Chapter 182-546 WAC
TRANSPORTATION SERVICES

Last Update: 4/7/26

WAC

182-546-0050 Ambulance transportation—General.
182-546-0100 Ambulance transportation—Program.
182-546-0125 Ambulance transportation—Definitions.
182-546-0150 Ambulance transportation—Client eligibility.
182-546-0200 Ambulance transportation—Scope of coverage.
182-546-0250 Ambulance transportation—Noncovered services.
182-546-0300 Ambulance transportation—General requirements for ambulance providers.
182-546-0400 Ambulance transportation—General limitations on payment for ambulance services.
182-546-0425 Ambulance transportation—During inpatient hospital stays.
182-546-0450 Ambulance transportation—Ground ambulance—Payment.
182-546-0500 Ambulance transportation—Ground ambulance—Payment in special circumstances.

GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT)

182-546-0510 GEMT program overview.
182-546-0515 GEMT provider participation and qualifications.
182-546-0520 GEMT supplemental payments.
182-546-0525 GEMT claim submission and cost reporting.
182-546-0530 GEMT interim supplemental payment.
182-546-0535 GEMT cost reconciliation and settlement process.
182-546-0540 GEMT records maintenance.
182-546-0545 GEMT auditing.
182-546-0600 Ambulance transportation—Procedure code modifiers.
182-546-0700 Ambulance transportation—Air ambulance—Payment.
182-546-0800 Ambulance transportation—Provided in another state or U.S. territory—Payment.
182-546-0900 Ambulance transportation—Provided outside the United States and U.S. territories—Payment.
182-546-1000 Ambulance transportation—Nonemergency ground—Payment.
182-546-1500 Ambulance transportation—Nonemergency air—Payment.
182-546-2500 Ambulance transportation to out-of-state treatment facilities—Coordination of benefits.
182-546-3000 Ambulance transportation—Transporting qualified trauma cases.
182-546-4100 Ambulance transportation—Behavioral health treatment—General.
182-546-4200 Ambulance transportation—Behavioral health treatment—Coverage.
182-546-4300 Ambulance transportation—Behavioral health treatment—Reimbursement.
182-546-4700 Ambulance transportation—Ambulance transport fund—Purpose.
182-546-4725 Ambulance transportation—Ambulance transport fund—Notices, payment, and interest.
182-546-5000 Nonemergency transportation—General.
182-546-5100 Nonemergency transportation—Definitions.
182-546-5200 Nonemergency transportation broker and provider requirements.
182-546-5300 Nonemergency transportation—Client eligibility.
182-546-5400 Nonemergency transportation—Client responsibility.
182-546-5500 Nonemergency transportation—Covered trips.
182-546-5550 Nonemergency transportation—Exclusions and limitations.
182-546-5600 Nonemergency transportation—Intermediate stops or delays.
182-546-5700 Nonemergency transportation—Local provider and trips outside client's local community.
182-546-5800 Nonemergency transportation—Trips out-of-state/out-of-country.
182-546-5900 Nonemergency transportation—Meals, lodging, escort/guardian.
182-546-6000 Nonemergency transportation—Authorization.
182-546-6100 Nonemergency transportation—Noncovered.
182-546-6200 Nonemergency transportation—Reimbursement.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-546-0001 Definitions. [WSR 11-14-075, recodified as § 182-546-0001, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0001, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0001, filed 1/16/01, effective 2/16/01.] Repealed by WSR 20-17-010, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29.

182-546-0505 GEMT definitions. [Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0505, filed 3/29/19, effective 5/1/19.] Repealed by WSR 20-17-010, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29.

182-546-4000 Transportation coverage under the Involuntary Treatment Act (ITA). [WSR 11-14-075, recodified as § 182-546-4000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-4000, filed 8/17/04, effective 9/17/04.] Repealed by WSR 20-17-010, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29.

182-546-4600 Ambulance transportation—Involuntary substance use disorder treatment—Ricky Garcia Act. [Statutory Authority: 2016 c 29 1st sp.s., RCW 41.05.021, and 41.05.160. WSR 18-21-042, § 182-546-4600, filed 10/8/18, effective 11/8/18.] Repealed by WSR 20-17-010, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29.

WAC 182-546-0050 Ambulance transportation—General. See WAC 182-546-0100 through 182-546-4300 for ambulance transportation and WAC 182-546-5000 through 182-546-6200 for brokered/nonemergency transportation.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0050, filed 8/6/20, effective 9/6/20.]

WAC 182-546-0100 Ambulance transportation—Program. (1) The provisions of this chapter take precedence with respect to ambulance services in cases of ambiguity in, or conflict with, other agency rules governing eligibility for health care services.

(2) The medicaid agency covers emergency and nonemergency ambulance transportation to and from a covered health care service, subject to the limitations and requirements in this chapter.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0100, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0100, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0100, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0125 Ambulance transportation—Definitions. The following definitions and those found in chapter 182-500 WAC apply to ambulance transportation services.

"Advanced life support (ALS)" - See RCW 18.73.030.

"Advanced life support (ALS) assessment" - Means an assessment performed by ALS trained personnel as part of an emergency response that was necessary because the client's reported conditions at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in an ambulance transport or determination that the client requires an ALS level of service or that the transport will be reimbursed at the ALS rate.

"Advanced life support, Level 1 (ALS1)" - Means the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.

"Advanced life support, Level 1 (ALS1) emergency" - Means medically necessary ALS1 services, as previously specified, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider is called, it responds immediately.

"Advanced life support, Level 2 (ALS2)" - Means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

(a) Endotracheal intubation;

(b) Cardiac pacing;
(c) Chest decompression;
(d) Creation of a surgical airway;
(e) Manual defibrillation/cardioversion;
(f) Placement of central venous line; or
(g) Placement of intraosseous line.

"Advanced life support (ALS) intervention" - Means a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician intermediate, emergency medical technician advanced, or paramedic.

"Aggregate fee schedule amount" - See RCW 74.70.020.

"Aid vehicle" - See RCW 18.73.030.

"Air ambulance" - Means a helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service.

"Allowable costs" - For the ground emergency medical transportation (GEMT) program only, allowable costs means an expenditure that meets the test of the appropriate Executive Office of the President of the United States, Office of Management and Budget (OMB) Circular.

"Ambulance" - Means a ground vehicle or aircraft designed and used to transport the ill and injured, provide personnel, facilities, and equipment to treat clients before and during transportation, and licensed in accordance with RCW 18.73.140.

"Ambulance transport provider" - See RCW 74.70.020.

"Bariatric patient" - Means a patient whose weight, height, or width exceeds the capacity standards of a normal ambulance gurney.

"Bariatric transport unit" - Means a specially equipped ambulance designed for the transportation of bariatric patients.

"Base rate" - Means the agency's minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, waiting time, and the normal overhead costs of doing business. The base rate excludes mileage.

"Basic life support (BLS)" - Means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined in chapter 18.73 RCW. The ambulance must be staffed by a person qualified as an emergency medical technician-basic (EMT basic) according to department of health (DOH) regulations. BLS does not require the ability to provide or deliver invasive medical procedures and services.

"Basic life support (BLS) emergency" - BLS services provided in an emergency response.

"Bed-confined" - Means the client is unable to perform all of the following actions:
(a) Get up from bed without assistance;
(b) Unable to bear weight or ambulate;
(c) Sit in a chair or wheelchair.

"Behavioral health disorder" - Means mental disorders and substance use disorders.

"Bordering city hospital" - Means a licensed hospital in a designated bordering city (see WAC 182-501-0175).

"Brokered transportation" - Means nonemergency transportation arranged by a broker under contract with the agency, to or from covered

health care services for an eligible client (also, see "Transportation provider" in WAC 182-546-5100).

"By report" - See WAC 182-500-0015.

"Children's long-term inpatient program (CLIP)" - Means psychiatric residential treatment provided as a result of judicial commitment or review of the CLIP committee for children five through 17 years of age.

"Closest and most appropriate" - The agency-contracted facility or level of care in which the expected clinical benefits (e.g., improved symptoms) outweigh the expected negative effect (e.g., adverse reactions) to such an extent that the treatment or transportation is justified. This facility may not necessarily be the closest provider based solely on driving distance.

"Conditional release" - Means a period of time the client is released from inpatient care to outpatient care, provided that the client continues to meet certain conditions according to RCW 71.05.340.

"Cost allocation plan (CAP)" - Means a document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The document also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received.

"Designated crisis responder (DCR)" - Means a behavioral health professional appointed by the county or other authority authorized in rule to perform duties specified in chapter 71.05 RCW and who has received substance use disorder training as determined by the division of behavioral health and recovery.

"Detention" or **"detain"** - Means the lawful confinement of a person, under chapter 71.05 RCW.

"Direct costs" - Means all costs identified specifically with a particular final cost objective in order to meet emergency medical transportation requirements. This includes unallocated payroll costs for personnel work shifts, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to delivering covered medical transportation services.

"Emergency medical service" - Means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting a client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

"Emergency medical transportation" - Means ambulance transportation during which a client receives necessary emergency medical services immediately prior to, or in transit to, an appropriate medical facility.

"Emergency response" - Means a BLS or ALS level of service that has been provided in immediate response to a 911 call or the equivalent.

"Evaluation and treatment facility" - See RCW 71.05.020.

"Federal financial participation (FFP)" - Means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) according to the state plan for medical assistance. Clients under Title 19, U.S. Health Resources and Services Administration (HRSA) are eligible for FFP.

"Gravely disabled" - Means a condition in which a person, as a result of a mental disorder, or as the result of the use of alcohol or other psychoactive chemicals:

(a) Is in danger of serious physical harm as a result of being unable to provide for personal health or safety; or

(b) Shows repeated and escalating loss of cognitive control over personal actions and is not receiving care essential for personal health or safety.

"Ground ambulance" - Means a ground vehicle designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation.

"Indirect costs" - Means the costs for a common or joint purpose benefiting more than one cost objective and allocated to each objective using an agency-approved indirect rate or an allocation methodology.

"Initial detention" - Means the period, up to 72 hours, in which a person is involuntarily placed in an evaluation and treatment facility under RCW 71.05.150 or 71.05.153 (see RCW 71.05.160). This period begins on the date and time the evaluation and treatment facility provisionally accepts the client for admission. See definition for "petition for initial detention."

