Chapter 182-540 WAC
KIDNEY DISEASE PROGRAM AND KIDNEY CENTER SERVICES

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WAC

KIDNEY DISEASE PROGRAM (STATE-FUNDED)

KIDNEY CENTER SERVICES

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-540-035 Kidney disease program (KDP)—Transfer of resources without adequate consideration. [WSR 11-14-075, recodified as § 182-540-035, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-035, filed 10/8/03, effective 11/8/03.] Repealed by WSR 13-23-065, filed 11/18/13, effective 1/1/14. Statutory Authority: RCW 41.05.021.

KIDNEY DISEASE PROGRAM (STATE-FUNDED)

WAC 182-540-001 Purpose. This chapter (WAC 182-540-001 through 182-540-065) contains rules for the state-funded kidney disease program (KDP) administered by the health care authority (the agency). The KDP is available for persons who have end-stage renal disease requiring dialysis or kidney transplant, or persons who have received a kidney transplant but who do not meet the eligibility standards for any other Washington apple health program including medicaid or state-only funded medical programs.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-001, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-001, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-001, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. WSR 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 182-540-005 Kidney disease program (KDP)—Definitions. The following definitions and those found in chapter 182-500 WAC, apply to this chapter for the purpose of administering the kidney disease program.

"Affiliate" - A facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

"Applicant for KDP" - A person who submits a new application for assistance under the kidney disease program (KDP), or an existing client who has had a break in eligibility of over thirty days;

"Application documentation" - A "medical eligibility determination" letter from the department of social and health services (DSHS) and/or a Washington apple health (WAH) eligibility determination letter from the health care authority (the agency) either approving or denying an application for WAH;

"Certification" - The kidney center or affiliate has determined a person eligible for the KDP for a defined period of time;

"End-stage renal disease (ESRD)" - The stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life. For purposes of the KDP, this includes persons who have received a transplant;

"KDP application" - The agency Form 13-566 which the person completes and submits to the KDP contractor to determine KDP eligibility;

"KDP client" - A person who has a diagnosis of ESRD or had a diagnosis of ESRD and has received a kidney transplant and has been determined eligible for the kidney disease program as determined by a KDP contractor;

"KDP contractor" - A kidney center or other ESRD facility that has contracted with the health care authority (the agency), kidney disease program to provide ESRD services to KDP clients;

"KDP manual" - A manual that describes the KDP contract guidelines and procedures for a KDP contractor;

"Kidney center" - A facility as defined and certified by the federal government to provide **ESRD** services.

"Kidney disease program (KDP)" - A state-funded program managed by the Washington state health care authority that provides financial assistance to eligible persons for the costs of **ESRD** medical care;

"Spenddown" - The process by which a person uses incurred medical expenses to offset income to meet the financial standards established by the agency. (See WAC 182-519-0110.)

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-005, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-005, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. WSR 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. WSR 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

WAC 182-540-015 Kidney disease program (KDP)—General eligibility criteria. (1) Persons must meet the following criteria to be eligible for the kidney disease program (KDP):

(a) Reside in the state of Washington as required under WAC 182-503-0520 or 182-503-0525;

(b) Be diagnosed with end-stage renal disease (ESRD) requiring dialysis or kidney transplant as defined in WAC 182-540-005 or have received a kidney transplant;

(c) Be determined ineligible for any other Washington apple health (WAH) program, including medicaid; the alien medical program described in WAC 182-507-0110; the medical care services (MCS) program described in WAC 182-508-0005; and another state-funded medical program with the following exceptions:

(i) Persons who are found eligible for the medically needy (MN) program but are required to meet the spenddown liability under WAC 182-519-0110 or who are found or become eligible for the alien emergency medical programs described in WAC 182-507-0110, are eligible for KDP until the spenddown liability has been met;

(ii) A KDP contractor may use KDP funding as available to pay for medical expenses on behalf of a spenddown client as expenses are incurred by the person, and those expenses will be treated as if the person incurred the financial liability for the expense;

(iii) When a KDP contractor uses KDP funding to pay for monthly health insurance premiums (including WSHIP premiums) on behalf of a spenddown client, those committed funds may continue to be paid even if the person becomes eligible for MN coverage by meeting the spenddown liability. Payment may continue until the person is no longer otherwise eligible for KDP or until the person applies to the agency and is found eligible for assistance in paying the premiums;

(iv) A KDP contractor may use KDP funding to pay for premiums under the health care for workers with disabilities program described in chapter 182-511 WAC if it is cost-effective for the kidney center and KDP funds are available.

