Chapter 182-552 WAC
RESPIRATORY CARE

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WAC

182-552-0001 Respiratory care—General.
182-552-0005 Respiratory care—Definitions.

CLIENT ELIGIBILITY

182-552-0100 Respiratory care—Client eligibility.
182-552-0150 Respiratory care—Clients residing in skilled nursing facilities, boarding homes, and adult family homes.

PROVIDERS

182-552-0200 Respiratory care—Provider requirements.
182-552-0250 Respiratory care—Proof of delivery.

APNEA MONITORS

182-552-0300 Respiratory care—Covered—Apnea monitors and supplies.

CPAP/BI-LEVEL RAD

182-552-0400 Respiratory care—Continuous positive airway pressure (CPAP) device and supplies.
182-552-0450 Mandibular advancement device.
182-552-0500 Respiratory care—Covered—Bi-level respiratory assist devices and supplies.

AIRWAY CLEARANCE DEVICES

182-552-0600 Respiratory care—Covered—Airway clearance devices.

NEBULIZERS/HUMIDIFIERS/INHALATION DRUGS

182-552-0650 Respiratory care—Covered—Nebulizers, humidifiers, and accessories.
182-552-0700 Respiratory care—Covered—Inhalation drugs and solutions.

OXYGEN AND OXYGEN EQUIPMENT

182-552-0800 Respiratory care—Covered—Oxygen and oxygen equipment.

OXIMETERS

182-552-0900 Respiratory care—Covered—Oximeters.

VENTILATORS

182-552-1000 Covered—Respiratory and ventilator equipment and supplies.

SUCTION PUMPS

182-552-1100 Respiratory care—Covered—Suction pumps and supplies.

NONCOVERED SERVICES

182-552-1200 Respiratory care—Noncovered services.

AUTHORIZATION

182-552-1300 Respiratory care—Authorization.
182-552-1325 Prior authorization.
182-552-1350 Limitation extension (LE).
182-552-1375 Expedited prior authorization (EPA).

REIMBURSEMENT

182-552-1400 Respiratory care—Reimbursement—General.
182-552-1500 Respiratory care equipment and supplies—Reimbursement—Decision to rent or purchase.
182-552-1600 Respiratory care equipment and supplies—Reimbursement—Methodology for purchase, rental, and repair.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-552-001 Scope. [WSR 11-14-075, recodified as § 182-552-001, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-005 Definitions. [WSR 11-14-075, recodified as § 182-552-005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-100 Client eligibility. [WSR 11-14-075, recodified as § 182-552-100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-200 Providers—General responsibilities. [WSR 11-14-075, recodified as § 182-552-200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-210 Required records. [WSR 11-14-075, recodified as § 182-552-210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-220 Requirements for oxygen providers. [WSR 11-14-075, recodified as § 182-552-220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-230 Requirements for infant apnea monitors. [WSR 11-14-075, recodified as § 182-552-230, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-240 Requirements for respiratory care practitioners. [WSR 11-14-075, recodified as § 182-552-240, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-300 Coverage. [WSR 11-14-075, recodified as § 182-552-300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-310 Coverage—Oxygen and oxygen equipment. [WSR 11-14-075, recodified as § 182-552-310, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies. [WSR 11-14-075, recodified as § 182-552-320, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-330 Coverage—Ventilator therapy, equipment, and supplies. [WSR 11-14-075, recodified as § 182-552-330, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-340 Coverage—Infant apnea monitor program. [WSR 11-14-075, recodified as § 182-552-340, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-350 Coverage—Respiratory and ventilator therapy. [WSR 11-14-075, recodified as § 182-552-350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-360 Coverage—Suction pumps and supplies. [WSR 11-14-075, recodified as § 182-552-360, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-370 Coverage—Inhalation drugs and solutions. [WSR 11-14-075, recodified as § 182-552-370, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-380 Coverage—Oximeters. [WSR 11-14-075, recodified as § 182-552-380, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-390 Coverage—Nursing facilities. [WSR 11-14-075, recodified as § 182-552-390, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-400 Reimbursement for covered services. [WSR 11-14-075, recodified as § 182-552-400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-410 Reimbursement methods. [WSR 11-14-075, recodified as § 182-552-410, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

182-552-420 Reimbursement methodology. [WSR 11-14-075, recodified as § 182-552-420, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. WSR 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.] Repealed by WSR 12-14-022, filed 6/25/12, effective 8/1/12. Statutory Authority: RCW 41.05.021.

WAC 182-552-0001 Respiratory care—General. (1) The respiratory care, equipment, and supplies described in this chapter applies to:

(a) Medicaid clients who require respiratory care in their homes, community residential settings, and skilled nursing facilities;

(b) Providers who supply respiratory care to medicaid clients; and

(c) Licensed health care professionals whose scope of practice allows for the provision of respiratory care.

(2) The agency covers the respiratory care listed in this chapter according to the limitations and requirements in this chapter.

(3) The agency pays for respiratory care for medicaid clients when it is:

(a) Covered;

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

(c) Medically necessary, as defined under chapter 182-500 WAC;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant within the scope of their licensure;

(e) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid billing guides and provider alerts;

(f) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid billing guides and provider alerts; and

(g) Provided and used within accepted medical or respiratory care community standards of practice.

(4) The agency does not require prior authorization for requests for covered respiratory care for medicaid clients that meets the clinical criteria set forth in this chapter.

(5) The agency requires prior authorization for covered respiratory care for medicaid clients when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The agency evaluates requests requiring prior authorization on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-552-1300, 182-552-1325, 182-552-1350, and 182-552-1375 for specific details regarding authorization.

(6) The agency evaluates on a case-by-case basis for medical necessity and appropriateness items, procedures, and services that do not have an established procedure code available and which are billed using miscellaneous procedure codes.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 24-21-163, s 182-552-0001, filed 10/23/24, effective 11/23/24. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 431.16 Section 1903 (i)(27) of the Social Security Act. WSR 19-21-087, § 182-552-0001, filed 10/14/19, effective 11/14/19. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0001, filed 6/25/12, effective 8/1/12.]

WAC 182-552-0005 Respiratory care—Definitions. The following definitions and those in chapter 182-500 WAC apply to this chapter.

"Adult family home" - A residential home licensed to care for up to six residents that provides rooms, meals, laundry, supervision, assistance with activities of daily living, and personal care. In addi-

tion to these services, some homes provide nursing or other special care and services.

"Apnea" - The cessation of airflow for at least 10 seconds.

"Apnea-hypopnea index (AHI)" - The average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. For purposes of this chapter, respiratory effort related arousals (RERAs) are not included in the calculation.

"Arterial PaO_2" - Measurement of partial pressure of arterial oxygen.

"Authorized prescriber" - A health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory care equipment, supplies, and services.

"Base year" - As used in this chapter, means the year in which the respiratory care current fee schedule is adopted.

"Bi-level respiratory assist device with backup rate" - A device that allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. In addition, these devices have a timed backup feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

"Bi-level respiratory assist device without backup rate" - A device that allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

"Blood gas study" - For the purposes of this chapter, is either an oximetry test or an arterial blood gas test.

"Boarding home" - Adult residential care (ARC) facility, enhanced adult residential care (EARC) facility, or assisted living (AL) facility.

"Central sleep apnea (CSA)" - Is defined as:

(1) An apnea-hypopnea index (AHI) greater than or equal to five; and

(2) Central apneas/hypopneas greater than 50 percent of the total apneas/hypopneas; and

(3) Central apneas or hypopneas greater than or equal to five times per hour; and

(4) Symptoms of either excessive sleepiness or disrupted sleep.

