WSR 24-23-009
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed November 8, 2024, 8:11 a.m., effective December 9, 2024]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (agency) reorganized rules related to enrollment and payment into proper sections, adding clarity, and removing the reconsideration process. WAC 182-502-0005 was revised to allow for back dating on the provider enrollment application and the nonbilling provider language was moved into this section from WAC 182-502-0006. WAC 182-502-0006 was repealed and incorporated into the other sections. WAC 182-502-0010 was updated to clarify requirements for nonbilling providers and requirements for servicing providers. WAC 182-502-0012 was revised to reflect that if the agency denies a request for enrollment, there is no longer a reconsideration process, but the provider can reapply. WAC 182-502-0030 added "failure to submit or failure to retain adequate documentation" to clarify that failed documentation can be considered a significant risk factor that can affect the provider's credibility or honesty. WAC 182-502-0040 was revised to reflect that terminations for convenience are the agency's final decision and there is no reconsideration process. WAC 182-502-0050 was revised to add a cross reference to chapter 182-502A WAC for additional information for disputes regarding overpayment. WAC 182-502-0100 was revised to add language that providers must be enrolled with the agency to receive payment for health care services, and other section additions include payment language that was removed from the previously listed WAC and moved to WAC 182-502-0100.

Citation of Rules Affected by this Order: Repealing WAC 182-502-0006; and amending WAC 182-502-0005, 182-502-0010, 182-502-0012, 182-502-0030, 182-502-0040, 182-502-0050, and 182-502-0100.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 24-17-079 on August 18, 2024.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/ Adopted	WAC Subsection	Reason
WAC 182-502-0005(5)		
Proposed	(5) A nonbilling provider enrolled only for purposes of ordering, prescribing, or referring health care services for a billing provider, is exempt from the rules in WAC 182-502-0160 and may bill a client for health care services when; (a) The provider is not acting in their capacity as an ordering, prescribing, or referring of health care services for a billing provider; (b) The provider is not enrolled with a managed care organization (MCO) that has a contract with the agency under WAC 182-538-067; and (c) The provider documents the client was informed the client would be billed for the health care services being provided.	Revised this section as a result of stakeholder comment. Provided additional clarity around billing the client policy including notifying the client prior to the delivery of services that they may be billed for the services provided.

Proposed/ Adopted	WAC Subsection	Reason
Adopted	(5) An individual who is enrolled through a nonbilling provider agreement is exempt from the rules in WAC 182-502-0160 and may bill a client for health care services when: (a) The provider is not enrolled with a managed care organization (MCO) that has a contract with the agency under WAC 182-538-067; (b) The provider is not acting in their capacity as an ordering, prescribing, or referring provider of health care services for clients; and (c) The provider documents that the client was informed prior to the delivery of services that: (i) The provider is enrolled only for purposes of ordering, prescribing, or referring health care services for clients; and (ii) The client may be billed for the health care services being provided.	
WAC 182-502-0100(2)		
Proposed	The agency pays claims only for health care services provided by or on behalf of a provider that is enrolled with the agency.	Restructured sentence for clarity.
Adopted	The agency pays for health care services only when the services are provided by or on behalf of a provider that is enrolled with the agency.	

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 7, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 7, Repealed 1.

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 7, Repealed 1.

Date Adopted: November 8, 2024.

Wendy Barcus
Rules Coordinator

OTS-5352.5

AMENDATORY SECTION (Amending WSR 23-21-061, filed 10/12/23, effective 11/12/23)

WAC 182-502-0005 Provider enrollment—Core provider agreement (CPA) or nonbilling provider agreement. (1) The agency only ((~~pays claims submitted for services provided by or on behalf of:~~

~~(a) A health care professional, health care entity, supplier or contractor of service that has an approved core provider agreement (CPA) with the agency;~~

~~(b) A servicing provider enrolled under an approved CPA with the agency; or~~

~~(c) A provider who has an approved agreement with the agency as a nonbilling provider in accordance with WAC 182-502-0006.~~

~~(2) Servicing providers performing services for a client must be enrolled under the billing providers' CPA.~~

~~(3) Any ordering, prescribing, or referring providers must be enrolled in the agency's claims payment system in order for any services or supplies ordered, prescribed, or referred by them to be paid. The national provider identifier (NPI) of any referring, prescribing, or ordering provider must be included on the claim form. Refer to WAC 182-502-0006 for enrollment as a nonbilling provider.~~

~~(4)~~)) enrolls a health care professional, health care entity, supplier, or contractor of service through approval of an application for:

(a) A core provider agreement (CPA);

(b) A nonbilling provider agreement; or

(c) Adding a servicing provider under either a CPA or a nonbilling provider agreement.

