

Chapter 182-500 WAC MEDICAL DEFINITIONS

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WAC

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-16-084, § 182-500-0005, filed 7/29/16, effective 8/29/16. WSR 11-14-075, recodified as § 182-500-0005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0005, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-500-0005, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. WSR 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. WSR 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; WSR 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

WAC 182-500-0010 Medical assistance definitions—A. "Administrative renewal" means the agency uses electronically available income data sources to verify and recertify a person's Washington apple health benefits for a subsequent certification period. A case is administratively renewed when the person's self-attested income is reasonably compatible (as defined in WAC 182-500-0095) with the informa-

tion available to the agency from the electronic data sources and the person meets citizenship, immigration, Social Security number, and age requirements.

"Agency" or **"medicaid agency"** means the Washington state health care authority (HCA).

"Agency's designee" means any entity expressly designated by the agency to act on its behalf.

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

"Alternative benefits plan" means the range of health care services included within the scope of service categories described in WAC 182-501-0060 available to persons eligible to receive health care coverage under the Washington apple health modified adjusted gross income (MAGI)-based adult coverage described in WAC 182-505-0250.

"Ancillary services" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy.

"Apple health for kids" is the umbrella term for health care coverage for certain groups of children that is funded by the state and federal governments under Title XIX medicaid programs, Title XXI Children's Health Insurance Program, or solely through state funds (including the program formerly known as the children's health program). Funding for any given child depends on the program for which the child is determined to be eligible. Apple health for kids programs are included in the array of health care programs available through Washington apple health (WAH).

"Attested income" means a self-declared statement of a person's income made under penalty of perjury to be true. (See also "self-attested income.")

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

"Authorized representative" is defined under WAC 182-503-0130.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-02-122, § 182-500-0010, filed 1/6/16, effective 2/6/16; WSR 15-15-143, § 182-500-0010, filed 7/17/15, effective 8/17/15. Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0010, filed 12/9/13, effective 1/9/14. WSR 11-14-075, recodified as § 182-500-0010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0010, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0015 Medical assistance definitions—B. "Behavioral health organization" means a single- or multiple-county authority or

other entity operating as a prepaid health plan with which the medic-aid agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area.

"Benefit package" means the set of health care service categories included in a client's health care program. See WAC 182-501-0060.

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

"Billing instructions" means provider guides. See WAC 182-500-0085.

"Blind" is a category of medical program eligibility that requires:

(a) A central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(b) A field of vision limitation so the widest diameter of the visual field subtends an angle no greater than twenty degrees from central.

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-500-0015, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-21-063, § 182-500-0015, filed 10/19/15, effective 11/19/15. WSR 11-14-075, recodified as § 182-500-0015, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0015, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0020 Definitions—C. "Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(b) The spouse of such parent or relative (including same sex marriage or domestic partner), even after the marriage is terminated by death or divorce.

(c) Other relatives including relatives of half-blood, first cousins once removed, people of earlier generations (as shown by the prefixes of great, great-great, or great-great-great), and natural parents whose parental rights were terminated by a court order.

"Carrier" means an organization that contracts with the federal government to process claims under medicare Part B.

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

"Categorically needy income level (CNIL)" is the standard used by the agency to determine eligibility under a categorically needy program.

"Categorically needy (CN) scope of care" is the range of health care services included within the scope of service categories described in WAC 182-501-0060 available to people eligible to receive benefits under a CN program. Some state-funded health care programs provide CN scope of care.

"Center of excellence" - 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)" - The federal agency that runs the medicare, medicaid, and children's health insurance programs, and the federally facilitated marketplace.

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

"Client" means a person who is an applicant for, or recipient of, any Washington apple health program, including managed care and long-term care. See definitions for "applicant" and "recipient" in RCW 74.09.741.

"Community spouse." See "spouse" in WAC 182-500-0100.

"Core provider agreement" is a written contract whose terms and conditions bind each provider in the fee-for-service program to applicable federal laws, state laws, and the agency's rules, provider alerts, billing guides, and other subregulatory guidance. See WAC 182-502-0005. The core provider agreement is a unilateral contract.

"Cost-sharing" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for nonnetwork providers, and spending for noncovered services.

"Cost-sharing reductions" means reductions in cost-sharing for an eligible person enrolled in a silver level plan in the health benefit exchange or for a person who is an American Indian or Alaska native enrolled in a qualified health plan (QHP) in the exchange.