"Interfacility" - Means transportation services between hospitals.

"Invasive procedure" - Means a medically necessary operative procedure in which skin or mucous membranes and connective tissues are cut or an instrument is introduced through a natural body orifice, e.g., an intubation tube. Invasive procedures include a range of procedures from minimally invasive (biopsy, excision) to extensive (organ transplantation). This does not include use of instruments for examinations or very minor procedures such as drawing blood.

"Involuntary Treatment Act (ITA)" - See chapters 71.05 and 71.34 RCW.

"Less restrictive alternative treatment" - Means a program of individualized treatment in a less restrictive setting than inpatient treatment and that includes the services described in RCW 71.05.585.

"Lift-off fee" - Means either of the two base rates the agency pays to air ambulance providers for transporting a client. The agency establishes separate lift-off fees for helicopters and airplanes.

"Loaded mileage" - Means the distance the client is transported in the ambulance.

"Medical attestation" - Means the medical professional is attesting to the fact that the client has a condition that justifies medical transportation and the level of care that is specified by BLS or ALS services and supplies. The condition must also be such that other means of transportation (such as taxi, bus, car, or other means) would be harmful to the client. (See WAC 182-500-0070 for additional information - Medically necessary definition.)

"Medical control" - Means the medical authority upon which an ambulance provider relies to coordinate prehospital emergency services, triage, and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan, by the department of health's (DOH) contracted medical program director, of the region in which the ambulance service is provided.

"Nonemergency ambulance transportation" - Means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services in transit, or the use of an air ambulance to or from an out-of-state health care service when the out-of-state health care service and air ambulance transportation are prior authorized by the agency. Nonemergency ambulance transportation is usually scheduled or prearranged. See definitions for "prone or supine transportation."

"Parent" - For the purpose of family initiated treatment under RCW 71.34.600 through 71.34.670, means a legal guardian, a person that has been given authorization to make health care decisions for the adolescent, a kinship caregiver who is involved in caring for the adolescent, or another relative who is responsible for the health care of the adolescent who may be required to provide a declaration under penalty of perjury stating that they are a relative responsible for the health care of the adolescent under RCW 9A.72.085.

"Petition for initial detention" - A document required by the superior court of Washington for admission of the client by the evaluation and treatment facility. This form is available on the Washington state superior court mental proceedings rules web page.

"Petition for revocation of a conditional release or less restrictive treatment" - Means a document completed by a designated crisis responder (DCR).

"Point of destination" - Means a health care facility generally equipped to provide the necessary medical, nursing, or behavioral health care necessary to treat the client's injury, illness, symptoms, or complaint.

"Point of pickup" - Means the location of the client at the time the client is placed on board the ambulance or transport vehicle.

"Prehospital care" - Means an assessment, stabilization, and emergency medical care of an ill or injured client by an emergency medical technician, paramedic, or other person before the client reaches the hospital.

"Prone or supine transportation" - Means transporting a client confined to a stretcher or gurney, with or without emergency medical services being provided in transit.

"Public institution" - Means a facility that is either an organizational part of a government entity or over which a governmental unit exercises final administrative control, (e.g., city/county jails and state correctional facilities).

"Publicly owned or operated" - Means an entity that is owned or operated by a unit of government. The unit of government is a state, city, county, special purpose district, or other governmental unit in the state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in the Indian Self-Determination and Education Assistance Act, Section 4.

"Qualifying expenditure" - Means an expenditure for covered services provided to an eligible beneficiary.

"Secure withdrawal management and stabilization facility" - Means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder.

"Service period" - Means July 1st through June 30th of each Washington state fiscal year.

"Shift" - Means a standard period of time assigned for a complete cycle of work as set by each participating provider.

"Specialty care transport (SCT)" - Means interfacility (hospital-to-hospital or hospital-to-skilled nursing facility) transportation of a critically injured or ill client by a ground ambulance vehicle under the command of ALS-trained personnel with additional training above the level of a paramedic.

"Standing order" - Means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or attending physician.

"Substance use disorder professional (SUDP)" - See WAC 182-500-0100.

"Transfer-down" - Means a transfer from a higher level facility to a facility of lower or equivalent level of care, or back to the original point of pickup (e.g., referring hospital or skilled nursing facility).

"Transfer-up" - Means a transfer from one hospital to a hospital of higher level care when the transfer and discharging hospital has inadequate facilities or care, or appropriate personnel to provide the necessary medical services required by the client.

"Trip" - Means a transportation one-way from the point of pickup to the point of destination by an authorized transportation provider.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 26-09-029, s 182-546-0125, filed 4/7/26, effective 5/8/26. Statutory Authority: Chapter 74.70 RCW, 41.05.021, 41.05.160 and 2020 c 354. WSR 21-15-010, § 182-546-0125, filed 7/8/21, effective 8/8/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0125, filed 8/6/20, effective 9/6/20.]

WAC 182-546-0150 Ambulance transportation—Client eligibility. (1) Clients are eligible for ambulance transportation to covered services subject to the requirements and limitations in this chapter.

(a) Clients in the following programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 182-501-0175:

(i) Medical care services (MCS) as described in WAC 182-508-0005;

(ii) Alien emergency medical (AEM) services as described in WAC 182-507-0115.

(b) Clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 182-546-0400(4).

(2) Clients enrolled in the agency's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with the agency's requirements. The agency pays for covered services for these clients according to the agency's published billing guides including, but not limited to, the *Tribal Health Billing Guide*.

(3) People under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to people who are being detained involuntarily for behavioral health treatment and being transported to or from bordering cities. See WAC 182-546-4100 through 182-546-4300.

(4) See WAC 182-546-0800 and 182-546-2500 for additional limitations on out-of-state coverage and coverage for clients with other insurance.

(5) The agency does not pay for ambulance services for persons living in public institutions, correctional facilities, and local jails, including people in work-release status with the following exceptions:

(a) If an incarcerated person is put on a legal ITA hold, the ITA eligibility supersedes the incarcerated status;

(b) If an incarcerated person is admitted to an inpatient care facility (not the emergency department), and must be transported to a second inpatient care facility to obtain the services needed. See WAC 182-503-0505(5).

(6) Clients in family planning only programs are not eligible for ambulance transportation services.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0150, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-091, § 182-546-0150, filed 6/5/18, effective 7/6/18. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-546-0150, filed 3/12/14, effective 4/12/14. Statutory Authority: RCW 41.05.021. WSR 13-16-006, § 182-546-0150, filed 7/25/13, effective 8/25/13. WSR 11-14-075, recodified as § 182-546-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0150, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0150, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0200 Ambulance transportation—Scope of coverage. (1) The ambulance program is a medical transportation service. The medicaid agency pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see WAC 182-501-0060);

(b) Medically necessary as defined in WAC 182-500-0070 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The closest and most appropriate agency-contracted medical provider of agency-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) The agency limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the agency does not cover the ambulance service. See WAC 182-546-0250 (1) and (2) for noncovered ambulance services.

(3) If medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, the agency requires the provider when billing the agency for that trip to:

(a) Attach the third-party determination to the claim; and

(b) Submit documentation showing that the trip meets the agency's medical necessity criteria. See WAC 182-546-1000 and 182-546-1500 for requirements for nonemergency ambulance coverage.

(4) The agency covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when the agency determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the agency must prior authorize the air ambulance transportation. See WAC 182-546-1500 for nonemergency air ambulance coverage.

(5) See also WAC 182-531-1740 Treat and refer services.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0200, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2017 c 273. WSR 19-19-090, § 182-546-0200, filed 9/18/19, effective 10/19/19. WSR 11-14-075, recodified as § 182-546-0200, 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, § 388-546-0200, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0200, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0200, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0250 Ambulance transportation—Noncovered services. (1) The medicaid agency does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 182-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC 182-546-4100 through 182-546-4300);

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC 182-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the agency does not cover the ambulance service, except as provided in WAC 182-546-0500(2) and 182-531-1740 Treat and refer services.

(3) The agency evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restric-

tions, the agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The agency approves such requests when medically necessary, according to the provisions of WAC 182-501-0165 and 182-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 182-502-0160 are met.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0250, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2017 c 273. WSR 19-19-090, § 182-546-0250, filed 9/18/19, effective 10/19/19. WSR 11-14-075, recodified as § 182-546-0250, 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, § 388-546-0250, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0250, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0250, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0300 Ambulance transportation—General requirements for ambulance providers. (1) Ambulances must be licensed, operated, and equipped according to applicable federal, state, and local statutes, ordinances and regulations. An air ambulance provider must have a current Federal Aviation Administration (FAA) air carrier operating certificate, or have a contractual relationship with an operator with a valid medical certificate.

(2) Ambulances must be staffed and operated by appropriately trained and certified personnel in accordance with chapter 18.73 RCW.

(3) Providers of ambulance services must:

(a) Meet the requirements of chapter 182-502 WAC and this chapter; and

(b) Document the medical necessity for transportation and related services billed to the medicaid agency. This documentation must be kept in the provider's file and include adequate descriptions of the severity and complexity of the client's condition at the time of the transportation and services, interventions, and supplies provided to the client prior to loading and in transit. The documentation must be made available for the agency to review upon request to ensure the agency's medical necessity criteria are met.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0300, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0300, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0300, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0400 Ambulance transportation—General limitations on payment for ambulance services. (1) In accordance with WAC 182-502-0100(8), the agency pays providers the lesser of the provid-

er's usual and customary charges or the maximum allowable rate established by the agency. The agency's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) The agency does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. The agency pays for loaded mileage only as follows:

(a) The agency pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) The agency pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

(3) The agency does not pay for ambulance services if:

(a) The client is not transported, unless the services are provided under WAC 182-531-1740 Treat and refer services;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 182-546-0500(2)).

(4) For clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs, the agency's payment is as follows:

(a) If medicare covers the service, the agency pays the lesser of:

(i) The full coinsurance and deductible amounts due, based upon medicaid's allowed amount; or

(ii) The agency's maximum allowable for that service minus the amount paid by medicare.