(2) The agency may enter into a single case agreement or other forms of written agreements with a health care professional, health care entity, supplier, or contractor of service.

(3) Servicing providers must comply with the requirements for providers in the agreement under which they are enrolled and agency rules.

(4) Only a licensed health care professional whose scope of practice includes ordering, prescribing, or referring under their licensure may enroll as a nonbilling provider.

(5) An individual who is enrolled through a nonbilling provider agreement is exempt from the rules in WAC 182-502-0160 and may bill a client for health care services when:

(a) The provider is not enrolled with a managed care organization (MCO) that has a contract with the agency under WAC 182-538-067;

(b) The provider is not acting in their capacity as an ordering, prescribing, or referring provider of health care services for clients; and

(c) The provider documents that the client was informed prior to the delivery of services that:

(i) The provider is enrolled only for purposes of ordering, prescribing, or referring health care services for clients; and

(ii) The client may be billed for the health care services being provided.

(6) For services provided out-of-state, refer to WAC 182-501-0180, 182-501-0182, ((~~and~~)) 182-501-0184, and 182-502-0120.

((~~(5) The agency does not pay for services provided to clients during the CPA application process or application for nonbilling provider process, regardless of whether the agency later approves or denies the application, except as provided in subsection (6) of this section or WAC 182-502-0006(5).~~

~~(6)~~)) (7) **Effective date of enrollment of a provider.**

(a) Enrollment of a provider applicant is effective on the date the agency approves the provider application for enrollment or a date designated by the agency.

((~~(a)~~)) (b) A provider applicant may ((~~ask for~~)) request an exception allowing an effective date earlier than the agency's approval of the provider application by submitting a written request to the agency((~~'s chief medical officer~~)).

(c) The request for an exception must specify the requested effective date and include an explanation justifying the earlier effective date.

(d) The ((~~chief medical officer~~)) agency will not authorize an effective date requested by the provider that is((~~:~~

~~(i)~~)) earlier than the effective date of any required license or certification((~~; or~~

~~(ii) More than 365 days prior to the agency's approval of the provider application~~)).

((~~(b)~~)) (e) The ((~~chief medical officer or designee~~)) agency may approve an exception((~~s~~)) as requested by the provider as follows for:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need ((~~as determined by the agency's chief medical officer or designee~~)).

((~~(c)~~)) (f) For federally qualified health centers (FQHCs), see WAC 182-548-1200. For rural health clinics (RHCs), see WAC 182-549-1200.

((~~(d)~~)) (g) Exceptions granted under this subsection ((~~(6)~~)) do not supersede or otherwise change the agency's timely billing requirements under WAC 182-502-0150.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-502-0006	Enrollment for nonbilling individual providers.

OTS-5654.1

AMENDATORY SECTION (Amending WSR 15-10-003, filed 4/22/15, effective 5/23/15)

WAC 182-502-0010 When the medicaid agency enrolls. (1) Nothing in this chapter obligates the medicaid agency to enroll any eligible health care professional, health care entity, supplier, or contractor of service who requests enrollment.

(2) To enroll as a provider (as defined in WAC 182-500-0085) with the agency, a health care professional, health care entity, supplier, or contractor of service rendering services in the state of Washington (persons or entities providing services out of Washington state see WAC 182-502-0120 and 182-501-0175) must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules, or, if exempt under federal law, according to the laws and rules of any other state((~~. Persons or entities outside of Washington state, see WAC 182-502-0120~~));

(b) Be enrolled with medicare, when required in specific program rules;

(c) Have current professional liability coverage, individually or as a member of a group, to the extent the health care professional, health care entity, supplier or contractor is not covered by the Federal Tort Claims Act, including related rules and regulations;

