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

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

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

(c) Providers must code the specific brand and model of wheelchair or CRT products dispensed according to the centers for medicare and medicaid services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates, and updates the maximum allowable fees for medical equipment and related services at least once yearly, unless otherwise directed by the legislature or determined necessary by the agency.

(3) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule or Competitive Bid Area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) Medicare fee schedules;

(b) Legislative direction;

(c) Input from stakeholders or relevant sources that the agency determines to be reliable and appropriate;

(d) Pricing clusters; or

(e) A by-report (BR) basis.

(4) The medicaid agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency's reimbursement rate is a percentage of the manufacturer's list or manufacturer's suggested retail price (MSRP), or a percentage of the wholesale acquisition cost (AC). The agency uses the following percentages:

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

(b) For wheelchair parts and add-on CRT accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(c) For wheelchair seat and back cushions, CRT manual wheelchair base, and up-charge modifications and seating systems, eighty percent of MSRP or one hundred forty percent of AC;

(d) For CRT power-drive wheelchair base, eighty-five percent of MSRP or one hundred forty percent of AC;

(e) For prosthetics and orthotics and medical supplies and related services, eighty-five percent of MSRP or one hundred twenty-five percent of AC;

(f) For other medical equipment, eighty percent of MSRP or one hundred twenty-five percent of AC;

(g) For medical supplies, eighty-five percent of MSRP or one hundred twenty-five percent of AC.

(5) When establishing reimbursement rates for medical equipment based on pricing clusters for a specific HCPCS code, the maximum al-

lowable fee is the median or average amount of all items in the cluster. The pricing cluster is comprised of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster due to:

(a) A client's medical needs;

(b) Product quality;

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

(d) Cost.

(6) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at either the DMEPOS rate divided by 0.15 or multiplied by ten. The agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule;

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

(a) Assure that payments are sufficient to enlist providers and maintain access to care and services; or

(b) Comply with legislative budget directives.

(8) The agency's maximum payment for medical equipment and related services is the lesser of either the:

(a) Providers' usual and customary charges; or

(b) Established rates, except as provided in WAC 182-543-8200.

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

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

(11) The agency's reimbursement rate for purchased or rented covered medical equipment and related services includes all of the following:

(a) Any adjustments or modifications to the medical equipment required within three months of the date of delivery or covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, and/or postage;

(e) Routine maintenance that includes testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting and set-up; and

(g) Instruction to the client or client's caregiver in the appropriate use of the medical equipment.

(12) Medical equipment and related services supplied to eligible clients under the following reimbursement methodologies are included in those methodologies and are not reimbursed under fee-for-service:

(a) Hospice providers' per diem reimbursement;

(b) Hospitals' diagnosis-related group (DRG) reimbursement;

(c) Managed care plans' capitation rate;

(d) Skilled nursing facilities' per diem rate; and

(e) Professional services' resource-based relative value system reimbursement (RBRVS) rate.

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

(14) The dispensing provider who furnishes the medical equipment to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any medical equipment the agency considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The equipment continues to be medically necessary.

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

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The equipment continues to be medically necessary.

(16) The agency does not reimburse for medical equipment, related services, and related repairs and labor charges under fee-for-service when the client is:

(a) An inpatient hospital client;

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

(c) Terminally ill and receiving hospice care; or

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

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

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(18) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the agency may pay the provider an amount it considers appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

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

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Part 440.70; 42 U.S.C. section 1396 (b)(i)(27). WSR 18-24-021, § 182-543-9000, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-9000, filed 3/25/14, effective 4/25/14. WSR 11-14-075, recodified as § 182-543-9000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-9000, filed 6/29/11, effective 8/1/11.]