(b) If medicare does not cover or denies ambulance services that the agency covers according to this chapter, the agency pays its maximum allowable fee; except the agency does not pay for clients on the qualified medicare beneficiaries (QMB) only program.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0400, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2017 c 273. WSR 19-19-090, § 182-546-0400, filed 9/18/19, effective 10/19/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-091, § 182-546-0400, filed 6/5/18, effective 7/6/18. Statutory Authority: RCW 41.05.021. WSR 13-16-006, § 182-546-0400, filed 7/25/13, effective 8/25/13. WSR 11-14-075, recodified as § 182-546-0400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0400, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0400, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0425 Ambulance transportation—During inpatient hospital stays. (1) The medicaid agency does not pay separately for ambulance transportation when a client remains as an inpatient client at the admitting hospital and the transportation to or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such serv-

ices is the responsibility of the admitting hospital, regardless of the payment method the agency uses to pay the hospital.

(2) **Hospital-to-hospital transfers.** Except as provided in subsections (3) and (5) of this section, the agency does not pay for hospital-to-hospital transfers of a client when ambulance transportation is requested solely to:

(a) Accommodate a physician's or other health care provider's preference for facilities;

(b) Move the client closer to family or home (i.e., for personal or family convenience); or

(c) Meet insurance requirements or hospital/insurance agreements.

(3) **Transfer-up services.** The agency pays for transfer-up ambulance transportation services as follows:

(a) Air ambulance transportation only when transportation by ground ambulance would cause sufficient delay as to endanger the client's life or substantially impair the client's health (e.g., in major trauma cases).

(b) Air ambulance transportation for medical and surgical procedures only and not for diagnostic purposes.

(c) The reason for the transfer-up must be clearly documented in the client's hospital chart and in the ambulance trip report.

(4) **Transfer-down services.** The agency pays for ground ambulance transfer-down services with a signed physician certification statement (PCS) or a nonphysician certification statement (NPCS).

(5) **Specialty care transport (SCT).** The agency pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport, provided:

(a) The criteria for covered hospital transfers are met; and

(b) The SCT is from an acute care hospital to another acute care hospital.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0425, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0425, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0425, filed 8/17/04, effective 9/17/04.]

WAC 182-546-0450 Ambulance transportation—Ground ambulance—Payment. (1) The medicaid agency pays for two levels of service for ground ambulance transportation: Basic life support (BLS) and advanced life support (ALS):

(a) A BLS ambulance trip is one in which the client receives basic, noninvasive medical services at the scene, point-of-pickup, or in transit to a hospital or other appropriate treatment facility.

(b) An ALS ambulance trip is one in which the client requires more complex life-saving services at the scene, point-of-pickup, or in transit to a hospital or other appropriate treatment facility. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel must provide the advanced medical services on board a properly equipped vehicle as defined by chapter 18.73 RCW. Examples of complex medical services or ALS procedures include, but are not limited to, the following:

(i) Administration of medication by intravenous push/bolus or by continuous infusion;

(ii) Airway intubation;
(iii) Cardiac pacing;
(iv) Chemical restraint;
(v) Chest decompression;
(vi) Creation of surgical airway;
(vii) Initiation of intravenous therapy;
(viii) Manual defibrillation/cardioversion;
(ix) Placement of central venous line; and
(x) Placement of intraosseous line.

(2) The agency pays for ambulance services (BLS or ALS) based on the client's medical condition and the medical services provided immediately prior to or during the trip.

(a) Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify an ambulance trip for the agency's payment at the ALS level of service unless ALS services were provided on-scene or in transit to the treatment facility.

(b) A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided on-scene or in transit to the treatment facility.

(c) An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client in transit to the treatment facility.

(3) An assessment and other intervention performed on-scene with no resulting transport does not qualify for payment from the agency, except when the client dies after treatment but before transport as provided in WAC 182-546-0500(2).

(4) The agency pays ground ambulance providers for mileage as follows:

(a) Loaded mileage only.

(b) Actual mileage incurred for covered trips (i.e., from the point-of-pickup to the destination) based on trip odometer readings.

(i) The agency uses the Washington state department of transportation's (WSDOT) mileage chart. The WSDOT mileage chart indicates shortest distance between points, including the use of the ferry system.

(ii) The agency uses alternative sources to calculate distance traveling when the origin or destination points are not listed in the WSDOT's mileage chart.

(iii) If the ferry system is the normal route for travel but is not used, the reason must be documented on the claim form when billing the agency. In this case, normal means the shortest route.

(iv) Miles traveled by the ferry. To be paid, providers must report by statute miles using the Washington state department of transportation (WSDOT) ferry route mileage chart located on the WSDOT website. Providers must thoroughly document the ferry route used, including a copy of the ferry ticket.

(5) The agency's base rate includes:

(a) Necessary personnel and services;

(b) Oxygen and oxygen administration; and

(c) Intravenous supplies and intravenous administration reusable supplies, disposable supplies, required equipment, and waiting time.

(6) The agency pays ground ambulance providers the same rate for mileage, regardless of the level of service (ALS or BLS). An odometer reading showing a fraction of a mile (partial mile) at the conclusion of a transport must be rounded up to the next whole unit (one mile). The agency pays for mileage when the client is transported to and from

medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

(7) The agency pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. All records are subject to agency review. Acceptable reasons for allowable extra mileage include, but are not limited to:

(a) The initial destination hospital was on "divert" status and not accepting patients; or

(b) A road construction project or other major obstacle caused a detour, or had to be avoided to save time.

(8) When multiple ambulance providers respond to an emergency call, the agency pays only the ambulance provider who actually provides the transportation.

(9) The agency pays for an extra attendant when the ground ambulance provider documents in the client's file the justification for the extra attendant and the extra attendant is on board for the trip because of one or more of the following:

(a) The client weighs three hundred pounds or more;

(b) The client is violent or difficult to move safely;

(c) The client is being transported for ITA purposes and the client must be restrained during the trip; or

(d) More than one client is being transported, and each requires medical attention or close monitoring.

(10) The agency pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting clients. Receipts must be attached to the claim submission for reimbursement. All ferry and bridge toll documentation must be kept in the client's file and made available to the agency for six years from the date of service in accordance with WAC 182-502-0020.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0450, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0450, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0450, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0500 Ambulance transportation—Ground ambulance—Payment in special circumstances. (1) When more than one client is transported in the same ground ambulance at the same time, the medicaid agency:

(a) Pays the ambulance providers at a reduced base rate for the second client who is being transported in the ambulance for medical treatment. This rate is set at seventy-five percent of the base rate for the applicable level of service (ALS or BLS) for the first client;

(b) Does not pay the ambulance provider a separate mileage charge for the second client being transported in the ambulance for medical treatment. The total payable mileage for the transport is from the first point of pickup.

(2) The agency pays an ambulance provider at the appropriate base rate (BLS or ALS) if no transportation takes place because the client

died before transport could occur but after the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. The intervention(s)/supplies provided must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies after medical interventions/supplies are provided but before transport takes place.

(3) In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets the agency's fee schedule definition of an ALS intervention, the BLS provider may bill the agency the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists. The provider must give the agency a copy of the agreement upon request. If a written agreement does not exist between the BLS and ALS entities, the agency will pay only for the BLS level of service. Only one ambulance provider may bill the agency for the transport.

(4) In ambulance service areas/jurisdictions that distinguish between residents and nonresidents, the provider must bill the agency the same rate for ambulance services provided to a client in a particular jurisdiction as would be billed for ambulance services to residents of the same jurisdiction.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0500, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0500, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0500, filed 1/16/01, effective 2/16/01.]

GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT)

WAC 182-546-0510 GEMT program overview. (1) The ground emergency medical transportation (GEMT) program permits publicly owned or operated providers to receive cost-based payments for emergency ground ambulance transportation of clients as described in subsection (2) of this section.

(2) This program is for clients under Title XIX of the federal Social Security Act and the Affordable Care Act (ACA) only. Participating providers do not receive supplemental payments for transporting:

(a) Medicaid applicants; or

(b) Medicare/medicaid clients with dual eligibility.

(3) The cost-based payment, when combined with the amount received from all other sources of reimbursement for medicaid, must not exceed one hundred percent of allowable costs.

(4) Fire departments/districts must use the approved CAP of their local government. If the local government does not have a CAP, they must use the Centers for Medicare and Medicaid Services (CMS)-approved cost report.

(5) The state general fund cannot be used for GEMT cost-based payments.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0510, filed

8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0510, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0515 GEMT provider participation and qualifications. (1) Participation in the program by a GEMT provider is voluntary.

(2) To qualify under this program and receive supplemental payments, a participating provider must:

(a) Provide ground emergency transportation services to clients as described in WAC 182-546-0510(2).

(b) Be publicly owned or operated as defined in WAC 182-546-0125.

(c) Be enrolled as a medicaid provider, with an approved core provider agreement, for the service period specified in the claim.

(d) Submit a participation agreement.

(e) Renew GEMT participation annually by submitting the Centers for Medicare and Medicaid Services (CMS)-approved cost report to the agency.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0515, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0515, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0520 GEMT supplemental payments. (1) The agency makes supplemental payments for the uncompensated and allowable costs incurred while providing GEMT services to clients, as defined by the United States Office of Management and Budget (OMB).

(a) The amount of supplemental payments, when combined with the amount received from all other sources of reimbursement from the medicaid program, will not exceed one hundred percent of allowable costs.

(b) If the participating provider does not have any uncompensated care costs, then the participating provider will not receive payment under this program.

(2) The total payment is equal to the participating provider's allowable costs of providing the services.

(a) The participating provider must certify the uncompensated expenses using the cost reporting process described under WAC 182-546-0525. This cost reporting process allows medicaid to obtain federal matching dollars to be distributed to participating providers.

(b) The participating provider must:

(i) Include the expenditure in its budget.

(ii) Certify that the claimed expenditures for the GEMT services are eligible for FFP and that the costs were allocated to the appropriate cost objective according to the cost allocation plan.

(iii) Provide evidence, specified by the agency, supporting the certification.

(iv) Submit data, specified by the agency, determining the appropriate amounts to claim as expenditures qualifying for FFP.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0520, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0520, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0525 GEMT claim submission and cost reporting. (1) Each participating provider is responsible for submitting claims to the agency for services provided to eligible clients. Participating providers must submit the claims according to the rules and billing instructions in effect at the time the service is provided.