"Chronic obstructive pulmonary disease (COPD)" - Any disorder that persistently obstructs bronchial airflow. COPD mainly involves two related diseases: Chronic bronchitis and emphysema. Both cause chronic obstruction of air flowing through the airways and in and out of the lungs. The obstruction is generally permanent and worsens over time.

"Complex sleep apnea (CompSA)" - A form of central apnea specifically identified by the persistence or emergence of central apneas or hypopneas, upon exposure to CPAP or a bi-level respiratory assist device without a back-up rate feature, when obstructive events have disappeared. These clients have predominantly obstructive or mixed apneas during the diagnostic sleep study occurring at greater than or equal to five times per hour. With use of a CPAP or bi-level respiratory assist device without a back-up rate feature, the client shows a pattern

of apneas and hypopneas that meets the definition of central sleep apnea (CSA).

"Continuous positive airway pressure (CPAP)" - A single-level device which delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and an interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

"Dependent edema" - Fluid in the tissues, usually ankles, wrists, and the arms.

"Emergency oxygen" - The immediate, short-term administration of oxygen to a client who normally does not receive oxygen but is experiencing an acute episode which requires oxygen.

"Erythrocythemia" - More hematocrit (red blood cells) than normal.

"FIO_2" - The fractional concentration of oxygen delivered to the client for inspiration. For the purpose of this policy, the client's prescribed FIO_2 refers to the oxygen concentration the client normally breathes when not undergoing testing to qualify for coverage of a respiratory assist device (RAD). That is, if the client does not normally use supplemental oxygen, their prescribed FIO_2 is that found in room air.

"FEV1" - The forced expired volume in one second.

"FVC" - The forced vital capacity.

"Group I" - Clinical criteria, set by medicare, to identify clients requiring oxygen. The agency follows the Group I clinical criteria listed in the Centers for Medicare and Medicaid Services National Coverage Determination for Home Use of Oxygen, which is found in the Medicare Coverage Database.

"Group II" - Clinical criteria, set by medicare, to identify clients who require oxygen. Their blood oxygen levels may be within normal range, however, they have complicating conditions that require supplemental oxygen use. The agency follows the Group II clinical criteria listed in the Centers for Medicare and Medicaid Services National Coverage Determination for Home Use of Oxygen, which is found in the Medicare Coverage Database.

"Group III" – Clients for whom intermittent home oxygen therapy is considered medically necessary to treat cluster headaches. These clients also have a documented clinical history that includes all of the following:

• At least five attacks of severe, strictly unilateral pain that is orbital, supraorbital, temporal, or in any combination of these sites, lasting 15 to 180 minutes, and occurring at least once every other day up to eight times a day;

• At least one of the following symptoms or signs, ipsilateral to the headache:

- Conjunctival injection and/or lacrimation;
- Nasal congestion and/or rhinorrhea;
- Eyelid edema;
- Forehead and facial sweating; or
- Miosis and/or ptosis;

• Occurring with a frequency at least once every other day up to eight times per day;

• Not better accounted for by another ICHD-3 diagnosis;

• Prevents ability to function in all activities; and

• Other treatment has failed.

"Home and community residential settings" - In-home, adult family home, or boarding home.

"Hypopnea" - A temporary reduction of airflow lasting at least 10 seconds and accompanied with a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent decrease in oxygen saturation. The AHI is the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device.

"Hypoxemia" - Less than normal level of oxygen in the blood.

"Maximum allowable" - The maximum dollar amount the medicaid agency reimburses a provider for a specific service, supply, or piece of equipment.

"Month" - For the purposes of this chapter, means 30 days.

"Nebulizer" - A medical device which administers drugs for inhalation therapy for clients with respiratory conditions such as asthma or emphysema.

"Obstructive sleep apnea (OSA)" - This syndrome refers to the interruption of breathing during sleep, due to obstructive tissue in the upper airway that collapses into the air passage with respiration.

"Oxygen" - Medical grade liquid or gaseous oxygen.

"Oxygen concentrator" - A medical device that removes nitrogen from room air and retains almost pure oxygen (87 percent to 95 percent) for delivery to a client.

"Oxygen system" - All equipment necessary to provide oxygen to a client.

"Portable oxygen system" - A system which allows the client to be independent of the stationary system for several hours, thereby providing mobility for the client.

"Pulmonary hypertension" - High blood pressure in the vessels that feed through the lungs, causing the right side of the heart to work harder to oxygenate blood.

"Respiratory care" - The care of a client with respiratory needs and all related equipment, oxygen, services, and supplies.

"Respiratory care practitioner" - A person licensed by the department of health according to chapter 18.89 RCW and chapter 246-928 WAC as a respiratory therapist (RT) or respiratory care practitioner (RCP).

"Respiratory effort related arousals (RERA)" - These occur when there is a sequence of breaths that lasts at least 10 seconds, characterized by increasing respiratory effort or flattening of the nasal pressure waveform, which lead to an arousal from sleep. However, they do not meet the criteria of an apnea or hypopnea.

"Restrictive thoracic disorders" - This refers to a variety of neuromuscular and anatomical anomalies of the chest/rib cage area that may result in hypoventilation, particularly while the client sleeps at night.

"Reasonable useful lifetime (RUL)" - For 36 month capped oxygen equipment, the RUL is five years. The RUL is not based on the chronological age of the equipment. It starts on the initial date of the rental and runs for five years from that date.

"Stationary oxygen system" - Equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-14-064, § 182-552-0005, filed 6/28/23, effective 8/1/23. Statutory Authority:

RCW 41.05.021. WSR 12-14-022, § 182-552-0005, filed 6/25/12, effective 8/1/12.]

CLIENT ELIGIBILITY

WAC 182-552-0100 Respiratory care—Client eligibility. (1) To receive respiratory care, a person must be eligible for one of the Washington apple health programs listed in the table in WAC 182-501-0060 or be eligible for the alien emergency medical (AEM) program (as described in WAC 182-507-0110).

(2) Persons who are enrolled in an agency-contracted managed care organization (MCO) must arrange for all respiratory care directly through his or her MCO.

(3) For persons residing in skilled nursing facilities, boarding homes, and adult family homes, see WAC 182-552-0150.

(4) Persons who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for respiratory care.

[Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-552-0100, filed 3/12/14, effective 4/12/14. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0100, filed 6/25/12, effective 8/1/12.]

WAC 182-552-0150 Respiratory care—Clients residing in skilled nursing facilities, boarding homes, and adult family homes. For eligible clients who reside in skilled nursing facilities, boarding homes, and adult family homes:

(1) The medicaid agency pays, according to the requirements in this chapter, for the chronic use of medically necessary respiratory care.

(2) The medicaid agency does not pay separately for the following:

(a) Emergency oxygen equipment and supplies; and

(b) Licensed respiratory care staff.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0150, filed 6/25/12, effective 8/1/12.]

PROVIDERS

WAC 182-552-0200 Respiratory care—Provider requirements. (1) To receive payment for respiratory care equipment and supplies under this chapter, a provider must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Obtain prior authorization from the medicaid agency, if required, before delivery to the client and before billing the agency;

(c) Keep initial and subsequent prescriptions according to the requirements within this chapter;

(d) Provide instructions to the client and/or caregiver on the safe and proper use of equipment provided;

(e) Have a licensed health care professional whose scope of practice allows for the provision of respiratory care. The licensed health care professional must also:

(i) Check equipment and ensure equipment settings continue to meet the client's needs; and

(ii) Communicate with the client's authorized prescriber if there are any concerns or recommendations.