(d) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(e) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(f) Sign, without modification, a core provider agreement (CPA) ((~~(HCA 09-015), disclosure of ownership form, and debarment form (HCA 09-016) or a contract with the agency~~)) or nonbilling provider agreement, and a debarment form. Servicing providers are not required to sign as their enrollment is based upon being included under an organizational CPA or nonbilling provider agreement;

(g) Agree to accept the payment from the agency as payment in full ((~~(~~))in accordance with 42 C.F.R. § 447.15 requiring acceptance of state payment as payment in full ((~~and~~)) (see also WAC 182-502-0160 billing a client);

(h) Fully disclose ownership, employees who manage, and other control interests (e.g., member of a board of directors or office), as requested by the agency. Indian health services clinics are exempt from this requirement((~~. If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and provide its national provider identifier (NPI) (if eligible for an NPI) to be used for submitting claims as the billing provider~~));

(i) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(j) Pass the agency's screening process, including license verifications, database checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450.

(i) The agency uses the same screening level risk categories that apply under medicare.

(ii) For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare; and

(k) ((~~Agree to~~)) Pay an application fee, if required by CMS under 42 C.F.R. 455.460.

(3) Servicing providers performing services for a client must be enrolled under the billing providers' CPA or a nonbilling provider agreement.

(4) Only a licensed health care professional whose scope of practice under their licensure includes ordering, prescribing, or referring may enroll as a nonbilling provider.

OTS-5655.1

AMENDATORY SECTION (Amending WSR 19-21-067, filed 10/11/19, effective 11/11/19)

WAC 182-502-0012 When the medicaid agency does not enroll. (1) The medicaid agency does not enroll a health care professional, health care entity, supplier, or contractor of service for reasons which include, but are not limited to, the following:

(a) The agency determines that:

(i) There is a quality of care issue with significant risk factors that may endanger client health, or safety, or both (see WAC 182-502-0030(1)((~~(a)~~)); or

(ii) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 182-502-0030(1)((~~(b)~~)).

(b) The health care professional, health care entity, supplier or contractor of service:

(i) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(ii) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(iii) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(iv) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(v) Is noncompliant with the department of health or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(vi) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(vii) Fails a background check, including a fingerprint-based criminal background check, performed by the agency. See WAC 182-502-0014 and 182-502-0016; or

(viii) Does not have sufficient liability insurance according to WAC 182-502-0016 for the scope of practice, to the extent the health care professional, health care entity, supplier or contractor of service is not covered by the Federal Tort Claims Act, including related rules and regulations.

(c) A site visit under 42 C.F.R. 455.432 reveals that the provider has failed to comply with a state or federal requirement.

(2) ((~~The agency may not pay for any health care service, drug, supply or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service whose application for a core provider agreement (CPA) has been denied or terminated.~~

~~(3) The agency may not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service who does not have a current CPA with the agency when the agency determines there is a potential danger to a client's health and/or safety.~~

~~(4) Nothing in this chapter precludes the agency from entering into other forms of written agreements with a health care professional, health care entity, supplier or contractor of service.~~

~~(5)~~)) If the agency denies an enrollment application under this section, the applicant may ((~~request that the agency reconsider the denial.~~

~~(a) The agency's decision at reconsideration is the agency's final decision.~~

~~(b) The agency reconsiders the applicant according to the process and guidelines outlined in subsections (1) through (4) of this section.~~

~~(c) The reconsideration process in this section is unrelated to the reconsideration process described in chapter 182-526 WAC~~)) reapply.

((~~(6)~~)) (3) Under 42 C.F.R. 455.470, the agency:

(a) Will impose a temporary moratorium on enrollment when directed by CMS; or

(b) May initiate and impose a temporary moratorium on enrollment when approved by CMS.

AMENDATORY SECTION (Amending WSR 19-21-067, filed 10/11/19, effective 11/11/19)

WAC 182-502-0040 Termination of ((a)) provider ((~~agreement~~)) enrollment—For convenience. (1) Either the medicaid agency or the provider may terminate the provider's ((~~participation~~)) enrollment with the agency for convenience with ((~~thirty~~)) 28 calendar days written notice ((~~served upon the other party~~)) in a manner which provides proof of receipt or proof of valid attempt to deliver the notice.