(2) On an annual basis, participating providers must certify and allocate their direct and indirect costs as qualifying expenditures eligible for FFP.

(3) The claimed costs must be necessary to carry out GEMT.

(4) Participating providers must complete cost reporting according to the Centers for Medicare and Medicaid Services (CMS)-approved cost identification principles and standards such as the most current editions of the CMS *Provider Reimbursement Manual* and the United States Office of Management and Budget Circular (OMB) Circular A-87.

(5) Participating providers must completely and accurately document the CMS-approved cost report as required under OMB Circular A-87 Attachment A.

(6) Participating providers must allocate direct and indirect costs to the appropriate cost objectives as indicated in the cost report instructions.

(7) Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to ground emergency ambulance services provided. Services do not include fire suppression.

(8) Revenues received directly, such as foundation grants and money from private fund-raising, are not eligible for certification because such revenues are not expenditures of a government entity.

(9) The sum of a participating provider's allowable direct and indirect costs are divided by the number of ground emergency medical transports to determine a participating provider's average cost per qualifying transport.

(10) Participating providers must complete an annual cost report documenting the participating provider's total CMS-approved, direct and indirect costs of delivering medicaid-covered services using a CMS-approved cost-allocation methodology. Participating providers must:

(a) Submit the cost report within five months after the close of the service period.

(b) Request an extension to the cost report deadline in writing to the agency, if needed. The agency will review requests for an extension on a case-by-case basis.

(c) Provide additional documentation justifying the information in the cost report, upon request by the agency.

(d) Assure the agency receives the cost report or additional documentation according to WAC 182-502-0020.

(i) Participating providers must comply with WAC 182-502-0020 to receive the supplemental payment under this program.

(ii) The agency pays the claims for the following service period according to the agency's current ambulance fee schedule.

(11) The costs associated with releasing a client on the scene without transportation by ambulance to a medical facility are eligible for FFP and are eligible expenditures.

(12) Other expenses associated with the prehospital care are eligible costs associated with GEMT.

(13) Expenditures are not eligible costs until the services are provided.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0525, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0525, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0530 GEMT interim supplemental payment. (1) The agency pays an interim supplemental payment for GEMT. These payments using the interim supplemental payment allows the agency to pay participating providers for GEMT. The payments will approximate the GEMT costs eligible for federal financial participation claimed through the certified public expenditure (CPE) process.

(2) The agency computes the interim supplemental payment for GEMT on an annual basis.

(3) To determine the interim supplemental payment for GEMT, the agency uses the most recently filed cost reports of all participating providers to determine an average cost per qualifying transport. Therefore, the cost per participating provider and the amount of interim supplemental payments will vary among the participating providers.

(4) The agency distributes the interim supplemental payments to participating providers on a weekly basis using claims data as documented in the agency's claim system.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0530, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0535 GEMT cost reconciliation and settlement process. (1) The agency reconciles each interim supplemental payment for GEMT to the provider's filed cost report for the service year in which interim supplemental payments are made.

(2) The agency compares the total medicaid-allowable costs to the interim supplemental payments paid to the participating providers as documented in the agency's claim system, resulting in cost reconciliation.

(3) The agency performs cost settlements based on the final Centers for Medicare and Medicaid Services (CMS)-approved cost report schedules for all participating providers.

(a) The agency:

(i) Recovers from the participating provider the federal payments that exceed the participating provider's cost per qualifying transport; or

(ii) Pays the participating provider if the cost per transport exceeds the interim supplemental payment amount.

(b) If a participating provider disputes the reimbursement rate before there is an overpayment, the provider may appeal under WAC 182-502-0220.

(c) If a participating provider disputes the agency's determination that the participating provider has been overpaid, the participating provider may request a hearing under WAC 182-502-0230.

(4) The agency reports to the CMS any difference between the payments of federal funds made to the participating providers and the federal share of the qualifying expenditures and returns excess funds to CMS.

(5) Each participating provider must agree to reimburse the agency for the costs associated with administering the GEMT program. The costs are collected during the final reconciliation and settlement process and cannot be included as an expense in the participating provider's cost report.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0535, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0540 GEMT records maintenance. In addition to the health care record requirements in WAC 182-502-0020, GEMT participating providers must also maintain records of accounting procedures and practices that reflect all direct and indirect costs, of any nature, spent performing GEMT services.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0540, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0545 GEMT auditing. (1) The agency may conduct audit or investigation activities, as described under chapters 74.09 RCW and 182-502A WAC, to determine compliance with the rules and regulations of the core provider agreement, as well as of the GEMT program.

(2) If an audit or investigation is initiated, the participating provider must retain all original records and supporting documentation until the audit or investigation is completed and all issues are resolved, even if the period of retention extends beyond the required six-year period required under WAC 182-502-0020.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0545, filed 8/6/20, effective 9/6/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0545, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0600 Ambulance transportation—Procedure code modifiers. When billing the medicaid agency for ambulance trips, ambulance providers must use procedure code modifiers.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0600, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0600, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0600, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0700 Ambulance transportation—Air ambulance—Payment. (1) The medicaid agency pays for air ambulance transportation for clients only when all of the following conditions are met:

(a) The client's medical condition requires immediate and rapid transportation beyond what ground ambulance can provide;

(b) The client's destination is an acute care hospital or appropriate trauma designated facility; and

(c) The vehicle and crew meet the requirements in WAC 182-502-0016 and this chapter.

(2) Other factors the agency may consider in payment decisions for air ambulance include:

(a) The point-of-pickup is not accessible by ground ambulance (e.g., mountain rescue);

(b) The necessary medical care is not available locally and time is of the essence; and

(c) The use of other means of air travel (e.g., commercial flight) is medically contraindicated.

(3) **Lift-off fee.** The agency pays a lift-off fee for each client being transported by air ambulance to an acute care facility for medical treatment.

(a) When more than one client is transported in the same ambulance at the same time, each client must meet medical necessity criteria for the provider to receive a lift-off fee for each client transported.

(b) The agency does not pay a lift-off fee:

(i) For a client onboard an air ambulance when the client is not being transported for medical treatment (e.g., a mother accompanying a child to the hospital).

(ii) When the air ambulance is dispatched in response to a call but the client is not transported by the aircraft.

(4) **Statute miles.** The agency pays an air ambulance provider for statute miles incurred for covered trips by paying from the client's point-of-pickup to the point of destination.

(a) When more than one client requiring medical treatment is transported in the same air ambulance at the same time, the ambulance provider must divide the statute miles traveled by the number of clients being transported for medical treatment and bill the agency the mileage portion attributable to each client.

(b) The agency does not pay for mileage for a client who is traveling in an air ambulance but is not being transported for medical treatment (e.g., a mother accompanying a child to the hospital). Only the statute miles directly associated with the client transported for treatment may be billed to the agency.

(5) **Extra mileage.** The agency does not pay for extra mileage incurred during an air ambulance transport, except in an unusual circumstance. The unusual circumstance must be clearly described and documented in the ambulance trip report and the client's file. The exception for an unusual circumstance does not apply to nonemergency air transports that are prior authorized by the agency. Unusual circumstances for incurring additional air miles include, but are not limited to:

(a) Having to avoid a no fly zone;

(b) Being forced to land at an alternate destination due to severe weather; and

(c) Being diverted to another designated trauma facility.

(6) **Lift-off fee plus mileage.** The agency's payment for an air ambulance transport (lift-off fee plus mileage) includes all necessary personnel, services, supplies, and equipment. The agency does not make separate payment to air ambulance providers for unbundled services (e.g., pediatric ventilators).

(7) **More than one travel segment.** When an ambulance transport requires more than one travel segment (leg) to complete, the agency limits its payment for the transport as follows:

(a) If a fixed-wing aircraft is used and the transport involves more than one lift-off for the same client on the same trip (e.g., transportation from Spokane to Portland, but the aircraft makes a stop in the Tri-Cities), the agency pays the air ambulance provider for one lift-off fee for the client and the total air miles.

(b) For nonemergency air ambulance transports that are prior authorized by the agency, the negotiated rate includes both air and ground ambulance services, unless the agency's authorization letter specifically allows for ground ambulance services to be billed separately.

(8) **Nonemergency air transportation – Prior authorization and negotiated rate.** Nonemergency air ambulance transportation must be prior authorized by the agency.

(a) Nonemergency air ambulance transportation includes scheduled transports to or from out-of-state treatment facilities (see WAC 182-546-1500).

(b) Nonemergency air ambulance transportation that is prior authorized by the agency are paid a negotiated rate. The negotiated rate is an all-inclusive rate and may include transportation for a legally responsible family member or legal guardian accompanying the client being transported for medical treatment.

(9) The agency does not pay:

(a) For food, lodging, and other expenses of air ambulance personnel when a scheduled transport is delayed because of changes in the medical status of the client to be transported, weather conditions, or other factors;

(b) For fuel, maintenance and other aircraft-related expenses resulting from transportation delays because of changes in the medical status of the client to be transported, weather conditions, or other factors;

(c) Separately for ground ambulance services to and from airports and treatment facilities when these transportation services are specifically included in the negotiated air ambulance rate; and

(d) For canceled air ambulance transports, for any reason.

(10) The agency does not pay private organizations for volunteer medical air ambulance transportation services unless no other air ambulance option is available. The use of private, volunteer air transportation must be prior authorized by the agency to be payable. If authorized by the agency, the agency's payment for the transport is the lesser of:

(a) The provider's actual incurred and documented cost (e.g., fuel); or

(b) The agency's established rate (fee schedule).

(11) If the agency determines, upon review, that an air ambulance transport was not:

(a) Medically necessary, the agency may deny, recoup, or limit its payment to the amount the agency would have paid to a ground ambulance provider for the same distance traveled; or

(b) To the closest, most appropriate agency-contracted hospital, the agency may deny, recoup, or limit its payment to the maximum amount it would have paid an air ambulance provider for a transport to the nearest, most appropriate agency-contracted facility.

(12) The agency uses commercial airline companies whenever the client's medical condition permits the client to be transported safely by nonmedical or scheduled carriers.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0700, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0700, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0700, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0800 Ambulance transportation—Provided in another state or U.S. territory—Payment. (1) The medicaid agency pays for emergency ambulance transportation provided to clients who are in another state or U.S. territory according to the provisions of WAC 182-501-0180, 182-501-0182, and 182-502-0120.