(f) Verify that the client has a valid prescription.

(i) To be valid, a prescription must:

(A) Be written, and signed and dated by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC); and

(B) State the specific items or services requested, including the quantity, frequency, and duration/length of need. Prescriptions that only state "as needed" or "PRN" are not sufficient; and

(C) For an initial prescription, not be older than three months from the date the prescriber signed the prescription; or

(D) For subsequent prescriptions, not be older than one year from the date the initial prescription was signed. (See WAC 182-552-0800 for exceptions.)

(2) The medicaid agency does not pay for respiratory care equipment and/or supplies furnished to the agency's clients when:

(a) The authorized prescriber who provides medical justification to the agency for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The authorized prescriber who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of respiratory care equipment, supplies, and related items.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-14-064, § 182-552-0200, filed 6/28/23, effective 8/1/23. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0200, filed 6/25/12, effective 8/1/12.]

WAC 182-552-0250 Respiratory care—Proof of delivery. (1) When a provider delivers equipment directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the medicaid agency requests that information.

(2) The medicaid agency requires the proof of delivery to:

(a) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client); and

(b) Include the client's name and a detailed description of the item(s) delivered, including the quantity, brand name, and serial number.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0250, filed 6/25/12, effective 8/1/12.]

APNEA MONITORS

WAC 182-552-0300 Respiratory care—Covered—Apnea monitors and supplies. (1) The medicaid agency covers, without prior authorization, the rental of an apnea monitor (cardiorespiratory monitor) with recording feature for a maximum of six months when:

(a) The client is less than one year of age and meets at least one of the following clinical criteria:

(i) Born less than thirty-seven weeks gestation, and the infant is not more than forty-three weeks corrected gestational age;

(ii) Had an apparent life-threatening apneic event (defined as requiring mouth-to-mouth resuscitation or vigorous stimulation);

(iii) Has been diagnosed with bradycardia and is being treated with caffeine, theophylline, or other stimulating agents;

(iv) Has documented gastro-esophageal reflux which results in apnea, bradycardia, or oxygen desaturation;

(v) Has documented apnea greater than twenty seconds in duration;

(vi) Has apnea for periods less than twenty seconds in duration and accompanied by bradycardia, cyanosis, or pallor;

(vii) Has bradycardia (defined as heart rate less than one hundred beats per minute);

(viii) Has oxygen desaturation below ninety percent;

(ix) Has neurologic/anatomic/metabolic or respiratory diseases affecting respiratory drive; or

(x) Is a subsequent sibling of an infant who died of sudden infant death syndrome (SIDS), until the client is one month older than the age at which the earlier sibling died and the client remains event-free; and

(b) The vendor has a licensed clinician with competency in pediatric respiratory care responsible for management of the client's apnea monitoring.

(2) For each subsequent rental period, the client must continue to meet the clinical criteria in subsection (1) of this section and the vendor must obtain prior authorization from the medicaid agency.

(3) Documentation of the result of the use of an apnea monitor must be kept in the client's record.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0300, filed 6/25/12, effective 8/1/12.]

CPAP/BI-LEVEL RAD

WAC 182-552-0400 Respiratory care—Continuous positive airway pressure (CPAP) device and supplies. (1) The medicaid agency covers, without prior authorization, one continuous positive airway pressure (CPAP) device including related supplies, per client, every five years. The CPAP device must have a data card and the client must meet the following clinical criteria:

(a) The client is diagnosed with obstructive sleep apnea (OSA) using a clinical evaluation and a positive attended polysomnogram

(PSG) performed in a sleep laboratory or an unattended home sleep test; and

(b) For clients age twenty-one and older:

(i) The client's polysomnogram or home sleep test demonstrates an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to fifteen events per hour; or

(ii) The client's polysomnogram or home sleep test demonstrates the AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with clinical documentation of:

(A) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or

(B) Hypertension, ischemic heart disease, or history of stroke.

(c) For clients age twenty and younger, the clinical criteria is considered met when there is a documented diagnosis of OSA and polysomnography demonstrates an apnea index (AI) or AHI equal to or greater than one and:

(i) Adenotonsillectomy has been unsuccessful in relieving OSA; or

(ii) Adenotonsillar tissue is minimal; or

(iii) Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (e.g., craniofacial anomaly, obesity) or adenotonsillectomy is contraindicated; or

(iv) Family does not wish to pursue surgical intervention.

(2) If a client meets the criteria in subsection (1) of this section but a CPAP device has been tried and proven ineffective, the medicaid agency will cover a bi-level respiratory assist device (RAD) without the back-up rate. Ineffective, in this case, is defined as documented failure to meet therapeutic goals using a CPAP during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure setting).

(3) The AHI is calculated on the average number of events per hour. If the AHI is calculated based on less than two hours of sleep, the total number of recorded events used to calculate the AHI must be at least the number of events that would have been required in a two-hour period (i.e., must reach greater than or equal to thirty events without symptoms or greater than or equal to ten events with symptoms). The medicaid agency pays for an initial three-month rental period for CPAP devices.

(4) The medicaid agency purchases a CPAP device after the three-month rental period when the following documentation of clinical benefit is recorded in the client's file:

(a) A face-to-face clinical reevaluation of the client by the authorized prescriber which documents that symptoms of obstructive sleep apnea are improved; and

(b) A review of objective evidence by the authorized prescriber of the client's adherence to use of the CPAP device. Adherence is defined as use of the CPAP device greater than or equal to four hours per night on seventy percent of nights during a consecutive thirty-day period anytime during the first three months of initial usage.

(5) The medicaid agency does not pay for a CPAP device when the client is diagnosed with upper airway resistance syndrome (UARS).

(6) The medicaid agency pays for the purchase of a heated humidifier for a CPAP device, once every five years from the date the item was deemed purchased, per client.

(7) Replacement of CPAP device.

(a) The medicaid agency requires prior authorization for the replacement of a CPAP device if the client has had the device for less than five years.

(b) After five years, the client must have a face-to-face evaluation with the treating authorized prescriber that documents that the client continues to use and benefit from the device. The medicaid agency does not require a new PSG (sleep test), trial period, or prior authorization.

(c) Replacement supplies - The medicaid agency pays for replacement supplies for a CPAP device as follows:

(i) Full face mask, limit one every six months;

(ii) Face mask interface for full face mask, limit one every three months;

(iii) Nasal interface (mask or cannula type), with or without head strap, limit one every six months;

(iv) Cushion for use on nasal mask interface, limit one every three months;

(v) Pillow for use on nasal cannula type interface, limit one pair every three months;

(vi) Headgear, chin strap, and tubing with or without integrated heating element, limit one every six months;

(vii) Filters - Disposable, limit two every thirty days;

(viii) Filters - Nondisposable, limit one every six months; and

(ix) Water chamber for humidifier, limit one every six months.

(d) Prior authorization is required if the client does not meet the clinical criteria in this section or if the medicaid agency has purchased a bi-level respiratory assist device for the client within the last five years.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-20-057, § 182-552-0400, filed 10/1/15, effective 11/1/15. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0400, filed 6/25/12, effective 8/1/12.]