(d) Submit an application for medicare to the Social Security Administration (SSA) within thirty calendar days of applying for KDP and provide the KDP contractor with a copy of SSA's approval or denial determination notice with the following exceptions:

(i) Clients that have any employer group health plan (EGHP) or COBRA plan; and

(ii) Clients who are still within the thirty-month EGHP period.

(e) Have countable income which is equal to or less than two hundred twenty percent of the federal poverty level (FPL);

(f) Have countable resources in an amount that is equal to or less than the resource standards under the qualified medicare beneficiary (QMB) program. Resource rules are defined in WAC 182-540-030;

(g) Report changes in circumstances as required under WAC 182-540-023.

(2) Persons are not eligible for KDP if they:

(a) Become eligible for another WAH program, including medicaid, the alien emergency medical program described in WAC 182-507-0110, medical care services and any other state-funded medical program, with the exceptions described in subsection (1)(c) of this section;

(b) Fail to apply for medicare within thirty days of being approved for KDP, or fail to follow through with the medicare application process required by the Social Security Administration;

(c) Are in custody of, or confined in, a public institution such as a state penitentiary or county jail;

(d) Reside in an institution for mental disease and are twenty-one through sixty-four years of age.

(3) Applicants for KDP do not have to meet citizenship criteria described in WAC 182-503-0535 to qualify for KDP.

(4) When a Social Security number has been issued to a person, it must be provided to the KDP contractor. Rules governing Social Security numbers are described in WAC 182-503-0515.

(5) The effective date of eligibility for KDP is the first day of the month in which the person submits the KDP application form, if eligible. A person may be eligible for retroactive coverage for expenses incurred within the three months immediately prior to the KDP application if the person:

(a) Meets the KDP financial eligibility criteria in this section;

(b) Has a diagnosis of ESRD requiring dialysis or kidney transplant as defined in WAC 182-540-005 or has received a kidney transplant; and

(c) Has incurred medical expenses potentially payable by the kidney disease program during the three-month retroactive period.

(6) A person who is subsequently found retroactively eligible for another WAH program during the three-month retroactive period is not eligible for KDP reimbursement of expenses which are billable to the other WAH program. KDP funds spent on the person's behalf must be reimbursed to the KDP with the following exceptions:

(a) Transportation expenses;

(b) Health insurance premiums;

(c) Expenses paid by the KDP which were used to meet a spenddown liability.

(7) There is no time limit on how long a person may be eligible for KDP as long as the person continues to meet ESRD criteria. The KDP contractor is responsible for certifying that the person meets the functional criteria for ESRD at the time of application and at the time of review.

(8) Persons who have received a kidney transplant are eligible for KDP until they no longer meet the requirements as described in this section.

(9) Persons who are aggrieved by a decision affecting eligibility for KDP have the right to an administrative hearing. See WAC 182-540-0060.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-015, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-015, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-015, filed 10/8/03, effective 11/8/03.]

WAC 182-540-021 Kidney disease program (KDP)—Household size. (1) Household size is used to determine the appropriate income standard for KDP eligibility and also whose income must be counted or not counted.

(2) The following members of a person's household must be included when determining the household size:

(a) The applicant's spouse if living in the same home;

(b) Dependent children eighteen years of age and younger with no income who live in the same household and for whom the person is legally responsible;

(c) Children nineteen through twenty-one years of age who are attending full-time school or college; and

(d) Any other members of a person's household that the person claimed as a dependent on their most recent federal income tax return.

(3) Children eighteen years of age and younger who have income or separate resources which may make an applicant ineligible for KDP may be included or excluded from the household size determination, depending on what is most beneficial for the KDP applicant. If a child is included in the household size, then their income and/or resources are also counted.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-021, filed 11/18/13, effective 1/1/14.]

WAC 182-540-022 Kidney disease program (KDP)—Income eligibility. (1) A household must have countable income at or below two hundred twenty percent of the federal poverty level for a person to be eligible for the kidney disease program (KDP). See WAC 182-540-021 to determine who must be included in the household and whose income counts.

