, the department pays the full amount of the procedure with the highest maximum allowable fee.

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(d) The department pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) The department does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) The department restricts reimbursement for surgery assists to selected procedures as follows:

(a) The department applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) The department bases payment splits between preoperative, intraoperative, and postoperative services on medicare determinations for given surgical procedures or range of procedures. The department pays any procedure that does not have an established medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[WSR 11-14-075, recodified as § 182-531-1700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1700, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1750 Transplant coverage for physician-related services. The department covers transplants when performed in a department-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[WSR 11-14-075, recodified as § 182-531-1750, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1750, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

WAC 182-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC 388-550-2000 for information about medical criteria to receive transplants.

[WSR 11-14-075, recodified as § 182-531-1800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1800, filed 12/6/00, effective 1/6/01.]

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

GENERAL PAYMENT METHODOLOGY

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

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

(3) The department 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 MPFSDDB, 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.

(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 department 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 department establishes maximum allowable fees, also known as "flat" fees.

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

(ii) The department 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 EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, the department pays the provider a flat fee only 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 department 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 department 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 department 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 department'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 department applies the increase after calculating budget-neutral fees. The department pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The department does not allow separate reimbursement for bundled services. However, the department 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 department to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[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.]

WAC 182-531-1900 Reimbursement—General requirements for physician-related services. (1) The department reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill the department according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) The department does not separately reimburse certain administrative costs or services. The department considers these costs to be included in the reimbursement. These costs and services include the following:

- (a) Delinquent payment fees;
- (b) Educational supplies;
- (c) Mileage;
- (d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, copying expenses;

(f) Service charges;

(g) Take home drugs; and

(h) Telephoning (e.g., for prescription refills).

(4) The department does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. The department reviews these codes for conformance to medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[WSR 11-14-075, recodified as § 182-531-1900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1900, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

WAC 182-531-2000 Increased payments for physician-related services for qualified trauma cases. (1) The health care authority's physician trauma care fund (TCF) is an amount that is legislatively appropriated to the medicaid agency each biennium for the purpose of increasing the agency's payment to physicians and other clinicians (those who are performing services within their licensed and credentialed scope of practice) providing qualified trauma care services to medical assistance clients covered under the agency's medical assistance programs.

(2) Trauma care services provided to clients in:

(a) Medicaid, disability lifeline (DL), incapacity-based medical care services (MCS), children's health insurance program (CHIP), and apple health for kids, qualify for enhanced rate payments from the TCF. Trauma care services provided to a DL or MCS client qualify for enhanced rates only during the client's certification period. See WAC 182-504-0010;

(b) The alien emergency medical (AEM), refugee assistance, and alien medical programs do not qualify for enhanced rate payments from the TCF; and

(c) The agency's managed care programs qualify for enhanced rate payments from the TCF, effective with dates of service on and after July 1, 2012.

(3) To receive payments from the TCF, a physician or other clinician must:

(a) Be on the designated trauma services response team of any department of health (DOH)-designated or DOH-recognized trauma service center;

(b) Meet the provider requirements in this section and other applicable rules;

(c) Meet the billing requirements in this section and other applicable rules; and

(d) Submit all information the agency requires to monitor the trauma program.

(4) Except as described in subsection (5) of this section and subject to the limitations listed, the agency makes payments from the TCF to physicians and other clinicians:

(a) For only those trauma services that are designated by the agency as "qualified." Qualified trauma care services include:

(i) Follow-up surgical services provided within six months of the date of the injury. These surgical procedures must have been planned during the initial acute episode of injury; and

(ii) Psychiatrist services provided during an inpatient stay immediately following, and within six months of, the qualifying traumatic injury.

(b) For hospital-based professional services-only, and for follow-up surgeries performed in a medicare-certified ambulatory surgery center (ASC). The follow-up surgery must have been performed within six months of the initial traumatic injury.

(c) Only for trauma cases that meet the injury severity score (ISS) (a summary rating system for traumatic anatomic injuries) criteria specified by the agency. The current qualifying ISS are:

(i) Thirteen or greater for an adult trauma patient (a client age fifteen or older); and

(ii) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).

(d) On a per-client basis in any DOH-designated or DOH-recognized trauma service center.

(e) At a rate of two and one-half times the agency's current fee-for-service rate for qualified trauma services, or other payment enhancement percentage the agency deems appropriate.