"Couple." See "spouse" in WAC 182-500-0100.

"Covered service" is a health care service contained within a "service category" that is included in a Washington apple health (WAH) benefits package described in WAC 182-501-0060. For conditions of payment, see WAC 182-501-0050(5). A noncovered service is a specific health care service (for example, cosmetic surgery), contained within a service category that is included in a WAH benefits package, for which the agency or the agency's designee requires an approved exception to rule (ETR) (see WAC 182-501-0160). A noncovered service is not an excluded service (see WAC 182-501-0060).

"Creditable coverage" means most types of public and private health coverage, except Indian health services, that provide access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under premium-based programs included in Washington apple health (WAH). Creditable coverage is described in 42 U.S.C. 300gg-3 (c) (1).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-04-095, § 182-500-0020, filed 2/5/19, effective 3/8/19; WSR 17-23-040, § 182-500-0020, filed 11/8/17, effective 12/9/17; WSR 16-18-019, § 182-500-0020, filed 8/26/16, effective 9/26/16; WSR 15-17-013, § 182-500-0020, filed 8/7/15, effective 9/7/15. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-052, § 182-500-0020, filed 7/29/14, effective 8/29/14. WSR 11-14-075, recodified as § 182-500-0020, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0020, filed 6/29/11, effective 7/30/11.]

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

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

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

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

(a) Can be expected to result in death;

(b) Has lasted or can be expected to last for a continuous period of not less than twelve months; or

(c) In the case of a child age seventeen or younger, means any physical or mental impairment of comparable severity.

Decisions on SSI-related disability are subject to the authority of federal statutes and rules codified at 42 U.S.C. Sec 1382c and 20 C.F.R., parts 404 and 416, as amended, and controlling federal court decisions, which define the old-age, survivors, and disability insurance (OASDI) and SSI disability standard and determination process. See WAC 182-500-0015 for definition of "blind."

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

"Dual eligible client" means a client who has been found eligible as a categorically needy (CN) or medically needy (MN) medicaid client and is also a medicare beneficiary. This does not include a client who is only eligible for a medicare savings program as described in chapter 182-517 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-02-046, § 182-500-0025, filed 12/27/18, effective 1/27/19. WSR 11-14-075, recodified as § 182-500-0025, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0025, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0030 Definitions—E. "Early and periodic screening, diagnosis and treatment (EPSDT)" is a comprehensive child health program that entitles infants, children, and youth to preventive care and

treatment services. EPSDT is available to people age twenty and younger who are eligible for any agency health care program. Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B. See chapter 182-534 WAC.

"Early elective delivery" means any nonmedically necessary induction or cesarean section before thirty-nine weeks of gestation. Thirty-nine weeks of gestation is greater than thirty-eight weeks and six days.

"Electronic signature" means a signature in electronic form attached to or associated with an electronic record including, but not limited to, a digital signature.

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

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

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or in part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.

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

- (a) Population-based health care coverage policies (WAC 182-501-0055 describes how the agency or its designee determines coverage of services for its health care programs by using evidence and criteria based on health technology assessments); and
- (b) Individual medical necessity decisions (WAC 182-501-0165 describes how the agency or its designee uses the best evidence available to determine if a service is medically necessary as defined in WAC 182-500-0030).

"Exception to rule." See WAC 182-501-0160 for exceptions to non-covered health care services, supplies, and equipment. See WAC 182-503-0090 for exceptions to program eligibility.

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

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-04-095, § 182-500-0030, filed 2/5/19, effective 3/8/19; WSR 15-24-021, § 182-500-0030, filed 11/19/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-052, § 182-500-0030, filed

7/29/14, effective 8/29/14. WSR 11-14-075, recodified as § 182-500-0030, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0030, filed 6/29/11, effective 7/30/11.]

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

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

[WSR 11-14-075, recodified as § 182-500-0035, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0035, filed 6/29/11, effective 7/30/11.]

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

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

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

(3) Was an institutionalized person who:

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

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

[WSR 11-14-075, recodified as § 182-500-0040, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0040, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0045 Medical assistance definitions—H. "Health benefit exchange" means the public-private partnership created pursuant to chapter 43.71 RCW.