(2) To receive payment from the agency, an out-of-state ambulance provider must:

(a) Meet the licensing requirements for Washington state and of the ambulance provider's home state or province;

(b) Have an approved core provider agreement with the agency.

(3) The agency pays for emergency ambulance transportation provided out-of-state for eligible clients when the transport is:

(a) Within the scope of the client's medical care program;

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

(c) To the closest, most appropriate treatment facility.

(4) The agency does not pay for an ambulance transport provided in another state for a client when:

(a) The client's medical eligibility program covers health care services within Washington state or designated bordering cities only. See WAC 182-546-0150 and 182-546-0200(5);

(b) The transport was nonemergency and was not prior authorized by the agency.

(5) The agency pays for emergency ambulance transportation at the lower of:

(a) The provider's billed amount; or

(b) The rate established by the agency.

(6) The agency does not pay for nonemergency (ground or air ambulance) transportation outside the state of Washington (i.e., both origin and destination points are outside the state's borders).

(7) An ambulance provider who transports a client to a facility outside the state (excluding designated bordering cities) or brings a client into the state from a location outside the state (excluding designated border cities) must obtain prior authorization from the agency for a nonemergency transport in order to be paid. See WAC 182-546-4000 for transports under the ITA.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0800, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-0800, filed 3/31/08, effective 5/1/08. Statutory Authority:

RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0800, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0800, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0900 Ambulance transportation—Provided outside the United States and U.S. territories—Payment. The medicaid agency does not pay for ambulance transportation for eligible clients traveling outside of the United States and U.S. territories. See WAC 182-501-0184 for ambulance coverage in British Columbia, Canada.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-0900, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-0900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-0900, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0900, filed 8/17/04, effective 9/17/04.]

WAC 182-546-1000 Ambulance transportation—Nonemergency ground—Payment. (1) The medicaid agency pays for nonemergency ground ambulance transportation when a client is transferred to a higher level facility, or when all of the following requirements are met:

(a) The ambulance transportation is medically necessary. See subsection (3) of this section for documentation requirements.

(b) The agency pays for nonemergency ground ambulance transportation with a completed PCS or NPCS form.

(i) All requests for nonemergency transports must be directed to the client's primary or attending physician or health care team who will complete the physician certification statement (PCS) form or nonphysician certification statement (NPCS) form. See subsection (3) of this section. The PCS/NPCS form or medical documentation must be maintained in the client's file.

(ii) In the event that the provider is unable to obtain the PCS or NPCS, the provider must maintain evidence of the attempts to obtain the PCS or NPCS in the client's file.

(2) The agency pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

(a) The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or

(b) The client's medical condition requires that they have basic ambulance level medical attention available during transportation, regardless of bed confinement.

(3) For nonemergency ambulance services from a psychiatric unit within a hospital to a behavioral health facility, the ambulance provider must obtain a licensed mental health professional (LMHP) (e.g., psychiatrist, MSW) signed PCS or NPCS within forty-eight hours after the transport.

(4) The agency covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under the following circumstances:

(a) From any point of origin to the nearest hospital with the ability to provide the type and level of care necessary for the client's illness or injury.

(b) From a hospital to the client's home when the place of residence is a residential care facility, the client must be transported by stretcher in a prone or supine position, the client is morbidly obese, or medical attention/monitoring is required in transit.

(c) For a bed-confined client who is receiving renal dialysis for treatment of end stage renal disease (ESRD), from the place of origin to the nearest facility with the ability to provide renal dialysis, including the return trip.

(5) The agency requires ambulance providers to thoroughly document the medical necessity for use of nonemergency ground ambulance transportation as follows:

(a) For scheduled, nonemergency ambulance services that are repetitive in nature, the ambulance provider must obtain a signed PCS from the client's attending physician or other designated medical professional certifying that the ambulance services are medically necessary. The PCS must specify the place of origin, destination, and the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services.

(b) A PCS for repetitive, nonemergency ambulance services (e.g., wound treatment center) is valid for sixty calendar days as long as the agency's medical necessity requirement for use of ambulance transportation is met. A new PCS is required every thirty calendar days after the initial sixty-day period for a client using repetitive, nonemergency ambulance services. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.

(c) For unscheduled, nonrepetitive, nonemergency ambulance services, the ambulance provider must obtain a signed PCS or NPCS within forty-eight hours after the transport. The PCS or NPCS must specify the place of origin and destination and certify that the ambulance services are medically necessary. If the provider is unable to obtain the signed PCS or NPCS within twenty-one calendar days following the date of transport from the attending physician or alternate provider, the provider must submit a claim to the agency. The provider must be able to show acceptable documentation of the attempts to obtain the PCS or NPCS.

(d) For an unscheduled, nonrepetitive, nonemergency ambulance service, if the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed nonphysician certification statement (NPCS) form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has knowledge of the client's medical condition at the time the ambulance service was furnished. One of the following members of the client's health care team may sign the certification form:

(i) A physician assistant;

(ii) A nurse practitioner;

(iii) A registered nurse;

(iv) A clinical nurse specialist;

(v) A hospital discharge planner;

(vi) A licensed practical nurse;

(vii) A social worker; or

(viii) A case manager.

(e) A copy of the signed PCS or NPCS must accompany the claim submitted to the agency.

(f) In addition to the signed PCS or NPCS, all other program criteria must be met in order for the agency to pay for the service.

(g) A signed PCS or NPCS must be attached to the claim submission for the following conditions:

(i) Altered mental status (i.e., alzheimer, dementia, acute psychosis, and suicide ideation - Not services that fall under the Involuntary Treatment Act;

(ii) Bariatric;

(iii) Bedbound (not able to stand or bear weight unassisted);

(iv) Continuous cardiac monitoring;

(v) Quadriplegic;

(vi) Requires a ventilator;

(vii) Requires continuous oxygen usage in transit; and

(viii) Tracheostomy (needed for prolonged respiratory support).

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-1000, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-1000, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-1000, filed 1/16/01, effective 2/16/01.]

WAC 182-546-1500 Ambulance transportation—Nonemergency air—Payment. (1) The medicaid agency pays for a nonemergency air ambulance transport only when the transport is prior authorized by the agency.

(2) The agency authorizes a nonemergency air ambulance transport only when the following conditions are met:

(a) The client's destination is an acute care hospital or approved rehabilitation facility; and

(b) The client's physical or medical condition is such that travel by any other means endangers the client's health; or

(c) Air ambulance is less costly than ground ambulance under the circumstances.

(3) The agency requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical necessity justification and all supporting documentation must be received, evaluated, and approved by the agency before the air ambulance transport takes place.

(4) The agency pays a negotiated rate for a medically necessary nonemergency interstate air ambulance transportation that the agency has prior authorized. The air ambulance provider is responsible for ensuring that all medical services necessary for the client's health and safety during the transport are available on board the vehicle or aircraft.

(5) Unless otherwise specified in the agency's authorization letter, the contractual amount for a nonemergency air ambulance transport includes:

(a) The cost of medically necessary ground transportation from the discharge facility to the point-of-pickup (airstrip); and

(b) The cost of medically necessary ground ambulance transportation from the landing point (airstrip) to the receiving facility.

(6) Payment for nonemergency air ambulance transportation clients may not exceed published fee schedule amounts, except when the agency expressly allows payment of a negotiated rate for a prior authorized nonemergency transport.

(7) Billing documentation must include a copy of the agency's authorization letter, adequate descriptions of the severity and complexity of the transport, and the medical interventions provided in transit.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-1500, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-1500, filed 8/17/04, effective 9/17/04.]

WAC 182-546-2500 Ambulance transportation to out-of-state treatment facilities—Coordination of benefits. (1) The medicaid agency does not pay for a client's ambulance transportation to an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

(2) For clients who are otherwise eligible for out-of-state coverage under WAC 182-546-0150, but have other third-party insurance, the agency may not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

(a) Denies the client's request for medical services out-of-state as not medically necessary;

(b) Denies the client's request for transportation as not medically necessary; or

(c) Denies the client's requested mode of transportation as not medically necessary.

(3) For clients who are otherwise eligible for out-of-state coverage under WAC 182-546-0150, but have other third-party insurance, the agency does not consider requests for transportation to or from out-of-state treatment facilities unless the client has requested coverage of the benefit from their primary insurer and been denied.

(4) If the agency authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, the agency's liability is limited to the cost of the least costly means of transportation that does not jeopardize the client's health, as determined by the agency in consultation with the client's referring physician.

(5) For clients eligible for out-of-state coverage but have other third-party insurance, the agency considers requests for transportation to or from out-of-state treatment facilities under the provisions of WAC 182-501-0165.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-2500, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-2500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057,

74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-2500, filed 8/17/04, effective 9/17/04.]

WAC 182-546-3000 Ambulance transportation—Transporting qualified trauma cases. The medicaid agency does not pay ambulance providers who meet department of health (DOH) criteria for participation in the statewide trauma network an additional amount for transports involving qualified trauma cases described in WAC 182-550-5450. Subject to the availability of trauma care fund (TCF) monies allocated for such purpose, the agency may make supplemental payments to these ambulance providers, also known as verified prehospital providers.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-3000, filed 8/6/20, effective 9/6/20. WSR 11-14-075, recodified as § 182-546-3000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. WSR 10-12-013, § 388-546-3000, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-3000, filed 8/17/04, effective 9/17/04.]

WAC 182-546-4100 Ambulance transportation—Behavioral health treatment—General. The medicaid agency pays for medically necessary ambulance transportation to and from a covered behavioral health service (see WAC 182-546-4300) subject to the conditions and limitations within this chapter. For purposes of Involuntary Treatment Act (ITA) and voluntary behavioral health services:

(1) The agency pays for transportation services for people involuntarily detained for behavioral health services when they have been assessed by a DCR and found to be one of the following:

(a) A danger to self;

(b) A danger to others;

(c) At substantial risk of inflicting physical harm upon the property of others; or

(d) Gravely disabled as a result of their behavioral health condition.

(2) The agency pays for ambulance transportation to take a client to and from an inpatient facility for behavioral health admission under the ITA.