(2) The KDP contractor determines the household's income based upon the information reported in the KDP application and may request additional verification if the information in the application is not clear. A KDP applicant must provide verification of all household income (and expenses, if self-employed) to the KDP contractor for a KDP eligibility determination.

(3) The agency does not count the following income:

(a) The first twenty dollars per month of unearned income for the entire household;

(b) Cost-of-living adjustments (COLAs) to Social Security disability benefits and supplemental security income (SSI) benefits that take effect in the calendar year of a KDP eligibility determination and any subsequent COLAs to these benefits received by:

(i) The applicant;

(ii) The applicant's spouse; or

(iii) Other family members included in the household size.

(c) Fifty percent of the gross earned income of any person included in the household size;

(d) Income received by a dependent child age eighteen or younger who is not included in the household size; or

(e) Any income source which is specifically excluded by federal law.

(4) The agency follows rules for SSI-related medical described in chapter 182-512 WAC to determine what income types count when determining eligibility for KDP.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-21-001, § 182-540-022, filed 10/8/15, effective 11/8/15. Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-022, filed 11/18/13, effective 1/1/14.]

WAC 182-540-023 Kidney disease program (KDP)—Change of circumstances. (1) A person who is approved for KDP is required to report changes in their circumstances to the KDP contractor within thirty days of the date of the change. The person is required to report the following changes:

(a) When total income for household members included in the KDP household size goes above two hundred twenty percent FPL and the change is expected to last for thirty calendar days or longer;

(b) When countable resources exceed the standards described in WAC 182-540-030;

(c) When there is a change in household members or household size;

(d) When the person is determined eligible for medicare; or

(e) When the person is no longer a resident in the state of Washington.

(2) If the change in circumstances reflects a change in the person's KDP eligibility, the person is required to fill out and submit a new KDP application, with a new effective date reflecting the changes made. The KDP contractor will end the person's previous application.

(3) If the person fails to report their change in circumstance which would result in the person's ineligibility for the program, the KDP contractor is not liable for paying expenses on the person's behalf. If expenses are paid on behalf of a person who is not eligible for KDP or eligible for Washington apple health, the requirements in WAC 182-502-0160 billing a client, do not apply.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-023, filed 11/18/13, effective 1/1/14.]

WAC 182-540-025 Kidney disease program (KDP)—Application and recertification requirements—KDP contractor. When a person applies for the kidney disease program (KDP), the KDP contractor must:

(1) Inform the applicant of the requirements for KDP eligibility as defined in this chapter, provide the applicant with the necessary forms and instructions to complete the KDP application, and provide the applicant with a copy of the person's rights and responsibilities.

(2) If required, help the applicant submit an application for medical benefits with the department of social and health services (DSHS) community services office or the health benefits exchange.

(a) The KDP contractor must obtain the person's application documentation from DSHS or the health benefits exchange and keep a copy in the person's record.

(b) The KDP contractor may authorize KDP payment pending the outcome of the medical application; however, if the person is subsequently approved for medical coverage for any month in which KDP funds were authorized, those expenses must not be billed to KDP. If KDP has already reimbursed those funds, the contractor must refund the KDP, subject to exceptions for transportation expenses, health insurance premiums, and expenses paid by the KDP which were used to meet a spend-down liability as described in WAC 182-540-015 (6)(a), (b), and (c).

(3) Inform the applicant of the requirement to apply for medicare and help with the application process. The KDP contractor must obtain a copy of the Social Security Administration's (SSA's) approval or denial of medicare entitlement and keep a copy in the person's record once a determination has been made by SSA.

(4) Determine eligibility using the agency's policies, rules, and instructions and provide the applicant with a timely written approval or denial notice within no more than sixty calendar days from the date of the KDP application.

(5) The KDP contractor may request an extension of the application time from the KDP program manager when extenuating circumstances prevent the person from completing the application or recertification process within the specified time limit.

(6) Forward the completed KDP application and the application documentation to the KDP program manager at the health care authority (HCA). The KDP program manager may amend or terminate a person's certification period within thirty calendar days of receipt if the application is incomplete or inaccurate.

(7) The KDP contractor certifies an eligible person for no more than one year from the first day of the month of application, unless the client:

(a) Needs medical coverage for less than one year; or

(b) Reports a change as described in WAC 182-540-0023 that makes the person ineligible for KDP.