WAC 182-552-0450 Mandibular advancement device. The agency covers the purchase of a mandibular advancement device for a client when the provider determines that the use of a continuous positive airway pressure (CPAP) device is medically contraindicated or the client cannot medically tolerate a CPAP device. Prior authorization is required for all eligible clients.

(1) The agency considers a mandibular advancement device to be medical equipment subject to the same billing requirements, restrictions, and limitations as other medical equipment according to chapter 182-543 WAC.

(2) For clients:

(a) Who have natural dentition, the agency pays for one custom-made mandibular advancement device every five years. The client must:

(i) Complete a face-to-face evaluation with a sleep medicine physician in an agency-designated center of excellence (COE) prior to sleep testing;

(ii) Be diagnosed with obstructive sleep apnea (OSA) using a clinical evaluation and positive attended polysomnogram (PSG); and

(iii) Meet the sleep testing criteria described in WAC 182-552-0400.

(b) Age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(3) The prescriber must keep the following in the client's record:

(a) Documentation of a CPAP trial lasting at least six consecutive months; and

(b) A description of why CPAP failed or an explanation of why CPAP is not the appropriate treatment.

(4) The mandibular advancement device must be titrated by a licensed provider who has documented experience in titrating these devices.

(5) The mandibular advancement device must be provided and billed by a licensed dentist who:

(a) Holds a certification in dental sleep medicine from the American Board of Dental Sleep Medicine (ABDSM); or

(b) Is the dental director of a dental sleep medicine facility accredited by the ABDSM; or

(c) Has completed agency-recognized continuing education in dental sleep medicine provided by the ABDSM or a comparable organization within the two years prior to providing the mandibular advancement device.

(6) The agency evaluates requests for authorization for mandibular advancement devices that exceed the limitations in this section on a case-by-case basis in accordance with WAC 182-501-0169.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-21-142, s 182-552-0450, filed 10/21/25, effective 11/21/25; WSR 19-18-049, § 182-552-0450, filed 8/30/19, effective 10/1/19.]

WAC 182-552-0500 Respiratory care—Covered—Bi-level respiratory assist devices and supplies. (1) The medicaid agency covers, without prior authorization, one bi-level respiratory assist device (RAD), with or without a back-up rate feature, per client every five years. The client must have a clinical disorder characterized as one of the following and meet the clinical criteria for the specific condition as listed in subsections (2) through (5) of this section.

(a) Restrictive thoracic disorders (e.g., neuromuscular diseases or severe thoracic cage abnormalities); or

(b) Severe chronic obstructive pulmonary disease (COPD); or

(c) Central sleep apnea or complex sleep apnea; or

(d) Hypoventilation syndrome.

(2) Restrictive thoracic disorders - The medicaid agency pays for, without prior authorization, a bi-level RAD either with or without the back-up rate feature, when all of the following clinical criteria are met:

(a) The client has been diagnosed with a neuromuscular disease (e.g., amyotrophic lateral sclerosis (ALS)) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for tuberculosis); and

(b) Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the individual's pulmonary limitation; and

(c) One or more of the following criteria are met:

(i) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2 (fractionated inspired oxygen concentration) is greater than or equal to forty-five mm Hg; or

(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum record time of two hours), done while breathing the client's prescribed recommended FIO_2; or

(iii) For a neuromuscular disease (only), either of the following:

(A) Maximal inspiratory pressure is less than sixty cm H_2O; or

(B) Forced vital capacity is less than or equal to fifty percent predicted.

(3) Severe chronic obstructive pulmonary disease (COPD).

(a) The medicaid agency pays, without prior authorization, for a bi-level RAD, without the back-up rate feature, when all of the following clinical criteria are met:

(i) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is greater than or equal to fifty-two mm Hg; and

(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at two LPM or the client's prescribed FIO_2, whichever is higher; and

(iii) Prior to initiating therapy, obstructive sleep apnea and treatment with CPAP has been considered and ruled out.

(b) The medicaid agency pays, without prior authorization, for a bi-level RAD, with the back-up rate feature, for clients with COPD who qualified for a bi-level RAD under (3)(a) of this section when:

(i) Started any time after a period of initial use of the bi-level RAD without the back-up rate feature when both of the following clinical criteria are met:

(A) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, shows that the client's $PaCO_2$ worsens greater than or equal to seven mm Hg compared to the original result from criterion in subsection (3)(a)(i) of this section; and

(B) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours) while using a bi-level RAD without the back-up rate feature that is not caused by obstructive upper airway events, i.e., AHI less than five; or

(ii) Started at a time no sooner than sixty-one days after initial issue of the bi-level RAD without the back-up rate feature, when both of the following clinical criteria are met:

(A) An arterial blood gas $PaCO_2$ is done while awake and breathing the client's prescribed FIO_2, still remains greater than or equal to fifty-two mm Hg; and

(B) Sleep oximetry while breathing with the bi-level RAD without back-up rate feature, demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at two LPM or the client's prescribed FIO_2, whichever is higher.

(4) Central sleep apnea or complex sleep apnea (i.e., not due to airway obstruction). The medicaid agency pays for, without prior authorization, a bi-level RAD with or without the back-up rate feature, when the client's polysomnogram test reveal all of the following:

(a) The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA);

(b) Significant improvement of the sleep-associated hypoventilation with the use of a bi-level RAD with or without the back-up rate feature on the settings that will be prescribed for initial use at home, while breathing the client's prescribed FIO_2.

(5) Hypoventilation syndrome.

(a) The medicaid agency pays for, without prior authorization, a bi-level RAD without the back-up rate feature, when the clinical criteria in (a)(i) and (ii) of this subsection, or either (a)(iii) or (iv) of this subsection are met:

(i) An initial arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is greater than or equal to forty-five mm Hg; and

(ii) Spirometry shows an FEV1/FVC greater or equal to seventy percent and an FEV1 greater than or equal to fifty percent of predicted; or

(iii) An arterial blood gas $PaCO_2$, done during sleep or immediately upon awakening, and breathing the client's prescribed FIO_2, shows the client's $PaCO_2$ worsened greater than or equal to seven mm Hg compared to the original result in (a) of this subsection; or

(iv) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five continuous minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events, i.e., AHI less than five.

(b) The medicaid agency pays for, without prior authorization, a bi-level RAD with the back-up rate feature, when the clinical criteria in (b)(i) and (ii) of this subsection, and either (b)(iii) or (iv) of this subsection are met:

(i) A covered bi-level RAD without the back-up rate feature is being used; and

(ii) Spirometry shows an FEV1/FVC greater than or equal to seventy percent and an FEV1 greater than or equal to fifty percent of predicted; and

(iii) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, shows that the client's $PaCO_2$ worsens greater than or equal to seven mm Hg compared to the ABG result performed to qualify the client for the bi-level RAD without the back-up rate feature; or

(iv) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five continuous minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events, i.e., AHI less than five while using a bi-level RAD without the back-up rate feature.

(6) For a bi-level RAD without the back-up rate feature, the medicaid agency pays as follows:

(a) An initial three-month rental period. In accordance with medicare's guidelines, the medicaid agency requires a face-to-face clinical reevaluation of the client by the treating authorized prescriber, between day thirty-one and day ninety-one of the rental period, which documents the following in the client's file to continue rental:

(i) The progress of the client's relevant symptoms; and

(ii) The client's compliance with using the device.

(b) Purchases after the requirements of (a) of this subsection are met.

(7) For a bi-level RAD with the back-up rate feature used with:

(a) An invasive interface, the medicaid agency pays for the rental only.