(3) The agency pays for ambulance transportation services to take a client to the hospital for a voluntary inpatient behavioral health stay when medically necessary.

(4) The DCR authorizes the treatment destination based on the client's legal status.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-4100, filed 8/6/20, effective 9/6/20.]

WAC 182-546-4200 Ambulance transportation—Behavioral health treatment—Coverage. (1) To be considered an Involuntary Treatment Act (ITA) transport, a client's involuntary status must have resulted from:

(a) A petition for initial detention filed by a DCR (seventy-two hour hold); and

(b) Continued hospitalization (fourteen-day, ninety-day, or one hundred eighty-day holds) under order of the superior court in a community hospital (not for clients residing in western or eastern state hospitals); or

(c) A petition for revocation of a conditional release or less restrictive treatment agreement.

(2) ITA transportation for a client is covered:

(a) From:

(i) The site of initial detention;

(ii) A court competency hearing;

(iii) A local emergency room department;

(iv) An evaluation and treatment facility;

(v) A state hospital; and

(vi) A secured detoxification facility or crisis response center.

(b) To:

(i) A state hospital;

(ii) A less restrictive alternative setting (except home);

(iii) A court competency hearing;

(iv) A local emergency room department;

(v) An evaluation and treatment facility; and

(vi) A secured detoxification facility or crisis response center.

(c) When provided by an ambulance transportation provider or law enforcement.

(d) When transported to the closest and most appropriate destination or a place designated by the DCR and/or courts. The reason for a diversion to a more distant facility must be clearly documented in the client's file.

(3) **Children's long-term inpatient program (CLIP)** - Transportation provided to a children's long-term inpatient program (CLIP) facility is considered a form of nonemergency medical transportation and requires a physician certification statement (PCS) or nonphysician certification statement (NPCS).

(4) **Parent initiated treatment (PIT)** - Use of nonemergency ambulance transportation to an inpatient psychiatric facility for voluntary inpatient admission must be medically necessary at the time of transport. The agency requires a PCS or NPCS signed by a psychiatric registered nurse, psychiatric advanced registered nurse practitioner (ARNP), or psychiatric physician's assistant (PA). The PCS or NPCS form documents the client's medical condition at the time of the transport.

(5) **Persons without apple health or other coverage** - If the person does not have apple health or any third-party health insurance, and the person or the person's family cannot pay for transportation related to services in RCW 71.05.150 through 71.05.310 and 71.05.340:

(a) The ambulance provider may submit a claim to the agency for that person; and

(b) The claim must be accompanied by back-up documentation consistent with Washington superior court mental proceeding Rule 2.2 and show that the transport occurred within three days of the person's detention.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-4200, filed 8/6/20, effective 9/6/20.]

WAC 182-546-4300 Ambulance transportation—Behavioral health treatment—Reimbursement. (1) The agency, as payer of last resort, pays the transportation costs for clients that a Washington designated crisis responder (DCR) detains under the ITA on a seventy-two hour initial detention or five-day revocation hold until the client is discharged from the evaluation and treatment facility or admitted to a state-managed inpatient facility.

(2) The agency pays only when it determines that the involuntarily detained client:

(a) Does not have any other third-party liability (TPL) payment source; and

(b) When requiring the client to pay would result in a substantial hardship upon the client or the client's family. Refer to WAC 182-502-0160.

(3) The DCR must complete and sign a copy of the agency's authorization of Secure Ambulance Transportation Services to/from Behavioral Health Services form (HCA 42-0003) and must keep it in the client's file.

(4) The agency establishes payment for behavioral health related transportation services when the transportation provider complies with the agency's requirements for drivers, driver training, vehicle and equipment standards and maintenance. Providers must clearly identify ITA transportation on the claim when billing the agency.

(5) The agency does not pay for transportation costs to or from out-of-state or bordering cities for clients under the ITA program under any circumstance.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2015 c 157, 2017 c 273, and 2016 1st sp.s. c 29. WSR 20-17-010, § 182-546-4300, filed 8/6/20, effective 9/6/20.]

WAC 182-546-4700 Ambulance transportation—Ambulance transport fund—Purpose. Chapter 74.70 RCW establishes the quality assurance fee for specified providers of emergency ambulance services through July 1, 2028. The fee is added to base funding from all other sources to support additional medicaid payments. The fee applies to nonpublic and nonfederal providers of emergency ambulance services. This is a dedicated fund established within the state treasury, known as the ambulance transport fund. The ambulance transport fund is used to receive and distribute funds.

[Statutory Authority: RCW 41.05.021, 41.05.160, 74.70.901, and 2023 c 11. WSR 24-18-059, § 182-546-4700, filed 8/28/24, effective 9/28/24. Statutory Authority: Chapter 74.70 RCW, 41.05.021, 41.05.160 and 2020 c 354. WSR 21-15-010, § 182-546-4700, filed 7/8/21, effective 8/8/21.]

WAC 182-546-4725 Ambulance transportation—Ambulance transport fund—Notices, payment, and interest. (1) The agency assesses each ambulance transport provider a quality assurance fee to be paid on a quarterly basis.

(2) The agency sends each ambulance transport provider an assessment notice or invoice specified due dates.

(3) The agency assesses interest and penalties on quality assurance fees not paid on the due date according to RCW 43.20B.695.

(a) Fee payments more than sixty days overdue include an assessed penalty equal to the interest charge and payment due for each month for which payment is not received after sixty days.

(b) Any interest or penalties is deposited in the ambulance transport fund.

(c) The agency may waive a portion or all of the interest or penalties, or both.

(4) If a payment is sixty days past due, the agency sends written notice of delinquent fees. After written notice, the agency will deduct the past due payment, along with interest and penalties, from any reimbursement.

[Statutory Authority: Chapter 74.70 RCW, 41.05.021, 41.05.160 and 2020 c 354. WSR 21-15-010, § 182-546-4725, filed 7/8/21, effective 8/8/21.]

WAC 182-546-5000 Nonemergency transportation—General. (1) The agency covers nonemergency nonambulance transportation to and from covered health care services, as required by 42 C.F.R. 431.53, subject to the limitations and requirements under WAC 182-546-5000 through 182-546-6200. See WAC 182-546-1000 for nonemergency ground ambulance transportation.

(2) The agency pays for nonemergency transportation for clients covered under state-funded medical programs subject to funding appropriated by the legislature.

(3) Clients may not select the transportation provider or the mode of transportation.

(4) A client's right to freedom of choice does not require the agency to cover transportation at unusual or exceptional cost in order to meet a client's personal choice of health care provider.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5000, filed 8/18/23, effective 9/18/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5000, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5000, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5000, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5000, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5000, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5100 Nonemergency transportation—Definitions. The following definitions and those found in chapter 182-500 WAC apply to nonemergency medical brokered transportation. Unless otherwise defined in WAC 182-546-5200 through 182-546-6000, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"Against medical advice (AMA)" - When a client elects to discharge from a health care facility against the advice of medical professionals.

"Ambulance" - See WAC 182-546-0125.

"Broker" - An organization or entity contracted with the agency to arrange nonemergency transportation and related services for clients.

"Drop off point" - The location authorized by the transportation broker for the client's trip to end.

"Early periodic screening, diagnosis, and treatment (EPSDT)" - See WAC 182-534-0050.

"Escort" - A person authorized by the transportation broker to accompany and be transported with a client to a health care service. An escort's transportation may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility skills, communication skills, or cultural issues.

"Guardian" - A person who is legally responsible for a client and who may be required to be present when a client is receiving health care services.

"Local community" - The client's city or town of residence or nearest location to residence.

"Local provider" - A provider, as defined in WAC 182-500-0085, who delivers covered health care service within the client's local community, and the treatment facility where the services are delivered within the client's local community.

"Lodging and meals" - Temporary housing and meals provided during a client's out-of-area medical stay.

"Mode" - A method of transportation assistance used by the general public that an individual client can use in a specific situation. Methods that may be considered include, but are not limited to:

- Air transport;
- Public bus;
- Commercial bus;
- Ferries/water taxis;
- Gas vouchers/gas cards;
- Grouped or shared-ride vehicles;
- Mileage reimbursement;
- Parking;
- Stretcher vans or cars;
- Taxi;
- Tickets;
- Tolls;
- Train;
- Volunteer drivers;
- Walking or other personal conveyance; and
- Wheelchair vans.

"Noncompliance or noncompliant" - When a client:

- Fails to appear at the pickup point of the trip at the scheduled pickup time;
- Misuses or abuses agency-paid medical, transportation, or other services;
- Fails to comply with the rules, procedures, or policies of the agency or those of the agency's transportation brokers, the brokers' subcontracted transportation providers, or health care service providers;
- Poses a direct threat to the health or safety of self or others; or
- Engages in violent, seriously disruptive, or illegal conduct.

"Pickup point" - The location authorized by the agency's transportation broker for the client's trip to begin.

"Return trip" - The return of the client to the client's residence, or another authorized drop-off point, from the location where a covered health care service has occurred.

"Service animal" - An animal individually trained to work or perform tasks for an individual with a disability. The work or task an animal has been trained to provide must be directly related to the individual's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the American with Disabilities Act.

"Stretcher car or van" - A vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route.

"Stretcher trip" - A transportation service that requires a client to be transported in a prone or supine position without medical attention during the trip. This may be by stretcher, board, gurney, or other appropriate device. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

"Transportation provider" - A person or company under contract with a broker to provide trips to eligible clients.

"Trip" - Transportation one-way from the pickup point to the drop off point by an authorized transportation provider.

"Urgent care" - 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 26-07-031, s 182-546-5100, filed 3/11/26, effective 4/11/26. Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5100, filed 8/18/23, effective 9/18/23; WSR 20-05-066, § 182-546-5100, filed 2/14/20, effective 3/16/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5100, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5100, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5100, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5100, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-5100, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5100, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5200 Nonemergency transportation broker and provider requirements. (1) The medicaid agency requires:

(a) Brokers and subcontracted transportation providers to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws, and the terms specified in their contracts;

(b) Brokers to:

(i) Screen their employees and subcontracted transportation providers and employees prior to hiring or contracting, and on an ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5; and

(ii) Report immediately to the agency any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5.