"Health insurance premium tax credit (HIPTC)" is a premium tax credit that is refundable and can also be paid in advance from the Internal Revenue Service to a taxpayer's insurance company to help cover the cost of premiums for a taxpayer enrolled in a qualified health plan (QHP) through the health benefit exchange. This tax credit is specified in Section 36B of the Internal Revenue Code of 1986.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive

medical services directly to an eligible enrolled client in exchange for a premium paid by the agency on a prepaid capitation risk basis.

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

"Health care service category" means a grouping of health care services listed in the table in WAC 182-501-0060. A health care service category is included or excluded depending on the client's medical assistance benefits package.

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

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

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0045, filed 12/9/13, effective 1/9/14. WSR 11-14-075, recodified as § 182-500-0045, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0045, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0050 Washington apple health definitions—I. "Ineligible spouse" see "spouse" in WAC 182-500-0100.

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

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

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

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

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

(c) Primarily for the diagnosis, treatment, or rehabilitation for people with mental retardation or a related condition.

(3) **"Medical institution"** - An entity that is organized to provide medical care, including nursing and convalescent care. The terms "medical facility" and "medical institution" are sometimes used interchangeably throughout Title 182 WAC.

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

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

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

(iii) Include adequate physician and nursing care.

(b) Medical institutions include:

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

(ii) "Hospital" - Defined in WAC 182-500-0045.

(iii) "Nursing facility (NF)" - An entity certified to provide skilled nursing care and long-term care services to medicaid recipients under Social Security Act Sec. 1919(a), 42 U.S.C. Sec. 1396r. Nursing facilities that may become certified include nursing homes licensed under chapter 18.51 RCW, and nursing facility units within hospitals licensed by DOH under chapter 70.41 RCW. This includes the nursing facility section of a state veteran's facility.

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

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

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

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

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

(a) Public institutions include:

(i) Correctional facility - An entity such as a state prison, or city, county, or tribal jail, or juvenile rehabilitation or juvenile detention facility.

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

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

(b) Public institutions do not include intermediate care facilities, entities that meet the definition of medical institution (such

as Harborview Medical Center and University of Washington Medical Center), or facilities in Retsil, Orting, and Spokane that are administered by the department of veteran's affairs and licensed as nursing facilities.

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

"Institutional review board" - A board or committee responsible for reviewing research protocols and determining whether:

- (1) Risks to subjects are minimized;
- (2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result;
- (3) Selection of subjects is equitable;
- (4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative;
- (5) Informed consent will be appropriately documented;
- (6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects;
- (7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data; and
- (8) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant people, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

"Institutionalized spouse" see "spouse" in WAC 182-500-0100.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-017, § 182-500-0050, filed 5/30/17, effective 6/30/17; WSR 15-17-013, § 182-500-0050, filed 8/7/15, effective 9/7/15. WSR 11-14-075, recodified as § 182-500-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0050, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0065 Definitions—L. "Limitation extension" see WAC 182-501-0169.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-02-046, § 182-500-0065, filed 12/27/18, effective 1/27/19. WSR 11-14-075, recodified as § 182-500-0065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0065, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0070 Definitions—M. "Managed care organization (MCO)" see WAC 182-538-050.

"Medicaid" means the federal medical aid program under Title XIX of the Social Security Act that provides health care to eligible people.

"Medicaid agency" means the state agency that administers the medicaid program. The Washington state health care authority (HCA) is the state's medicaid agency.

"Medicaid transformation project" refers to the demonstration granted to the state by the federal government under section 1115 of the Social Security Act. Under this demonstration, the federal government allows the state to engage in a five-year demonstration to support health care systems, to implement reform, and to provide new targeted medicaid services to eligible clients with significant needs.

"Medical assistance" is the term the agency and its predecessors use to mean all federal or state-funded health care programs, or both, administered by the agency or its designees. Medical assistance programs are referred to as Washington apple health.

"Medical care services (MCS)" means the limited scope health care program financed by state funds for clients who are eligible for the aged, blind, or disabled (ABD) cash assistance (see WAC 388-400-0060) or the housing and essential needs (HEN) referral program (see WAC 388-400-0065) and not eligible for other full-scope programs due to their citizenship or immigration status.