(b) A noninvasive interface, the medicaid agency pays as follows:

(i) An initial three-month rental period. In accordance with medicare's guidelines, the medicaid agency requires a face-to-face clinical reevaluation of the client by the treating authorized prescriber, between day thirty-one and day ninety-one of the rental period, which documents the following in the client's file to continue rental:

(ii) The progress of the client's relevant symptoms; and

(iii) The client's compliance with using the device.

(iv) Purchase after a total of thirteen months of rental.

(8) Prior authorization is required if the client does not meet the clinical criteria in this section or if the medicaid agency has purchased a CPAP device or other respiratory assist device for the client within the last five years.

(9) Replacement of bi-level RAD. The medicaid agency's policy for replacement of a bi-level RAD is the same as for a CPAP device. See WAC 182-552-0400(6).

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0500, filed 6/25/12, effective 8/1/12.]

AIRWAY CLEARANCE DEVICES

WAC 182-552-0600 Respiratory care—Covered—Airway clearance devices. Chest physiotherapy (CPT), which is also known as percussion and postural drainage (P/PD), is traditionally seen as the standard of care of secretion clearance methods. There are client instances when conventional manual CPT is unavailable, ineffective, or not tolerated. The medicaid agency then covers the following types of airway clearance devices when medically necessary for an individual with a diagnosis that is characterized by excessive mucus production and difficulty clearing secretions:

(1) Mechanical percussors. One per client, per lifetime;

(2) Oscillatory positive expiratory pressure devices. One per client every one hundred and eighty days;

(3) Positive expiratory pressure devices. Requires prior authorization (PA);

(4) Cough stimulating device, alternating positive and negative airway pressure. Requires PA; and

(5) High frequency chest wall oscillation air-pulse generator system. Requires PA.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0600, filed 6/25/12, effective 8/1/12.]

NEBULIZERS/HUMIDIFIERS/INHALATION DRUGS

WAC 182-552-0650 Respiratory care—Covered—Nebulizers, humidifiers, and accessories. (1) The medicaid agency covers, without prior authorization, the purchase of a nebulizer and related compressor, with limits, when the following medicare clinical criteria are met.

(a) Small volume nebulizer and related compressor for the administration of inhalation drugs for:

(i) The management of obstructive pulmonary disease;

(ii) A client with cystic fibrosis or bronchiectasis;

(iii) A client with HIV, pneumocystosis, or complications of organ transplants; or

(iv) Persistent, thick, or tenacious pulmonary secretions.

(b) Large volume nebulizer and related compressor to deliver humidity to a client with thick, tenacious secretions and who has one or more of the following:

(i) Cystic fibrosis;

(ii) Bronchiectasis;

(iii) A tracheostomy; or

(iv) A tracheobronchial stent.

(c) Filtered nebulizer when necessary to administer pentamidine to clients with HIV, pneumocystosis, or complications of organ transplants.

(2) The medicaid agency limits payments, per client, as follows:

(a) Compressor - One every five years. Requires thirteen months rental first. After thirteen months, the compressor is considered purchased.

(b) Nebulizer with compressor - One every five years. Reimbursement includes instruction on the proper use and cleaning of the equipment.

(3) The medicaid agency pays separately for medically necessary accessories as follows:

(a) Administration set. Purchase only.

(i) With small volume filtered or nonfiltered pneumatic nebulizer, disposable. Limited to one per client every thirty days.

(ii) With small volume nonfiltered pneumatic nebulizer, nondisposable. Limited to one per client every six months.

(b) Aerosol mask, used with nebulizer. Purchase only. Limited to one per client every thirty days.

(c) Corrugated tubing, used with large volume nebulizer. Purchase only.

(i) Disposable, limited to one unit (one hundred feet) per client every sixty days.

(ii) Nondisposable, limited to one unit (ten feet) per client every twelve months.

(d) Face tent. Purchase only. Limited to one per client every thirty days.

(e) Filter. Purchase only.

(i) Disposable, limited to two per client every thirty days.

(ii) Nondisposable, limited to one per client every ninety days.

(f) Large volume nebulizer, disposable, unfilled, used with aerosol compressor. Limited to ten per client every thirty days.

(g) Small volume nonfiltered pneumatic nebulizer, disposable. Purchase only. Limited to two per client every thirty days.

(h) Tracheostomy mask, each. Purchase only. Limited to four per client every thirty days.

(i) Heated humidifier with temperature monitor and alarm for clients who have a tracheostomy but who are not ventilator dependent. Monthly rental only. Prior authorization is required.

(j) Water collection device, used with large volume nebulizer. Purchase only. Limited to eight per client every thirty days.

(k) Water, distilled, used with large volume nebulizer, 1000 ml. Limited to fifty units per client every thirty days.

(l) Immersion external heater for a nebulizer. Purchase only. Prior authorization is required.

(4) Providers must monitor the amount of supplies and accessories a client is actually using and assure that the client has nearly exhausted the supply on hand prior to dispensing any additional items.

(5) The medicaid agency does not pay for a large volume nebulizer, related compressor/generator, and water or saline when used predominantly to provide room humidification.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0650, filed 6/25/12, effective 8/1/12.]

WAC 182-552-0700 Respiratory care—Covered—Inhalation drugs and solutions. Inhalation drugs and solutions are included in the medicaid agency's prescription drug program. Refer to chapter 182-530 WAC.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0700, filed 6/25/12, effective 8/1/12.]

OXYGEN AND OXYGEN EQUIPMENT

WAC 182-552-0800 Respiratory care—Covered—Oxygen and oxygen equipment. (1) The medicaid agency covers oxygen and oxygen equipment as provided in this chapter.

(2) The agency pays for the rental of a stationary oxygen system and/or a portable oxygen system, as follows:

(a) For clients, age 20 and younger, when prescribed by the client's treating practitioner; or

(b) For clients, age 21 and older, when prescribed by a practitioner and the client meets:

(i) Medicare's Group I or Group II clinical criteria; or

(ii) The Group III clinical criteria described in WAC 182-552-0005.

(c) If a client age 21 and older does not meet the clinical criteria in this subsection, prior authorization is required. The agency reviews requests for prior authorization under WAC 182-501-0165.

(3) Oxygen and oxygen equipment - Capped rental:

(a) Capped rental applies to in-home oxygen use only;

(b) The medicaid agency's payment for stationary oxygen system equipment and/or portable oxygen system equipment is limited to 36-monthly rental payments. During the rental period, the medicaid agency's payment includes any supplies, accessories, oxygen contents, delivery and associated costs, instructions, maintenance, servicing, and repairs;

(c) Oxygen systems are deemed capped rental (provider continues to own the equipment) after 36 months.

(i) The supplier who provides the oxygen equipment for the first month must continue to provide any necessary oxygen equipment and related items and services through the 36-month rental period unless one of the exceptions in (e) of this subsection is met.

(ii) The same provider is required to continue to provide the client with properly functioning oxygen equipment (including maintenance and repair), and associated supplies for the remaining 24 months of the equipment's reasonable useful lifetime (RUL).

(iii) The same provider may bill the medicaid agency for oxygen contents, disposable supplies, and maintenance fees only. Maintenance fee payment is limited to one every six months.

(d) At any time after the end of the five-year RUL for the oxygen equipment, the provider may replace the equipment, thus beginning a new 36-month rental period.