(c) Drivers and passengers to comply with all applicable federal, state, and local laws and regulations during transport.

(2) Brokers:

(a) Must determine the level of assistance needed by the client (e.g., curb-to-curb, door-to-door, door-through-door, hand-to-hand) and the mode of transportation to be used for each authorized trip;

(b) Must select the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;

(c) Must have subcontracts with transportation providers in order for the providers to be paid by the broker;

(d) Must provide transportation services comparable to those available to the general public in the local community;

(e) May subcontract with licensed ambulance providers for nonemergency trips in licensed ground ambulance vehicles; and

(f) Must negotiate in good faith a contract with a federally recognized tribe that has all or part of its contract health service delivery area, as established by 42 C.F.R. Sec. 136.22, within the broker's service region, to provide transportation services when requested by that tribe. The contract must comply with federal and state requirements for contracts with tribes. When the agency approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 182-546-5100 through 182-546-6200, tribal members may obtain their transportation services from the tribe or tribal agency with coordination from and payment through the transportation broker.

(3) If the broker is not open for business and is unavailable to give advance approval for transportation to an urgent care appointment or after a hospital discharge, the subcontracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's after-hours instructions and request a retroactive authorization from the broker within two business days of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(4) If the subcontracted transportation provider provides transportation as described in subsection (3)(a) of this section, the broker may grant retroactive authorization and must document the reason in the client's trip record.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5200, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5200, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5200, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5200, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5200, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5300 Nonemergency transportation—Client eligibility. (1) The agency pays for nonemergency transportation for Washington apple health (WAH) clients, including persons enrolled in an agency-contracted managed care organization (MCO), to and from health care services when the health care service(s) meets the requirements in WAC 182-546-5500.

(2) Persons assigned to the patient review and coordination (PRC) program according to WAC 182-501-0135 may be restricted to certain providers.

(a) Brokers may authorize transportation of a PRC client to only those providers to whom the person is assigned or referred by their primary care provider (PCP), or for covered services which do not require referrals.

(b) If a person assigned to PRC chooses to receive service from a provider, pharmacy, or hospital that is not in the person's local community, the person's transportation is limited per WAC 182-546-5700.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5300, filed 5/20/16, effective 6/20/16. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-546-5300, filed 3/12/14, effective 4/12/14. WSR 11-17-032, recodified as § 182-546-5300, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5300, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5300, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5400 Nonemergency transportation—Client responsibility. (1) Clients must comply with applicable state, local, and federal laws during transport.

(2) Clients must comply with the rules, procedures and policies of the medicaid agency, brokers, the brokers' subcontracted transportation providers, and health care service providers.

(3) A client who is noncompliant may have limited transportation mode options available.

(4) Clients must request, arrange, and obtain authorization for transportation at least two business days before a health care appointment, except when the request is for an urgent care appointment or a hospital discharge. Requests for trips to urgent care appointments must not be to an emergency department (also known as an emergency room).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5400, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5400, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5400, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5400, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5400, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5500 Nonemergency transportation—Covered trips. (1) The medicaid agency covers nonemergency transportation for a Washington apple health client to and from health care services if all of the following apply:

(a) The health care services are:

(i) Within the scope of coverage of the eligible client's benefit services package;

(ii) Covered as defined in WAC 182-501-0050 through 182-501-0065 and the specific program rules; and

(iii) Authorized, as required under specific program rules.

(b) The health care service is medically necessary as defined in WAC 182-500-0070;

(c) The health care service is being provided:

(i) Under fee-for-service, by an agency-contracted provider;

(ii) Through an agency-contracted managed care organization (MCO), by an MCO provider;

(iii) Through a behavioral health organization (BHO), by a BHO contractor; or

(iv) Through one of the following providers, as long as the provider is eligible for enrollment as a medicaid provider (see WAC 182-502-0012):

(A) A medicare enrolled provider;

(B) A provider in the network covered by the client's primary insurance where there is third-party insurance;

(C) A provider performing services paid for by the Veteran's Administration, charitable program, or other voluntary program (Shriners, etc.).

(d) The trip is to a local provider as defined in WAC 182-546-5100 (see WAC 182-546-5700(3) for local provider exceptions);

(e) The transportation is the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;

(f) The trip is authorized by the broker before a client's travel; and

(g) The trip is a minimum of three-quarters of a mile from pick-up point to the drop-off point (see WAC 182-546-6200(7) for exceptions to the minimum distance requirement).

(2) Coverage for nonemergency medical transportation is limited to one roundtrip per day, with the exception of multiple medical appointments which cannot be accessed in one roundtrip.

(3) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 26-07-031, s 182-546-5500, filed 3/11/26, effective 4/11/26. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-546-5500, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-5500, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5500, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5500, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.08.090 and 42 C.F.R. Part 440. WSR 10-05-079, § 388-546-5500, filed 2/15/10, effective 3/18/10. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5500, filed 3/2/01, effective 4/2/01.]

WAC 182-546-5550 Nonemergency transportation—Exclusions and limitations. (1) The following service categories listed in WAC 182-501-0060 are subject to the following exclusions and limitations:

(a) Adult day health (ADH) - Nonemergency transportation for ADH services is not provided through the brokers. ADH providers are responsible for arranging or providing transportation to ADH services.

(b) Against medical advice (AMA) discharges - Nonemergency transportation is not provided through the brokers for clients that elect to discharge from a facility or hospital AMA.

(c) Ambulance - Nonemergency ambulance transportation is not provided through the brokers except as specified in WAC 182-546-5200 (2)(e).

(d) Emergency department (ED) - When a client is discharged from the ED, brokers may provide transportation only to another medicaid-covered service or to the client's residence.

(e) Hospice services - Nonemergency transportation is not provided through the brokers when the health care service is related to a client's hospice diagnosis. See WAC 182-551-1210.

(f) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, except for complex rehabilitation technology (CRT) and DME equipment that needs to be fitted to the client (such as braces/crutches, wheelchairs).

(g) Medical nutrition services - Nonemergency transportation is not provided through the brokers to pick up medical nutrition products.

(h) Medical supplies/equipment, nondurable (MSE) - Nonemergency transportation is not provided through the brokers for MSE services.

(i) The following mental health and substance use disorder services:

(i) Nonemergency transportation brokers generally provide one round trip per day. The broker must request agency approval for additional trips for off-site activities.

(ii) Nonemergency transportation of an involuntarily detained person under the Involuntary Treatment Act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider.

(iii) Nonemergency transportation is not provided through the brokers to or from information and assistance services which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(j) Program of all-inclusive care for the elderly (PACE)-nonemergency transportation for clients in the PACE program is not provided through the brokers. The PACE contractor is responsible for transportation to PACE services.

(k) Standalone pharmacy trips - Transportation that occurs solely for the purpose of picking up a medication prescribed by a health care provider from a pharmacy.

(i) The broker may provide mileage reimbursement to the client or coordinate a standalone pharmacy trip only when:

(A) The client cannot receive the medication through the mail and such transportation assistance has been requested two business days in advance; or

(B) Documentation from a medical professional has been provided to the broker that indicates medication was prescribed for a condition that requires urgent treatment.

(ii) A standalone pharmacy trip that meets the conditions of (k) of this subsection is restricted to one trip per week per household,

unless documentation from a medical professional indicates the medication must be picked up urgently.

(iii) Documentation of medical necessity from the client's health care provider, pharmacy, or other medical professional is required before the broker can authorize a standalone pharmacy trip more frequently than once a week per household.

(iv) If the client has a scheduled trip to an eligible medical appointment in the same week as a pharmacy pick up, the prescription must be picked up when in route to or from the medical appointment. See WAC 182-546-5600 (3)(b).

(2) Service animals as defined in WAC 182-546-5100 may be transported with clients.

(3) The following programs do not have a benefit for brokered nonemergency transportation through the agency:

(a) Federal medicare savings and state-funded medicare buy-in programs (see chapter 182-517 WAC);

(b) Family planning services - Nonemergency transportation is not provided for clients that are enrolled only in family planning only services; and

(c) Alien emergency medical (AEM) - See WAC 182-507-0115.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5550, filed 8/18/23, effective 9/18/23; WSR 20-05-066, § 182-546-5550, filed 2/14/20, effective 3/16/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5550, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5550, filed 1/14/15, effective 2/14/15. WSR 11-17-059, recodified as § 182-546-5550, filed 8/15/11, effective 8/15/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5550, filed 7/12/11, effective 8/12/11.]

WAC 182-546-5600 Nonemergency transportation—Intermediate stops or delays. (1) The agency does not pay for any costs related to intermediate stops or delays that are not directly related to the original approved trip, including trips that would, or did, result in additional transportation costs due to client convenience.

(2) Brokers may authorize intermediate stops or delays for clients if the broker determines that the intermediate stop is:

(a) Directly related to the original approved trip; or

(b) Likely to limit or eliminate the need for supplemental covered trips.

(3) The agency considers the following reasons to be related to the original trip:

(a) Transportation of the client to and from an immediate subsequent medical referral/appointment; or

(b) Transportation of the client to a pharmacy to obtain one or more prescriptions when in route to or from the covered service and the pharmacy is within a reasonable distance of the usual route to the medical appointment. The agency does not pay for transportation of the client to a pharmacy to obtain medicare Part D prescriptions unless the prescription is billable to medicaid and not paid by medicare Part D.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5600, filed 8/18/23, effective

9/18/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-5600, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5600, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5600, filed 7/12/11, effective 8/12/11.]

WAC 182-546-5700 Nonemergency transportation—Local provider and trips outside client's local community. (1) A client receiving services provided under fee-for-service or through a medicaid agency-contracted managed care organization (MCO) may be transported to a local provider only.

(a) A local provider's medical specialty may vary as long as the provider is capable of providing medically necessary care that is the subject of the appointment or treatment;

(b) A provider may be considered an available local provider if:

(i) Providers in the client's local community are not accepting medicaid clients; or

(ii) Providers in the client's local community are not contracted with the client's MCO, primary care case management group, or third-party coverage.

(2) Brokers are responsible for considering and authorizing exceptions. See subsection (3) of this section for exceptions.

(3) A broker may transport a client to a provider outside the client's local community for covered health care services when any of the following apply:

(a) The health care service is not available within the client's local community.