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

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

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

"Medical services card" or **"services card"** means the card the agency issues at the initial approval of a person's Washington apple health benefit. The card identifies the person's name and medical services identification number but is not proof of eligibility. The card may be replaced upon request if it is lost or stolen, but is not required to access health care through Washington apple health.

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

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

"Medically needy income level (MNIL)" means the standard the agency uses to determine eligibility under the medically needy program. See WAC 182-519-0050.

"Medicare" is the federal government health insurance program under Titles II and XVIII of the Social Security Act. For additional information, see www.Medicare.gov.

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

"Medicare cost-sharing" means out-of-pocket medical expenses related to services provided by medicare. For clients enrolled in medi-

care, cost-sharing may include Part A and Part B premiums, co-insurance, deductibles, and copayments for medicare services. See chapter 182-517 WAC.

"Minimum essential coverage" means coverage under 26 U.S.C. Sec. 5000A(f).

"Modified adjusted gross income (MAGI)" means the adjusted gross income as determined by the Internal Revenue Service under the Internal Revenue Code of 1986 (IRC) increased by:

(a) Any amount excluded from gross income under 26 U.S.C. Sec. 911;

(b) Any amount of interest received or accrued by the client during the taxable year which is exempt from tax; and

(c) Any amount of Title II Social Security income or Tier 1 railroad retirement benefits excluded from gross income under 26 U.S.C. Sec. 86. See chapter 182-509 WAC for additional rules regarding MAGI.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 2017 3rd sp.s. c 1 § 213 (1)(c). WSR 19-09-058, § 182-500-0070, filed 4/15/19, effective 7/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-500-0070, filed 5/24/17, effective 7/1/17. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-06-109, § 182-500-0070, filed 3/2/16, effective 4/2/16. Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0070, filed 12/9/13, effective 1/9/14. Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-500-0070, filed 9/13/12, effective 10/14/12. WSR 11-14-075, recodified as § 182-500-0070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp. sess. c 15. WSR 11-14-053, § 388-500-0070, filed 6/29/11, effective 7/30/11.]

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

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

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

"Nonapplying spouse" see "spouse" in WAC 182-500-0100.

"Nonbilling provider" is a health care professional enrolled with the agency only as an ordering, referring, prescribing provider for the Washington medicaid program and who is not otherwise enrolled as a medicaid provider with the agency.

"Noncovered service" see "covered service" in WAC 182-500-0020.

"Nonphysician practitioner" means the following professionals who work in collaboration with an ordering physician: Nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant.

"Nursing facility" see "institution" in WAC 182-500-0050.

"Nursing facility long-term care services" are services in a nursing facility when a person does not meet the criteria for rehabilitation. Most long-term care assists people with support services. (Also called custodial care.)

"Nursing facility rehabilitative services" are the planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-500-0075, filed 11/27/18, effective 1/1/19. Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-500-0075, filed 9/11/13, effective 10/12/13. WSR 11-14-075, recodified as § 182-500-0075, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0075, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0080 Medical assistance definitions—O. "Ordering and referring provider" means any physician or other health care professional who orders or refers items or services for clients eligible for Washington's health care programs administered by the agency.

"Outpatient" means a patient receiving care in a hospital outpatient setting or a hospital emergency department, or away from a hospital such as in a physician's office or clinic, the patient's own home, or a nursing facility.

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

[Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-500-0080, filed 9/11/13, effective 10/12/13. WSR 11-14-075, recodified as § 182-500-0080, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0080, filed 6/29/11, effective 7/30/11.]

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

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

"Prescribing provider" means a health care professional authorized by law or rule to prescribe drugs to Washington apple health (WAH) clients.

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

"Prosthetic device" means a preventive, replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice under state law.

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

(a) A signed core provider agreement or contract with the agency or the agency's designee, and is authorized to provide health care, goods, and services to WAH clients; or

(b) Authorization from a managed care organization (MCO) that contracts with the agency or the agency's designee to provide health care, goods, and services to eligible WAH clients enrolled in the MCO plan.

"Provider guide" means an agency publication that describes a specific benefit covered under WAH, which includes client eligibility verification instructions, provider responsibilities, authorization requirements, coverage, billing, and how to complete and submit claims.