(e) A 36-month rental period may restart before the end of the five-year RUL in the following situations only. Providers must follow the medicaid agency's expedited prior authorization process, see WAC 182-552-1300, Respiratory care——Authorization.

(i) The initial provider is no longer providing oxygen equipment or services;

(ii) The initial provider's core provider agreement with the medicaid agency is terminated or expires;

(iii) The client moves to an area which is not part of the provider's service area (this applies to medicaid only clients);

(iv) The client moves into a permanent residential setting; or

(v) The pediatric client is transferred to an adult provider.

(f) The medicaid agency may restart the 36-month rental period when equipment is replaced under WAC 182-501-0050(7). Providers must obtain prior authorization from the medicaid agency.

(4) Stationary oxygen systems/contents.

(a) The medicaid agency pays a maximum of one rental payment for stationary oxygen systems including contents, per client, every 30 days. The medicaid agency considers a stationary oxygen system as one of the following:

(i) Compressed gaseous oxygen;

(ii) Stationary liquid oxygen; or

(iii) A concentrator.

(b) Contents only: The medicaid agency pays a maximum of one payment for stationary oxygen contents, per client, every 30 days, when the client owns the stationary oxygen system or the capped monthly rental period is met.

(c) Maintenance: The medicaid agency pays for one maintenance fee of 50 percent of the monthly rental rate for a stationary oxygen concentrator and oxygen transfilling equipment every six months only when the capped rental period is met or the client owns the stationary oxygen concentrator.

(5) Portable oxygen systems/oxygen contents:

(a) The medicaid agency pays a maximum of one rental payment for portable oxygen systems including oxygen contents, per client, every 30 days. The medicaid agency considers a portable oxygen system to be either gas or liquid.

(b) Contents only: The medicaid agency pays a maximum of one payment for portable oxygen contents, per client, every 30 days, when the client owns the portable oxygen system or when the capped monthly rental period is met.

(c) Maintenance: The medicaid agency pays for one maintenance fee of 50 percent of the monthly rental rate for a portable oxygen concentrator and oxygen transfilling equipment every six months only when the capped rental period is met or the client owns the portable oxygen concentrator.

(6) The medicaid agency does not pay for oxygen therapy and related services, equipment or supplies for clients 21 years of age and older, with, but not limited to, the following conditions:

(a) Angina pectoris in the absence of hypoxemia;

(b) Dyspnea without cor pulmonale or evidence of hypoxemia; and

(c) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia.

(7) The medicaid agency does not pay separately for humidifiers with rented oxygen equipment. All accessories, such as humidifiers necessary for the effective use of oxygen equipment are included in the monthly rental payment.

(8) The medicaid agency does not pay separately for spare tanks of oxygen and related supplies as backup or for travel.

(9) The medicaid agency requires a valid prescription for oxygen in accordance with WAC 182-552-200.

(a) For both initial and ongoing prescriptions for the use of oxygen, the medicaid agency requires documented verification that oxygen saturations or lab values substantiate the need for continued oxygen use for each client.

(b) The medicaid agency does not accept lifetime certificates of medical need (CMNs).

(10) The medicaid agency requires that documentation of oxygen saturation and lab values taken to substantiate the medical necessity of continued oxygen be kept in the client's record.

(11) Oxygen supplies - Replacement. The medicaid agency pays for replacement oxygen supplies after the 36 month capped rental period or if the client owns the equipment as follows:

(a) Nasal cannula, limited to two per client every 30 days;

(b) Tubing (oxygen), limited to one replacement per client every 30 days; and

(c) Variable concentration mask, limited to two per client every 30 days.

(12) See WAC 182-552-1200, Respiratory care——Noncovered services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-14-064, § 182-552-0800, filed 6/28/23, effective 8/1/23. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0800, filed 6/25/12, effective 8/1/12.]

OXIMETERS

WAC 182-552-0900 Respiratory care——Covered——Oximeters. (1) The medicaid agency covers the purchase of oximeters for clients eighteen years of age and older with prior authorization as follows:

(a) One standard oximeter, per client, every twenty-four months; or

(b) One enhanced oximeter, per client, every thirty-six months.

(2) The medicaid agency covers the purchase of oximeters for clients seventeen years of age and younger, in the home, as follows:

(a) When the client meets one of the following clinical criteria:

(i) Has chronic lung disease and is on supplemental oxygen;

(ii) Has a compromised or artificial airway; or

(iii) Has chronic lung disease requiring ventilator or bi-level respiratory assist device; and

(b) The following limitations apply:

(i) One standard oximeter, per client, every twenty-four months, without prior authorization; or

(ii) One enhanced oximeter, per client, every thirty-six months, with expedited prior authorization.

(3) The medicaid agency pays for replacement supplies as follows:

(a) Cables for enhanced oximeter only, limited to two per client per year. Prior authorization (PA) is required.

(b) Probes.

(i) Nondisposable, limited to one per client every one hundred eighty days.

(ii) Disposable, limited to four per client every thirty days.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0900, filed 6/25/12, effective 8/1/12.]

VENTILATORS

WAC 182-552-1000 Covered—Respiratory and ventilator equipment and supplies. (1) The medicaid agency covers the rental of a ventilator, equipment, and disposable ventilator supplies when the client requires periodic or continuous mechanical ventilation for the treatment of chronic respiratory failure resulting from hypoxemia or hypercapnia.

(2) The agency's payment for the monthly rental includes ventilator maintenance and accessories including, but not limited to, humidifiers, nebulizers, alarms, temperature probes, batteries, chargers, adapters, connectors, fittings, tubing, disposable circuits, and filters. The agency does not pay separately for ventilator accessories unless the client owns the ventilator system, see subsection (5) of this section.

(3) To receive payment, ventilators, equipment, and related disposable supplies must:

(a) Be used exclusively by the client for whom it is requested;

(b) Be FDA-approved; and

(c) Not be included in any other reimbursement methodology such as, but not limited to, a diagnosis-related group (DRG).

(4) The agency pays for a back-up (secondary) ventilator at fifty percent of the monthly rental rate when one or more of the following clinical criteria are met:

(a) The client cannot maintain spontaneous or adequate ventilations for four or more consecutive hours;

(b) The client lives in an area where a replacement ventilator cannot be provided within two hours;

(c) The client requires mechanical ventilation during mobility as prescribed in their plan of care.

(5) The agency pays for the purchase of the following replacement ventilator accessories only for client-owned ventilator systems:

(a) Gel-cell battery charger - One every twenty-four months;

(b) Gel-cell heavy-duty battery - One every twenty-four months;

(c) Battery cables - Once every twenty-four months; and

(d) Breathing circuits - Four every thirty days.

(6) All ventilators require expedited prior authorization (EPA), as described in WAC 182-552-1375.

(a) At the time of authorization, the following information must be documented in the client's record and made available to the agency upon request:

(i) Medical history, unless request is for continuation of services;

(ii) Diagnosis and degree of impairment;

(iii) Degree of ventilatory support required; and

(iv) Ventilator settings and parameters including mode and type of ventilator ordered at the time of the authorization.

(b) If the client has no clinical potential for being weaned from ventilatory support, the EPA is valid for twelve months;

(c) If the client has the potential to be weaned, the EPA is valid for six months.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-14-081, § 182-552-1000, filed 7/2/18, effective 8/2/18. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1000, filed 6/25/12, effective 8/1/12.]

SUCTION PUMPS

WAC 182-552-1100 Respiratory care—Covered—Suction pumps and supplies. (1) The medicaid agency covers suction pumps and supplies when medically necessary for airway clearance or tracheostomy suctioning.

