WAC 182-538A-095 Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees. (1) The rules in WAC 182-538-095 apply to this chapter. If the rules are in conflict, this chapter takes precedence.

(2) An enrollee in fully integrated managed care (FIMC) or behavioral health services only (BHSO) is eligible only for the scope services identified as covered in WAC 182-501-0060 and other program rules based on the enrollee's eligibility program, including the alternative benefit plan (ABP), categorically needy (CN), or medically needy (MN) programs.

(3) The managed care organization (MCO) covers services included under the FIMC medicaid contract for an FIMC or BHSO enrollee. An MCO may, at its discretion, cover services not required under the FIMC medicaid contract.

(4) The agency covers services identified as covered for an FIMC or BHSO enrollee that are not included in the FIMC medicaid contract.

(5) The MCO is not required to pay for services covered under the FIMC medicaid contract for an FIMC or BHSO enrollee if the services are:

(a) Determined not to be medically necessary for the enrollee as defined in WAC 182-500-0070;

(b) Received by the enrollee from a participating specialist that required prior authorization but were not prior authorized by the MCO;

(c) Nonemergency services received by the enrollee from nonparticipating providers that were not prior authorized by the MCO; or

(d) Received by the enrollee in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

(6) The provider may bill the enrollee for noncovered services if the requirements of WAC 182-502-0160 are met.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-095, filed 2/11/16, effective 4/1/16.]