"Public institution" see "institution" in WAC 182-500-0050.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-21-063, § 182-500-0085, filed 10/19/15, effective 11/19/15. Statutory Authority: RCW 41.05.021, 2013 2nd sp.s. c 4, and Patient Protection and Affordable Care Act (P.L. 111-148). WSR 14-06-045, § 182-500-0085, filed 2/26/14, effective 3/29/14. Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-500-0085, filed 9/11/13, effective 10/12/13. WSR 11-14-075, recodified as § 182-500-0085, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0085, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0090 Medical assistance definitions—Q. "Qualified health plan (QHP)" means a health insurance plan that has been certified by the Washington health benefit exchange to meet at minimum the standards described in 45 C.F.R. Part 156, Subpart C and RCW 43.71.065 and offered in accordance with the process described in 45 C.F.R. Part 155, Subpart K and RCW 43.71.065.

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0090, filed 12/9/13, effective 1/9/14.]

WAC 182-500-0095 Medical assistance definitions—R. "Reasonably compatible" means the amount of a person's self-attested income (as defined in WAC 182-500-0100) and the amount of a person's income verified via electronic data sources are either both above or both below the applicable income standard for Washington apple health (WAH). When self-attested income is less than the standard for WAH, but income from available data sources is more than the WAH standard, or when the self-attested income cannot be verified via electronic data sources, the self-attested income is considered not reasonably compatible.

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-500-0095, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0095, filed 12/9/13, effective 1/9/14. WSR 11-14-075, recodified as § 182-500-0095, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0095, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0100 Medical assistance definitions—S. "Self-attestation" means a person's written, verbal, or electronic declaration of his or her income and/or circumstances made under penalty of perjury, confirming a statement to be true. (See also "attested income.")

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

"Spouse" means a person who is legally married to another person. Washington state recognizes other states' determinations of legal and common-law marriages between two persons.

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

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

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

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

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

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

(5) **"Institutionalized spouse"** means a legally married person who has attained institutional status as described in chapter 182-513 WAC, and receives services in a medical institution or from a home or community-based waiver program described in chapter 182-515 WAC. A person

is considered married if not divorced, even when physically or legally separated from his or her spouse.

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

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

"State supplemental payment (SSP)" is a state-funded cash benefit for certain individuals who are either recipients of the Title XVI supplemental security income (SSI) program or who are clients of the division of developmental disabilities. The SSP allotment for Washington state is a fixed amount of twenty-eight million nine hundred thousand dollars and must be shared between all individuals who fall into one of the groups listed below. The amount of the SSP may vary each year depending on the number of individuals who qualify. The following groups are eligible for an SSP:

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0100, filed 12/9/13, effective 1/9/14. WSR 11-14-075, recodified as § 182-500-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0100, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0105 Medical assistance definitions—T. "Tax dependent" means a person for whom a tax filer claims an exemption on his or her federal income tax return. A tax dependent may be either a qualifying child or a qualifying relative under 26 U.S.C. Sec. 152 for a taxable year.

"Tax filer" means a person who expects to file a federal income tax return.

"Third party" means an entity other than the medicaid agency or the agency's designee that may be liable to pay all or part of the cost of health care for a Washington apple health (WAH) client.

"Third-party liability (TPL)" means the legal responsibility of an identified third party or parties to pay all or part of the cost of health care for a WAH client. See client obligations in establishing TPL under WAC 182-503-0540.

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

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

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

- (a) An intentional act that changes ownership or title; or
- (b) A failure to act that results in a change of ownership or title.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-21-063, § 182-500-0105, filed 10/19/15, effective 11/19/15. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-06-068, § 182-500-0105, filed 2/28/14, effective 3/31/14. WSR 11-14-075, recodified as § 182-500-0105, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0105, filed 6/29/11, effective 7/30/11.]

WAC 182-500-0110 Medical assistance definitions—U. "Urgent care" means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day or the following day.

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

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

WAC 182-500-0120 Medical assistance definitions—W. "Washington apple health" means the public health insurance programs for eligible Washington residents. Washington apple health is the name used in Washington state for medicaid, the children's health insurance program (CHIP), and state-only funded health care programs.

"Washington Healthplanfinder" is a marketplace for individuals, families, and small businesses in Washington state to compare and enroll in health insurance coverage and gain access to premium tax credits, reduced cost sharing, and public programs such as Washington apple health. Washington Healthplanfinder is administered by the Washington health benefit exchange.

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (Public Law 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 13-14-019, § 182-500-0120, filed 6/24/13, effective 7/25/13.]