(2) The medicaid agency pays for a maximum of two suction devices per client in a five-year period as follows:

(a) The medicaid agency rents one primary suction device (stationary or portable) per client, for use in the home and one secondary suction device, per client, for backup or portability.

(b) The medicaid agency considers the suction devices purchased after twelve months rental.

(3) The medicaid agency pays for supplies for suction devices as follows:

(a) Catheter - Closed system. Limit one per day per client.

(b) Catheter - Any type other than closed system:

(i) Clients eight years of age and older, one hundred fifty per client, every thirty days;

(ii) Clients seven years of age and younger, three hundred per client, every thirty days.

(c) Oropharyngeal suction catheter, limited to four per client every thirty days.

(d) Canister - Disposable:

(i) Limited to five per client every thirty days for primary suction device;

(ii) Limited to five per client every thirty days for secondary suction device.

(e) Canister - Nondisposable. Limited to one per client every twelve months.

(f) Tubing. Limited to fifteen per client every thirty days.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1100, filed 6/25/12, effective 8/1/12.]

NONCOVERED SERVICES

WAC 182-552-1200 Respiratory care—Noncovered services. (1) The medicaid agency pays for respiratory care only when listed as covered in this chapter. In addition to the noncovered services found in WAC 182-501-0070, the medicaid agency does not cover:

(a) Emergency or stand-by oxygen systems;

(b) Portable nebulizers;

(c) Kits and concentrates for use in cleaning respiratory equipment;

(d) Intrapulmonary percussive ventilation systems and related accessories;

(e) Batteries for a CPAP;

(f) Items or services which primarily serve as a convenience for the client or caregiver;

(g) Oximetry checks;

(h) Loaner equipment.

(2) The medicaid agency evaluates a request for respiratory care listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1200, filed 6/25/12, effective 8/1/12.]

AUTHORIZATION

WAC 182-552-1300 Respiratory care—Authorization. (1) The medicaid agency requires providers to obtain authorization for covered respiratory care as required in this chapter, chapters 182-501 and 182-502 WAC, and in published agency medicaid provider guides and/or provider notices or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the medicaid agency as specified in the agency's published respiratory care medicaid provider guide.

(b) For expedited prior authorization (EPA), a provider must document that the client has met the clinically appropriate EPA criteria outlined in the medicaid provider guide. The appropriate EPA number must be used when the provider bills the medicaid agency.

(c) Upon request, a provider must provide documentation to the medicaid agency showing how the client's condition met the criteria for PA or EPA.

(2) Authorization requirements in this chapter are not a denial of service.

(3) When a service requires authorization, the provider must properly request authorization in accordance with the medicaid agency's rules, medicaid provider guides, and provider notices.

(4) When authorization is not properly requested, the medicaid agency rejects and returns the request to the provider for further action. The medicaid agency does not consider the rejection of the request to be a denial of service.

(5) The medicaid agency's authorization of service(s) does not necessarily guarantee payment.

(6) The medicaid agency evaluates requests for authorization of covered respiratory care equipment and supplies that exceed limitations in this chapter on a case-by-case basis in accordance with WAC 182-501-0169.

(7) The medicaid agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100 (1)(c).

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1300, filed 6/25/12, effective 8/1/12.]

WAC 182-552-1325 Prior authorization. (1) The medicaid agency requires providers to obtain prior authorization for certain items and services before delivering that item or service to the client, except when the items and services are covered by a third-party payer. The item or service must also be delivered to the client before the provider bills the medicaid agency.

(2) All prior authorization requests must be accompanied by a completed General Information for Authorization form (HCA 13-835), in addition to any program specific medicaid agency forms as required within this chapter. Agency forms are available online at http://hrsa.dshs.wa.gov/mpforms.shtml.

(3) When the medicaid agency receives the initial request for prior authorization, the prescription(s) for those items or services must not be older than three months from the date the agency receives the request.

(4) The medicaid agency requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

(a) The manufacturer's name;

(b) The equipment model; and

(c) A detailed description of the item.

(5) For prior authorization requests, the medicaid agency requires the prescribing provider to furnish client-specific justification for respiratory care. The medicaid agency does not accept general standards of care or industry standards for generalized equipment as justification.

(6) The medicaid agency considers requests for new respiratory care that do not have assigned health care common procedure coding system (HCPCS) codes and are not listed in the agency's published issuances, including medicaid provider guides and provider notices. These items require prior authorization. The provider must furnish all of the following information to the medicaid agency to establish medical necessity:

(a) A detailed description of the item(s) or service(s) to be provided;

(b) The cost or charge for the item(s);

(c) A copy of the manufacturer's invoice, price list or catalog with the product description for the item(s) being provided; and

(d) A detailed explanation of how the requested item(s) differs from an already existing code description.

(7) The medicaid agency does not pay for the purchase, rental, or repair of respiratory care equipment that duplicates equipment the client already owns or rents. If the provider believes the purchase, rental, or repair of respiratory care equipment is not duplicative, the provider must request prior authorization and submit the following to the medicaid agency:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet the client's medical needs; and

(c) Upon request, documentation showing how the client's condition met the criteria for PA or EPA.

(8) A provider may resubmit a request for prior authorization for an item or service that the medicaid agency has denied. The medicaid agency requires the provider to include new documentation that is relevant to the request.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1325, filed 6/25/12, effective 8/1/12.]

WAC 182-552-1350 Limitation extension (LE). (1) The medicaid agency limits the amount, frequency, or duration of certain covered respiratory care, and reimburses up to the stated limit without requiring prior authorization.

(2) Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

(3) The medicaid agency requires a provider to request prior authorization for a limitation extension (LE) in order to exceed the stated limits for respiratory care. All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific medicaid agency forms as required within this chapter. Agency forms are available online at http://hrsa.dshs.wa.gov/mpforms.shtml.

(4) The medicaid agency evaluates such requests for LE under the provisions of WAC 182-501-0169.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1350, filed 6/25/12, effective 8/1/12.]

WAC 182-552-1375 Expedited prior authorization (EPA). (1) The expedited prior authorization (EPA) process is designed to eliminate the need for written requests for prior authorization for selected respiratory care procedure codes.

(2) The medicaid agency requires a provider to create an authorization number for EPA for selected respiratory care procedure codes. The process and criteria used to create the authorization number is

explained in the agency published respiratory care medicaid provider guide. The authorization number must be used when the provider bills the medicaid agency.

(3) Upon request, a provider must provide documentation to the medicaid agency showing how the client's condition met the criteria for EPA.

(4) A written request for prior authorization is required when a situation does not meet the EPA criteria for selected respiratory care procedure codes.

(5) The medicaid agency may recoup any payment made to a provider under this section if the provider did not follow the EPA process and criteria.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1375, filed 6/25/12, effective 8/1/12.]

REIMBURSEMENT

WAC 182-552-1400 Respiratory care—Reimbursement—General. (1) The medicaid agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for covered respiratory care provided on a fee-for-service (FFS) basis as follows:

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

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

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

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

(ii) Comply with legislative budget directives.

(3) The medicaid agency's maximum payment for respiratory care is the lesser of either of the following:

(a) Provider's usual and customary charges; or

(b) Established rates, except as provided in WAC 182-502-0110(3).

(4) The medicaid agency is the payer of last resort for clients with medicare or third-party insurance.