(8) Within sixty calendar days prior to the end of a person's certification period, the KDP contractor must assist a person with completing a recertification for KDP. To be eligible for ongoing KDP funding, a person must meet the requirements described in WAC 182-540-026(2).

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-025, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-025, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-025, filed 10/8/03, effective 11/8/03.]

WAC 182-540-026 Kidney disease program (KDP)—Application and recertification requirements—Client. (1) An applicant for KDP must:

(a) Complete the KDP application form and submit any necessary documentation to the KDP contractor in order to make an eligibility determination;

(b) Do one of the following:

(i) Provide application documentation from the department of social and health services (DSHS) or the Washington Healthplanfinder verifying that the applicant applied for Washington apple health (WAH) within the six-month period prior to the month of application for KDP, and that the application for WAH was denied due to an eligibility requirement and not because the person failed to complete the application process; or

(ii) Submit an application for WAH to DSHS and/or via the Washington Healthplanfinder, as applicable, and provide the KDP contractor with a copy of the application documentation when an eligibility determination has been made; and

(c) Apply for medicare within thirty calendar days of applying for KDP and provide written proof from the Social Security Administration that the application was approved or denied. A copy of the proof must be kept in the person's record.

(2) At the end of the KDP certification period, a person may reapply for continued KDP eligibility. To complete the recertification, the client must:

(a) Complete a new KDP application no later than thirty calendar days beyond the end of the original certification period and submit any documentation necessary to determine eligibility to the KDP contractor; and

(b) Submit a new application for WAH and provide a copy to the KDP contractor.

(3) A person who fails to follow through with the required application or recertification processes or fails to provide requested verifications within the time limits requested by the KDP contractor is not eligible for KDP funding and the application will be denied.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-026, filed 11/18/13, effective 1/1/14.]

WAC 182-540-030 Kidney disease program (KDP)—Resource eligibility. (1) The person's household must have countable resources at or below the limits established for the qualified medicare beneficiary (QMB) program for the person to be eligible for the kidney disease program. QMB resource standards for an individual and a couple are listed at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

(2) See WAC 182-540-021 to determine who must be included in the household when making a determination of whose resources count.

(3) The following resources are not counted:

(a) A home, defined as real property owned by a client as their principal place of residence together with surrounding and contiguous property;

(b) Household furnishings;

(c) One burial plot per household member or irrevocable burial plans with a mortuary;

(d) Up to one thousand five hundred dollars for a person or three thousand dollars for a couple set aside in a revocable burial account;

(e) Any resource which is specifically excluded by federal law.

(4) The agency follows rules for SSI-related medicaid determinations described in WAC 182-512-0200 through 182-512-0550 when determining whether any other resources are countable with the exception of subsection (5) of this section.

(5) The agency follows rules in chapter 182-516 WAC when a person owns a trust, an annuity, or a life estate.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-01-033, § 182-540-030, filed 12/8/15, effective 1/8/16. Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-030, filed 11/18/13, effective 1/1/14.]

WAC 182-540-045 Kidney disease program (KDP) contractor requirements. (1) The kidney disease program (KDP) contractor must:

(a) Be a medicare-certified end-stage renal disease (ESRD) facility; and

(b) Have a valid KDP client services contract with the agency.

(2) The KDP contractor must provide, directly or through an affiliate:

(a) Professional consultation, personal instructions, medical treatment and care, drug products and all supplies necessary for car-

rying out a medically sound end-stage renal disease (ESRD) treatment program;

(b) Dialysis for clients with ESRD when medically indicated;

(c) Coordination of care with a kidney transplant center;

(d) Treatment for conditions directly related to ESRD such as anemia, vascular, or peritoneal access care; and

(e) Supplies and equipment for home dialysis.

(3) The provider must maintain adequate records for audit and review purposes, including:

(a) Medical charts and records that meet the requirements of WAC 182-502-0020; and

(b) Documentation of expenses and amounts paid by the KDP to assist clients in meeting a spenddown requirement as described in WAC 182-519-0100.

(4) The contractor must meet other obligations as required by its contract with the KDP program.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-045, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-045, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-045, filed 10/8/03, effective 11/8/03.]