(i) The agency monitors the payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the SFY will not exceed the legislative appropriation for that SFY.

(ii) Laboratory and pathology charges are not eligible for payments from the TCF. (See subsection (6)(b) of this section.)

(5) When a trauma case is transferred from one hospital to another, the agency makes payments from the TCF to physicians and clinicians, according to the ISS score as follows:

(a) If the transferred case meets or exceeds the appropriate ISS threshold described in subsection (4)(c) of this section, providers who furnish qualified trauma services, whether in the transferring or receiving facility, are eligible for payments from the TCF.

(b) If the transferred case is below the ISS threshold described in subsection (4)(c) of this section, only providers who furnish qualified trauma services in the receiving hospital are eligible for payments from the TCF.

(6) The agency makes a TCF payment to a physician or clinician:

(a) Only when the provider submits an eligible trauma claim with the appropriate trauma indicator within the time frames specified by the agency; and

(b) On a per-claim basis. Each qualifying trauma service and/or procedure on the provider's claim is paid at the agency's current fee-for-service rate, multiplied by the appropriate payment enhancement percentage described in subsection (4)(e) of this section. Laboratory and pathology services and/or procedures are not eligible for payments from the TCF and are paid at the agency's current fee-for-service rate.

(7) For purposes of the payments from the TCF to physicians and other clinicians, all of the following apply:

(a) The agency considers a request for a claim adjustment submitted by a provider only if the agency receives the adjustment request within three hundred sixty-five days from the date of the initial trauma service. At its discretion, and with sufficient public notice, the agency may adjust the dead-

line for submission and/or adjustment of trauma claims in response to budgetary or other program needs;

(b) Except as provided in subsection (7)(a) of this section, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the agency as specified in WAC 182-502-0150(3). See WAC 182-502-0150 (11) and (12) for other time limits applicable to trauma claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total payments from the TCF disbursed to providers by the agency in an SFY cannot exceed the amount appropriated by the legislature for that SFY. The agency has the authority to take whatever actions are needed to ensure the agency stays within its TCF appropriation (see subsection (4)(e)(i) of this section).

[Statutory Authority: RCW 41.05.021, WSR 12-14-041, § 182-531-2000, filed 6/27/12, effective 7/28/12. WSR 11-14-075, recodified as § 182-531-2000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. WSR 10-12-013, § 388-531-2000, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.500, and chapter 43.20A RCW. WSR 08-18-029, § 388-531-2000, filed 8/27/08, effective 9/27/08. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 05-20-050, § 388-531-2000, filed 9/30/05, effective 10/31/05; WSR 04-19-113, § 388-531-2000, filed 9/21/04, effective 10/22/04.]

WAC 182-531-2010 Enhanced reimbursement—Independent advanced registered nurse practitioners (ARNPs).

(1) Effective for dates of service July 1, 2013, through December 31, 2014, the agency is authorized by the legislature to increase reimbursement rates to medicare levels for independent ARNPs who provide qualified primary care services to eligible medicaid clients.

(2) For the purpose of this section, the following definitions apply:

(a) Independent ARNP – Means a health care practitioner who is not supervised by an eligible primary care physician and not already receiving increased rates for evaluation and management services and vaccine administration services as provided under the Affordable Care Act, section 1202.

(b) Qualified primary care services – Means evaluation and management services and vaccine administration services provided to eligible medicaid clients.

(3) The agency calculates the enhanced rate for independent ARNPs using medicare's payment methodology.

(a) ARNP services are paid at eighty percent of the lesser of the actual charge or eighty-five percent of what a physician is paid under the medicare physician fee schedule.

(b) For the purpose of this enhanced rate calculation, the amount payable to a physician is determined by the Centers for Medicare and Medicaid Services (CMS) as authorized by C.F.R. 447.405 for qualified services in calendar years 2013 and 2014.

(4) If the enhanced rate is less than the agency's published fee schedule rate, the agency's payment will equal the published rate.

(5) This rate increase does not apply to either of the following:

(a) Federally qualified health center services and rural health clinic services reimbursed as part of the encounter rate.

(b) Services provided under state-only funded programs.

(c) Services paid at an enhanced or supplemental rate through a separate provision or regulation.

[Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213(26). WSR 14-06-049, § 182-531-2010, filed 2/26/14, effective 3/29/14.]