(5) The medicaid agency does not pay for respiratory care provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

(6) The medicaid agency's payment rate for covered oxygen and respiratory equipment and supplies includes all of the following:

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

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

(c) Telephone calls;

(d) Shipping, handling, and postage;

(e) Maintenance for rented equipment including, but not limited to, testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting or setup, or both; and

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

(7) Respiratory care equipment, supplies, and related repairs and labor charges that are supplied to eligible clients under the following payment methodologies are included in those methodologies and are not reimbursed under fee-for-service (FFS):

(a) Hospice provider's per diem reimbursement;

(b) Hospital's diagnosis-related group (DRG) reimbursement;

(c) Managed care organization's capitation rate;

(d) Skilled nursing facilities per diem rate; and

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

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

(9) The dispensing provider who furnishes respiratory care equipment or supplies to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any equipment or supply that the medicaid agency considers purchased requires repair during the applicable warranty period;

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

(c) The respiratory care equipment or supply continues to be medically necessary.

(10) If rental respiratory equipment or supplies must be replaced during the warranty period, the medicaid agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the respiratory equipment or supply provided to the client if:

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

(b) The respiratory care equipment or supply continues to be medically necessary.

(11) The medicaid agency does not pay for respiratory care equipment and supplies, or related repairs and labor charges under FFS when the client is any of the following:

(a) An inpatient hospital client;

(b) Terminally ill and receiving hospice care; or

(c) Enrolled in a risk-based MCO that includes coverage for such items or services, or both.

(12) The medicaid agency rescinds any purchase order for a prescribed item if the equipment or supply was not supplied to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by an MCO.

(13) See also WAC 182-543-9000 for general reimbursement.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 431.16 Section 1903 (i)(27) of the Social Security Act. WSR 19-21-087, § 182-552-1400, filed 10/14/19, effective 11/14/19. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1400, filed 6/25/12, effective 8/1/12.]

WAC 182-552-1500 Respiratory care equipment and supplies—Reimbursement—Decision to rent or purchase. (1) The medicaid agency bases the decision to rent or purchase respiratory care equipment and supplies for a client, or pay for repairs and associated labor for client-owned equipment, on cost and on the length of time the client needs the equipment.

(2) A provider must not bill the medicaid agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(3) The medicaid agency purchases new equipment only.

(a) A new item that is placed with a client initially as a rental item is considered a new item by the medicaid agency at the time of purchase.

(b) A used item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the medicaid agency.

(4) The medicaid agency requires a dispensing provider to ensure the item rented to a client is:

(a) In good working order; and

(b) Comparable to equipment the provider rents to individuals with similar medical equipment needs who are either private pay or who have other third-party coverage.

(5) The medicaid agency's minimum rental period for covered respiratory care equipment and supplies is one day.

(6) The medicaid agency's reimbursement amount for rented respiratory care equipment and supplies includes all of the following:

(a) A full service warranty;

(b) Cost of delivery to, or pick up from, the client's residence and, when appropriate, to and from the room in which the equipment will be used;

(c) Fitting, setup, adjustments, and modifications;

(d) Maintenance, repair and/or replacement, and cleaning of the equipment;

(e) Instructions to the client and/or client's caregiver for safe and proper use of the equipment; and

(f) All medically necessary accessories, contents, and disposable supplies, unless separately billable according to the agency's current respiratory care medicaid provider guide.

(7) The medicaid agency considers some rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only; this equipment is identified in the respiratory care medicaid provider guide.

(8) Respiratory care equipment and supplies purchased by the medicaid agency for a client are the client's property, unless identified as capped rental items by the agency. Capped rental items are considered the property of the provider and are identified in the respiratory care medicaid provider guide.

(9) The medicaid agency stops paying for any rented equipment effective the date of a client's death. The medicaid agency prorates monthly rentals as appropriate.

(10) For a client who is eligible for both medicare and medicaid, the medicaid agency pays only the client's coinsurance and deductibles. The medicaid agency discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:

(a) The reimbursement amount reaches medicare's reimbursement cap for the equipment; or

(b) Medicare considers the equipment purchased.

(11) The medicaid agency does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

(12) The medicaid agency does not pay for:

(a) Defective equipment;

(b) The cost of materials covered under the manufacturer's warranty or administrative fees charged by the manufacturer to perform warranty or repair work; or

(c) Repair or replacement of equipment as a result of the client's carelessness, negligence, recklessness, or misuse in accordance with WAC 182-501-0050(7). The medicaid agency may request documentation (e.g., police report, etc.) at its discretion.

(13) Capped rental oxygen equipment and client-owned equipment:

(a) Capped rental oxygen equipment is considered to have a reasonable useful lifetime of five years. The medicaid agency will pay for new equipment on capped rental items for eligible clients after five years of continuous use, at which point the capped rental period of thirty-six months will start again.

(b) Equipment is considered to be client-owned if it is not identified as a capped rental item in the agency's respiratory care medicaid provider guide and if the medicaid agency has reached the maximum reimbursement for the item.

(c) The agency pays for the repair of client-owned respiratory equipment with prior authorization. The age of the equipment is considered, and all of the following criteria must be met:

(i) All warranties are expired;

(ii) The cost of the repair is less than fifty percent of the cost of a new item and the provider has supporting documentation; and

(iii) The repair has a warranty for a minimum of ninety days.

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1500, filed 6/25/12, effective 8/1/12.]

WAC 182-552-1600 Respiratory care equipment and supplies—Reimbursement—Methodology for purchase, rental, and repair. (1) The medicaid agency sets, evaluates, and updates the maximum allowable fees for respiratory care equipment and supplies at least once yearly, unless otherwise directed by the legislature or determined necessary by the agency.

(2) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or competitive bid area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) Medicare fee schedules;
(b) Legislative direction;
(c) Input from stakeholders or relevant sources that the agency determines to be reliable and appropriate;
(d) Pricing clusters; or
(e) A by-report (BR) basis.

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

(4) When establishing payment rates for respiratory care equipment and supplies based on pricing clusters for a specific health care common procedure coding system (HCPCS) code, the maximum allowable fee is the median or average amount of all items in the cluster. The pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster due to any one or more of the following:
(a) A client's medical needs;
(b) Product quality;
(c) Introduction, substitution, or discontinuation of certain brands/models; or
(d) Cost.

(5) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness, and payment value on a case-by-case basis. The agency's payment rate is eighty percent of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or one hundred percent (oxygen only) or one hundred twenty-five percent (all other respiratory items) of the wholesale acquisition cost (AC).

(6) The agency pay for repairs of client-owned equipment only, with prior authorization (PA). In addition to agency-specific forms identified in the agency's respiratory care billing guide, providers must meet all of the following requirements to receive PA and payment for a repair of client-owned equipment:
(a) The provider must submit a manufacturer pricing sheet showing the manufacturer's list price, MSRP, or manufacturer invoice showing the cost of the repair, identifying and itemizing the parts. The invoice must indicate the wholesale AC, the manufacturer's list price, or MSRP for all parts used in the repair for which payment is being sought.
(b) The provider must follow HCPCS coding guidelines and submit a PA request accordingly with actual labor units identified and supported by documentation.

(7) The agency pays for actual labor charges according to the agency's current fee schedule. The agency does not pay for base labor charges or other administrative-like fees.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 431.16 Section 1903 (i)(27) of the Social Security Act. WSR 19-21-087, § 182-552-1600, filed 10/14/19, effective 11/14/19. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1600, filed 6/25/12, effective 8/1/12.]