WAC 182-540-055 Kidney disease program (KDP) covered services. (1) The kidney disease program (KDP) covers the cost of health care services essential to the treatment of end-stage renal disease (ESRD) and its complications. Within available funding and at the discretion of the KDP contractor covered services include:

(a) Dialysis:

(i) Center dialysis - Covers the cost of dialysis, necessary supplies, and related services provided in a kidney center;

(ii) Home dialysis - Covers the cost of providing dialysis and related services in the home; and

(iii) Dialysis while hospitalized - Covers the cost of dialysis and related services while the KDP client is confined to an acute care facility and is unable to dialyze at his/her regular site.

(b) Medication - As defined in the approved drug list in the KDP manual;

(c) Access surgery (venous and peritoneal) - Covers costs associated with surgically preparing the client for dialysis and medical complications related to the access site;

(d) Laboratory tests and X-rays considered to be part of the overall treatment plan for ESRD;

(e) Pretransplant work-up including, but not limited to, transportation, lodging, and physician visits;

(f) Post-transplant visit to assess client's ESRD status to include, but is not limited to, transportation, lodging, and physician visits;

(g) Health insurance premium including copays and deductibles when found to be cost-effective;

(h) Spenddown expenses when found to be cost-effective; and

(i) Other services as approved by the agency's KDP program manager.

(2) If the KDP pays for medical and dental services required to receive a transplant, and the KDP client does not follow through with their recommended treatment plan in order to receive or make progress

towards receiving a transplant, the KDP contractor must submit a request for a determination of noncompliance to the agency's KDP manager. If the request is approved, KDP funds must not be used for any follow-up or additional services. Once the KDP client makes progress with their treatment plan, the agency may rereview the request.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-055, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-055, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-055, filed 10/8/03, effective 11/8/03.]

WAC 182-540-060 Kidney disease program (KDP) client appeal rights. (1) Clients have the right to appeal:

(a) KDP eligibility decisions made by the person's KDP contractor;

(b) Coverage decisions made by the contractor or the first decision submitted by the agency for medical services or devices that are not considered to be for the treatment of the person's ESRD diagnosis; or

(c) The denial, made by the KDP contractor, of services found in WAC 182-540-055(1) which have been denied by a KDP contractor.

(2) Clients do not have the right to appeal:

(a) Reimbursement based on covered or noncovered procedure codes or rates; or

(b) The KDP contractor's decision to not cover services found in WAC 182-540-055(1) when the KDP contractor has gone over its KDP allotted funding.

(3) A client who is aggrieved by a decision made by the KDP contractor may request review of the decision to the agency within thirty days of receiving the notice of the decision by sending a written request for review to the agency's KDP Program Manager, Health Care Authority, P.O. Box 45510, Olympia, WA 98504-5510.

(4) The request for review must clearly identify the name and address of the client requesting the review.

(5) Within thirty days of receiving the request for review, the KDP program manager will send the client a written decision. Failure to request review does not prevent the client from appealing the decision under subsection (6) of this section.

(6) Within ninety days of receiving the KDP contractor's or the KDP program manager's written decision, the client can appeal the decision by sending a written request for hearing to the Health Care Authority, P.O. Box 45504, Olympia, WA 98504-5540.

(7) The request for hearing:

(a) Must clearly identify the name, address, and telephone number of the client requesting the hearing;

(b) Should include a copy of the KDP program manager's written decision which the client is appealing.

(8) The hearing is usually conducted by telephone by an agency presiding officer in accordance with WAC 182-526-0025(1). The client requesting the hearing is responsible for making sure that the agency's presiding officer has the correct telephone number to contact the party for the hearing.

(9) The agency's presiding officer may refer the case in writing to the office of administrative hearings when the:

(a) Client requests an in-person hearing to accommodate a disability; and

(b) The presiding officer determines that the agency does not have the resources needed to conduct the in-person hearing.

(10) When an administrative law judge (ALJ) employed by the office of administrative hearings conducts the hearing on behalf of the agency, the ALJ issues an initial order in accordance with WAC 182-526-0025(1) and 182-526-0215(4). Any party may appeal the initial order to an agency review judge in accordance with WAC 182-526-0575.

(11) When a presiding officer employed by the agency conducts the hearing, the agency's presiding officer issues a final order. Any party may request reconsideration of the final order in accordance with chapter 182-526 WAC. The party who requested the hearing, but not the agency, may file a petition for judicial review as provided in WAC 182-526-0605 and 182-526-0620.