(i) If requested by the broker, the client or the client's provider must provide documentation from the client's primary care provider (PCP), specialist, or other appropriate provider verifying the medical necessity for the client to be served by a health care provider outside of the client's local community.

(ii) If the service is not available in the client's local community, the broker may authorize transportation to the nearest provider where the service may be obtained;

(b) The transportation to a provider outside the client's local community is required for continuity of care.

(i) If requested by the broker, the client or the client's provider must submit documentation from the client's PCP, specialist, or other appropriate provider verifying the existence of ongoing treatment for medically necessary care by the provider and the medical necessity for the client to continue to be served by the health care provider.

(ii) If the broker authorizes transportation to a provider outside the client's local community based on continuity of care, this authorization is for a limited period of time for completion of ongoing care for a specific medical condition. Each transport must be related to the ongoing treatment of the specific condition that requires continuity of care.

(iii) Ongoing treatment of medical conditions that may qualify for transportation based on continuity of care include, but are not limited to:

(A) Active cancer treatment;

(B) Recent transplant (within the last twelve months);

(C) Scheduled surgery (within the next sixty days);

(D) Major surgery (within the previous ninety days); or

(E) Third trimester of pregnancy;

(c) The health care service is paid by a third-party payer who requires or refers the client to a specific provider within their network;

(d) The total cost to the agency, including transportation costs, is lower when the health care service is obtained outside of the client's local community; and

(e) A provider outside the client's local community has been issued a global payment by the agency for services the client will receive, and the broker determines it to be cost effective to provide transportation for the client to complete treatment with this provider.

(4) Brokers determine whether an exception should be granted based on documentation from the client's health care providers and program rules.

(5) When a client or a provider moves to a new community, the existence of a provider-client relationship, independent of other factors, does not constitute a medical need for the broker to authorize and pay for transportation to the previous provider.

(6) The health care service must be provided in the state of Washington or a designated border city, unless the agency specifically authorizes transportation to an out-of-state provider in accordance with WAC 182-546-5800.

(7) If local Washington apple health providers refuse to see a client due to the client's noncompliance, the agency does not authorize or pay more for nonemergency transportation to a provider outside the client's local community.

(a) In this circumstance, the agency pays for the least costly, most appropriate, mode of transportation from one of the following options:

(i) Transit bus fare;

(ii) Commercial bus or train fare;

(iii) Gas voucher/gas card; or

(iv) Mileage reimbursement.

(b) The agency's payment, whether fare, tickets, voucher, or mileage reimbursement, is determined using the number of miles from the client's authorized pickup point (e.g., client residence) to the location of the local health care provider who otherwise would have been available if not for the client's noncompliance.

(8) The agency may grant an exception to subsection (7) of this section for a life-sustaining service or as reviewed and authorized by the agency's medical director or designee in accordance with WAC 182-502-0050 and 182-502-0270.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-5700, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5700, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5700, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5700, filed 7/12/11, effective 8/12/11.]

WAC 182-546-5800 Nonemergency transportation—Trips out-of-state/out-of-country. (1) The agency reviews requests for out-of-state nonemergency transportation in accordance with regulations for

covered health care services including, but not limited to, WAC 182-501-0180, 182-501-0182 and 182-501-0184. Out-of-state requests must be submitted to the agency no less than seven business days prior to the client's anticipated travel date.

(2) The agency does not pay for nonemergency transportation to or from locations outside of the United States and U.S. territories, except as allowed under WAC 182-501-0184 for British Columbia, Canada.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5800, filed 8/18/23, effective 9/18/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-5800, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5800, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5800, filed 7/12/11, effective 8/12/11.]

WAC 182-546-5900 Nonemergency transportation—Meals, lodging, escort/guardian. (1) The agency may pay for meals and lodging for clients who must be transported to health care services outside of the client's local community. The agency's transportation brokers determine when meals and lodging are necessary based on a client's individual need.

(2) Brokers may authorize payment for meals and lodging for up to one calendar month. Extensions beyond the initial calendar month must be prior authorized by the broker on a month-to-month, week-to-week, or as-needed basis.

(3) Brokers may not authorize payment for alcohol, cannabis, or other nonfood items.

(4) Brokers follow the agency's guidelines in determining the reasonable costs of meals and lodging. The reasonable cost of lodging and meals is measured against the state per diem for the location where the client is receiving covered health care services.

(5) The agency pays for the transportation of an authorized escort, including meals and lodging, when all of the following apply:

(a) The client is present, except as stated in subsection (5) of this section; and

(b) The broker determines the transportation costs of an escort are necessary based upon the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.

(6) The agency may authorize and pay for the transportation of an authorized escort or guardian, with or without the presence of the client, if the broker determines, and documents, that the presence of the authorized escort or guardian is necessary to ensure that the client has access to medically necessary care.

(7) Lodging and meals for all out-of-state nonemergency transportation must be prior authorized by the agency. Border areas as defined by WAC 182-501-0175 are considered in-state under this section and subsequent sections.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-5900, filed 8/18/23, effective 9/18/23; WSR 20-05-066, § 182-546-5900, filed 2/14/20, effective 3/16/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-5900, filed 1/14/15, effective 2/14/15. WSR

11-17-032, recodified as § 182-546-5900, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5900, filed 7/12/11, effective 8/12/11.]

WAC 182-546-6000 Nonemergency transportation—Authorization. (1) The medicaid agency contracts with brokers to authorize or deny requests for transportation services.

(2) Exceptional requests to transport a client may be referred to the agency's medical director or designee for review.

(3) Nonemergency medical transportation, other than ambulance, must be prior authorized by the broker. See WAC 182-546-5200 (3) and (4) and 182-546-6200(4) for granting retroactive authorization.

(4) The broker mails a written notice of denial to each client who is denied authorization of transportation.

(5) A client who is denied nonemergency transportation under this chapter may request an administrative hearing, if one is available under state and federal law.

(6) If the agency approves a medical service under exception to rule (ETR), the authorization requirements of this section apply to transportation services related to the ETR service.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-12-022, § 182-546-6000, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-6000, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-6000, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-6000, filed 7/12/11, effective 8/12/11.]

WAC 182-546-6100 Nonemergency transportation—Noncovered. (1) The medicaid agency does not cover nonemergency transportation that is not specifically addressed in WAC 182-546-5000 through 182-546-6200.

(2) Brokers do not provide nonemergency transportation for admissions under the Involuntary Treatment Act (ITA), as defined in WAC 182-546-4000.

(3) The agency does not provide escorts or cover the cost of wages of escorts.

(4) The agency does not cover the purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles under the nonemergency transportation program. The purchase or repair of equipment for a privately owned vehicle or modification of a privately owned vehicle is not a health care service. Exception to rule (ETR) as described in WAC 182-501-0160 is not available for equipment that is not a health care service.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-6100, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-6100, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-6100, filed 7/12/11, effective 8/12/11.]

WAC 182-546-6200 Nonemergency transportation—Reimbursement. (1) To be reimbursed for trips, meals, or lodging, the requestor must

receive prior authorization from the broker at least two business days in advance of the client's travel.

(2) A client must request reimbursement of preauthorized expenditures for trips, meals, or lodging within 30 calendar days after their medical appointment. The broker may consider reimbursement requests beyond 30 calendar days if a client shows good cause as defined in WAC 388-02-0020 for having not requested reimbursement within 30 calendar days.

(3) To be reimbursed for transportation-related services, the requestor must provide the broker with legible copies of:

(a) Itemized receipt(s);

(b) The operator's valid driver's license;

(c) Valid vehicle registration; and

(d) Proof of insurance for the vehicle/operator at the time of the trip.

(4) The agency or the broker may retroactively authorize and reimburse for transportation costs, including meals and lodging when:

(a) A client is approved for a delayed certification period as defined in WAC 182-500-0025, or for a retroactive eligibility period as defined in WAC 182-500-0095, or is retroactively eligible for a medically needy program which requires a spenddown as defined in WAC 182-500-0100;

(b) The transportation costs were not used to meet a client spenddown liability in accordance with WAC 182-519-0110;

(c) The transportation costs for which retroactive reimbursement is requested falls within the period of retroactive eligibility or delayed certification;

(d) The client received medically necessary services that were covered by the client's medical program for the date(s) of service for which retroactive reimbursement is requested; and

(e) The request for retroactive reimbursement is made within 60 calendar days from the date of eligibility notification (award letter), not to exceed eight months from the date(s) of service for which reimbursement is requested.

(5) When transportation cost(s) are retroactively authorized, the reimbursement amount must not exceed the reimbursement amount that would have been authorized prior to the date(s) of service.

(6) To be paid by the broker for nonemergency transportation services:

(a) Ambulance providers must be subcontracted with the broker in accordance with WAC 182-546-5200.

(b) Nonambulance providers must be subcontracted with the broker in accordance with WAC 182-546-5200.

(7) The agency, through its contracted brokers, does not pay for nonemergency transportation when:

(a) The health care service the client is requesting transportation to or from is not a service covered by the client's medical program;

(b) The covered health care service is within three-quarters of a mile from the pick-up point, except when:

(i) The client's documented and verifiable medical condition and personal capabilities demonstrates that the client is not able to walk three-quarters mile distance;

(ii) The trip involves an area that the broker determines is not physically accessible to the client; or

(iii) The trip involves an area that the agency's broker considers to be unsafe for the client, other riders, or the driver.

(c) The client has personal or informal transportation resources that are available and appropriate to the clients' needs;

(d) Fixed-route public transportation service is available to the client within three-quarters of a mile walking distance. Exceptions to this rule may be granted by the transportation broker when the need for more specialized transportation is documented. Examples of such a need may be the client's use of a portable ventilator, a walker, or a quad cane; or

(e) The mode of transport that the client requests is not necessary, suitable, or appropriate to the client's medical condition.

[Statutory Authority: RCW 41.05.021, 41.05.160, 42 C.F.R. §§ 431.53 and 440.170. WSR 23-17-118, § 182-546-6200, filed 8/18/23, effective 9/18/23; WSR 20-05-066, § 182-546-6200, filed 2/14/20, effective 3/16/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-03-050, § 182-546-6200, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-6200, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-6200, filed 7/12/11, effective 8/12/11.]