WSR 22-06-047
EMERGENCY RULES
HEALTH CARE AUTHORITY

[Filed February 24, 2022, 2:45 p.m., effective February 24, 2022, 2:45 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority is revising this section to allow for payment of office visits for clients under the alien emergency medical (AEM) program when the visit is specifically for the assessment and treatment of the COVID-19 virus.

Citation of Rules Affected by this Order: Amending WAC 182-507-0115.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This rule making is in response to the Governor's Proclamation 20-05 declaring a State of Emergency for all counties throughout the state of Washington because of the coronavirus disease 2019 (COVID-19) and the secretary of the federal Department of Health and Human Services declaration of a public health emergency related to COVID-19. This emergency rule making is necessary to preserve the public health, safety, and general welfare by allowing payment for the office visit for an AEM client for the assessment and treatment of the COVID-19 virus.

This emergency filing replaces the emergency rules filed under WSR 21-22-061 on October 28, 2021. The agency is refiling to continue the emergency rule. Since the last emergency filing, the agency's CR-102 Proposed rule making expired January 3, 2022. The agency's CR-101 Preproposal statement of inquiry filed under WSR 20-15-077 remains in effect while the agency continues to monitor the changing conditions presented by COVID-19 and its variants.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 24, 2022.

Wendy Barcus
Rules Coordinator

OTS-2140.1

AMENDATORY SECTION (Amending WSR 12-24-038, filed 11/29/12, effective 12/30/12)

WAC 182-507-0115 Alien emergency medical program (AEM). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets ((~~(a) and (b) or (c)~~)) the requirements of (a) of this subsection, as well as the requirements of either (b), (c), or (d) of this subsection:

(a) The medicaid agency determines that the primary condition requiring treatment ((~~meets the definition of~~)) is an emergency medical condition as defined in WAC 182-500-0030, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(i) Inpatient;

(ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section); or

(d) For the assessment and treatment of the COVID-19 virus, the agency covers one physician visit provided in any outpatient setting, including the office or clinic setting, or via telemedicine, online digital or telephonic services to assess/evaluate and test, if clinically indicated, as follows:

(i) If the test is positive, in addition to the services described in (b) of this subsection and subsection (2)(b) of this section, any medically necessary services to treat, including:

(A) Follow-up office visits;

(B) Medications, prior authorization requirements may apply;

(C) Respiratory services and supplies; and

(D) Medical supplies, prior authorization requirements may apply.

(ii) If a test is negative, any treatment described in (d)(i)(A) through (B) of this subsection, as a precautionary measure for an anticipated positive test result.

(e) The coverage described in (d) of this subsection is in effect only during the time period, as determined by the agency in its sole discretion, that a public health emergency related to COVID-19 exists.

(2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:

(a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

(b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(i) Medications;

(ii) Laboratory, X-ray, and other diagnostics and the professional interpretations;

(iii) Medical equipment and supplies;

(iv) Anesthesia, surgical, and recovery services;

(v) Physician consultation, treatment, surgery, or evaluation services;

(vi) Therapy services;

(vii) Emergency medical transportation; and

(viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the agency or its designee as described in subsection (3) of this section.

(3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the agency or its designee under this program. Exceptions:

(a) For admissions to treat COVID-19 or complications thereof, the agency will cover up to two postdischarge physician follow-up visits, regardless of how the visits are conducted or where they are conducted.

(b) Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

(a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - The admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 182-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the agency to be a qualifying emergency medical condition, including but not limited to:

(i) Laboratory X-ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(d) Services provided outside the hospital settings described in subsection (1) of this section including, but not limited to:

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;

(xi) Vision services;

(xii) Hearing services;

(xiii) Dental services;

(xiv) Durable and nondurable medical supplies;

(xv) Nonemergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4) of this section.

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

[Statutory Authority: RCW 41.05.021. WSR 12-24-038, § 182-507-0115, filed 11/29/12, effective 12/30/12. WSR 12-13-056, recodified as § 182-507-0115, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. WSR 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]