(12) The hearing rules found in chapter 182-526 WAC apply to any administrative hearing requested in accordance with subsection (6) of this section. Where the program rules in this chapter conflict with the hearing rules contained in chapter 182-526 WAC, the program rules in this chapter prevail.

(13) Failure to timely request a hearing will result in the loss of right to appeal.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-060, filed 11/18/13, effective 1/1/14.]

WAC 182-540-065 Kidney disease program (KDP)—Reimbursement. (1) The agency reimburses KDP contractors:

(a) Within the limits of legislative funding for the program;

(b) According to the terms of each kidney center's contract with the agency; and

(c) According to the provisions of the KDP manual.

(2) The KDP contractor must submit the following documentation to the agency's KDP program manager within the time limits specified within the KDP contract:

(a) A description of the services for which reimbursement is requested; and

(b) The person's approved KDP application if the application had not previously been provided to the KDP program manager.

(3) A KDP client is not liable and must not be billed for charges incurred under KDP due to the failure of the KDP contractor to bill the agency within the time limits specified in the contract.

(4) The agency limits KDP reimbursement for out-of-state services to fourteen days per calendar year. Reimbursement is paid only to KDP contractors. Out-of-state dialysis providers must operate under subcontract or agreement with an in-state KDP contractor in order to receive reimbursement under this program.

[Statutory Authority: RCW 41.05.021. WSR 13-23-065, § 182-540-065, filed 11/18/13, effective 1/1/14. WSR 11-14-075, recodified as § 182-540-065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-065, filed 10/8/03, effective 11/8/03.]

KIDNEY CENTER SERVICES

WAC 182-540-101 Purpose and scope. This section describes the medicaid agency reimbursement rules for free-standing kidney centers providing dialysis and end-stage renal disease services to agency clients.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-101, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-101, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-101, filed 10/8/03, effective 11/8/03.]

WAC 182-540-105 Definitions. The following definitions and those found in chapter 182-500 WAC, apply to this chapter.

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to end stage renal disease (ESRD) patients.

"Agreement" means a written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining reimbursement for those services.

"Composite rate" means a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

"Continuous ambulatory peritoneal dialysis (CAPD)" means a type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine. (See "Peritoneal dialysis.")

"Continuous cycling peritoneal dialysis (CCPD)" means a type of peritoneal dialysis where the patient dialyzes at home and uses an automated peritoneal cycler for delivering dialysis.

"Dialysate" means an electrolyte solution used in dialysis containing elements such as potassium and sodium chloride. It surrounds the membrane or fibers and allows the exchange of substances with the patient's blood in the dialyzer.

"Dialysis" means a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

"Dialysis session" means the period beginning when the patient arrives at the facility and ending when the patient departs from the facility. For home dialysis, it means the period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine.

"Dialyzer" means the synthetic porous membrane or fibers contained in a supporting structure, through which blood flows to eliminate harmful substances and replace them with useful ones.

"Durable medical equipment (DME)" means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"End-stage renal disease (ESRD)" means the stage of renal impairment that is irreversible and permanent and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life.

"Epoetin alpha (EPO)" means the biologically engineered protein that stimulates the bone marrow to make new red blood cells. It is used in the treatment of anemia.

"Free-standing kidney center" means a limited care facility not operated by a hospital that is certified by the federal government to provide ESRD services.

"Home dialysis" means any dialysis performed at home.

"Home dialysis helper" means a person trained to assist the client in home dialysis.

"In-facility dialysis" - For the purpose of this chapter only, "in-facility dialysis" means dialysis of any type performed on the premises of a kidney center or other free-standing ESRD facility.

"Intermittent peritoneal dialysis (IPD)" means a type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper.

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide ESRD services;

(2) Provide the services specified in this chapter; and

(3) Promote and encourage home dialysis for a client when medically indicated.

"Peritoneal dialysis" means a procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis, and intermittent peritoneal dialysis.

"Standard ESRD lab tests" means certain laboratory tests that the Centers for medicare and medicaid include in their composite rate calculations. These tests are identified in the agency kidney center services billing instructions.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-105, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-105, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-105, filed 10/8/03, effective 11/8/03.]

WAC 182-540-110 Eligibility. (1) To be eligible for the kidney center services described in this section, a person must be diagnosed with end-stage renal disease (ESRD) or acute renal failure and be covered under:

(a) One of the Washington apple health programs listed in the table in WAC 182-501-0060;

(b) Alien emergency medical; or

(c) Qualified medicare beneficiary (QMB) - (The agency pays only for medicare premium, coinsurance and deductible).

(2) Managed care enrollees must have dialysis services arranged directly through their designated plan.

[Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-540-110, filed 3/12/14, effective 4/12/14. WSR 11-14-075, recodified as § 182-540-110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-110, filed 10/8/03, effective 11/8/03.]

WAC 182-540-120 Provider requirements. To receive reimbursement from the medicaid agency for providing care to agency clients, a kidney center must:

(1) Be a medicare-certified end-stage renal disease (ESRD) facility and have a signed core provider agreement with the agency (see chapter 182-502 WAC);

(2) Meet requirements found in chapter 182-502 WAC;

(3) Provide only those services within the scope of their provider's license; and

(4) Provide, either directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment, care, and all supplies necessary for carrying out an medically sound ESRD treatment program, including:

(a) Dialysis for ESRD clients;

(b) Kidney transplant treatment, either directly or by referral, for ESRD clients when medically indicated;

(c) Treatment for conditions directly related to ESRD;

(d) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and

(e) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-120, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-120, filed 10/8/03, effective 11/8/03.]

WAC 182-540-130 Covered services. (1) The medicaid agency covers the following services and supplies subject to the restrictions and limitations in this section and other applicable published WAC:

(a) In-facility dialysis;

(b) Home dialysis;

(c) Training for self-dialysis;

(d) Home dialysis helpers;

(e) Dialysis supplies;

(f) Diagnostic lab work;

(g) Treatment for anemia; and

(h) Intravenous drugs.

(2) Covered services are subject to the limitations specified by the agency. Providers must obtain prior authorization (PA) or expedited prior authorization (EPA) before providing services that exceed specified limits in quantity, frequency, or duration (refer to WAC 182-501-0165 and 182-501-0169).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-130, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-130, 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, § 388-540-130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-130, filed 10/8/03, effective 11/8/03.]

WAC 182-540-140 Noncovered services. (1) The medicaid agency does not reimburse kidney centers for the following:

(a) Blood and blood products (refer to WAC 182-540-190);

(b) Personal care items such as slippers and toothbrushes; or

(c) Additional staff time or personnel costs. Staff time is paid through the composite rate. Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 182-540-160).

(2) The agency evaluates a request for any service listed as noncovered in this chapter under WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-140, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-140, 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, § 388-540-140, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-140, filed 10/8/03, effective 11/8/03.]

WAC 182-540-150 Reimbursement—General. (1) Kidney center services described in this section are paid by one of two methods:

(a) **Composite rate payments** - This is a payment method in which all standard equipment, supplies, and services are calculated into a blended rate.

(i) A single dialysis session and related services are reimbursed through a single composite rate payment (refer to WAC 182-540-160).

(ii) Composite rate payments for continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) are limited to thirty-one per month for an individual client.

(iii) Composite rate payments for all other types of dialysis sessions are limited to fourteen per month for an individual client.

(b) **Noncomposite rate payments** - End-stage renal disease (ESRD) services and items covered by the medicaid agency but not included in the composite rate are billed and paid separately (refer to WAC 182-540-170).

(2) **Limitation extension request** - The agency evaluates billings for covered services that are subject to limitations or other restrictions, and approves the services beyond those limitations or restrictions when medically necessary under WAC 182-501-0165 and 182-501-0169.

(3) **Take-home drugs** - The agency reimburses kidney centers for take-home drugs only when they meet the conditions described in WAC 182-540-170(1). Other drugs for at-home use must be billed by a pharmacy and be subject to the agency's pharmacy rules.

(4) **Medical nutrition** - Medical nutrition products must be billed by a pharmacy or a durable medical equipment (DME) provider.

(5) **Medicare eligible clients** - The agency does not reimburse kidney centers as a primary payer for medicare eligible clients.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-150, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-150, 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, § 388-540-150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-150, filed 10/8/03, effective 11/8/03.]

WAC 182-540-160 Items and services included in the composite rate. (1) The following equipment, supplies, and services for in-facility and home dialysis are included in the composite rate:

(a) Medically necessary dialysis equipment;

(b) All dialysis services furnished by the facility's staff;

(c) Standard end-stage renal disease laboratory tests (refer to WAC 182-540-180);

(d) Home dialysis support services including delivery, installation, and maintenance of equipment;

(e) Purchase and delivery of all necessary dialysis supplies;

(f) Declotting of shunts and any supplies used to declot shunts;

(g) Oxygen and the administration of oxygen;

(h) Staff time used to administer blood and nonroutine parenteral items;

(i) Noninvasive vascular studies; and

(j) Training for self-dialysis and home dialysis helpers.

(2) The medicaid agency issues a composite rate payment only when all the items and services in subsection (1) of this section are furnished or available at each dialysis session.

(3) If the facility fails to furnish or have available any of the items in subsection (1) of this section, the agency does not pay for any part of the items and services that were furnished.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-160, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-160, filed 10/8/03, effective 11/8/03.]

WAC 182-540-170 Items and services not included in the composite rate. The following items and services are not included in the composite rate and must be billed separately, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) Drugs related to treatment, including but not limited to epoetin alpha (EPO) and diazepam. The drug must:

(a) Be prescribed by a physician;

(b) Meet the rebate requirements described in WAC 182-530-7500; and

(c) Meet the requirements of WAC 246-905-020 when provided for home use.

(2) Supplies used to administer drugs and blood;

(3) Blood processing fees charged by the blood bank (refer to WAC 182-540-190); and

(4) Home dialysis helpers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-170, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-170, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-170, filed 10/8/03, effective 11/8/03.]

WAC 182-540-180 Laboratory services. (1) Laboratory services included in the composite rate, performed by either the facility or an independent laboratory, must not be billed separately except as provided for in (b) of this subsection:

(a) Standard end-stage renal disease (ESRD) lab tests are included in the composite rate when performed at recommended intervals (see billing instructions for current list).

(b) The standard ESRD lab tests referred to in (a) of this subsection can be reimbursed separately from the composite rate only when it is medically necessary to test more frequently:

(i) Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of end-stage renal disease is not sufficient;

(ii) The claim must include information on the nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of the test(s); or

(iii) An ICD-9CM diagnosis code may be shown in lieu of a narrative description.

(2) All separately billable, ESRD laboratory services must be billed by and reimbursed to the lab that performs the test.

[WSR 11-14-075, recodified as § 182-540-180, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-180, filed 10/8/03, effective 11/8/03.]

WAC 182-540-190 Blood products and services. (1) The medicaid agency reimburses free-standing kidney centers for:

(a) Blood processing and other fees assessed by nonprofit blood centers that do not charge for the blood or blood products themselves; and

(b) Costs incurred by the center to administer its in-house blood procurement program.

(2) The agency does not reimburse centers for blood or blood products (refer to WAC 182-550-6500).

(3) Staff time used to administer blood or blood products is reimbursed only through the composite rate (refer to WAC 182-540-150 and 182-540-160).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-190, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-190, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R.

405.2101. WSR 03-21-039, § 388-540-190, filed 10/8/03, effective 11/8/03.]

WAC 182-540-200 Epoetin alpha (EPO) therapy. The medicaid agency reimburses the kidney center for EPO therapy when:

(1) Administered in the kidney center to a client:

(a) With a hematocrit less than thirty-three percent or a hemoglobin less than eleven when therapy is initiated;

(b) Continuing EPO therapy with a hematocrit between thirty and thirty-six percent; or

(c) Medical justification documented in the client's record is required for hematocrits more than thirty-six or hemoglobins more than twelve. Medical justification includes:

(i) Documentation that the dose is being titrated downward to bring a patient's hematocrit back within target range; or

(ii) Documentation that it is medically necessary for the client to have a target hematocrit more than thirty-six percent.

(2) Provided to a home dialysis client:

(a) Under the same hematocrit and hemoglobin guidelines as stated in (1)(a) and (b) of this section; and

(b) When permitted by Washington board of pharmacy rules. (Refer to WAC 246-905-020 Home dialysis program—Legend drugs.)

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-200, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-200, filed 10/8/03, effective 11/8/03.]

WAC 182-540-210 Injectable drugs given in the kidney center. Injectable drugs administered in the kidney center are reimbursed up to the medicaid agency published maximum fees.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-14-040, § 182-540-210, filed 6/24/15, effective 7/25/15. WSR 11-14-075, recodified as § 182-540-210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. WSR 03-21-039, § 388-540-210, filed 10/8/03, effective 11/8/03.]