(2) Termination((~~s~~)) of enrollment for convenience ((~~are not eligible for the dispute resolution process described in WAC 182-502-0050. Terminations for convenience are eligible for reconsideration as described in WAC 182-502-0012~~)) is the agency's final decision.

(3) If a provider is terminated for convenience, the agency pays for authorized services provided up to the date of termination only.

AMENDATORY SECTION (Amending WSR 13-17-047, filed 8/13/13, effective 10/1/13)

WAC 182-502-0050 Provider dispute of an agency action. The process described in this section applies only when agency rules allow a provider to dispute an agency decision under this section.

(1) In order for the agency to review a decision previously made by the agency, a provider must submit the request to review the decision:

(a) Within ((~~twenty-eight~~)) 28 calendar days of the date on the agency's decision notice;

(b) To the address listed in the decision notice; and

(c) In a manner that provides proof of receipt.

(2) A provider's dispute request must:

(a) Be in writing;

(b) Specify the agency decision that the provider is disputing;

(c) State the basis for disputing the agency's decision; and

(d) Include documentation to support the provider's position.

(3) The agency may request additional information or documentation. The provider must submit the additional information or documen-

tation to the agency within ((~~twenty-eight~~)) 28 calendar days of the date on the agency's request.

(4) The agency closes the dispute without issuing a decision and with no right to further review under subsection (6) of this section when the provider:

(a) Fails to comply with any requirement of subsections (2), (3), and (4) of this section;

(b) Fails to cooperate with, or unduly delays, the dispute process; or

(c) Withdraws the dispute request in writing.

(5) The agency will send the provider a written notice of dispute closure or written dispute decision.

(6) The provider may request the director of the health care authority or designee to review the written dispute decision according to the process in WAC 182-502-0270.

(7) This section does not apply to disputes regarding overpayment. For disputes regarding overpayment, see WAC 182-502-0230 and chapter 182-502A WAC.

OTS-5656.1

AMENDATORY SECTION (Amending WSR 23-21-061, filed 10/12/23, effective 11/12/23)

WAC 182-502-0030 Termination of provider enrollment—For cause. (1) The medicaid agency may immediately terminate a provider's enrollment for any one or more of the following reasons, each of which constitutes cause:

(a) Provider exhibits significant risk factors that endanger client health or safety. These factors include, but are not limited to:

(i) Moral turpitude;

(ii) Sexual misconduct according to chapter 246-16 WAC or in profession specific rules of the department of health (DOH);

(iii) A statement of allegations or statement of charges by DOH or equivalent from other state licensing boards;

(iv) Restrictions or limitations placed by any state licensing, credentialing, or certification agency on the provider's current credentials or practice;

(v) Limitations, restrictions, or loss of hospital privileges or participation in any health care plan or failure to disclose the reasons to the agency;

(vi) Negligence, incompetence, inadequate or inappropriate treatment, or lack of appropriate follow-up treatment;

(vii) Patient drug mismanagement, failure to identify substance use disorder, or failure to refer the patient for substance use disorder treatment once identified;

(viii) Use of health care providers or health care staff who are unlicensed to practice or who provide health care services that are outside their recognized scope of practice or the standard of practice in the state of Washington;

(ix) Failure of the health care provider to comply with the requirements of WAC 182-502-0016;

(x) Failure of the health care provider with a substance use disorder(s) to furnish documentation or other assurances as determined by the agency to adequately safeguard the health and safety of Washington apple health clients that the provider:

(A) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(B) Is receiving treatment adequate to ensure that the disorder will not affect the quality of the provider's practice.

(xi) Infection control deficiencies;

(xii) Failure to maintain adequate professional malpractice coverage;

(xiii) Medical malpractice claims or professional liability claims that constitute a pattern of questionable or inadequate treatment, or contain any gross or flagrant incident of malpractice; or

(xiv) Any other act that the agency determines is contrary to the health and safety of its clients.

(b) Provider exhibits significant risk factors that affect the provider's credibility or honesty. These factors include, but are not limited to:

(i) Failure to meet the requirements in WAC 182-502-0010 and 182-502-0020;

(ii) Dishonesty or other unprofessional conduct;

(iii) Civil or criminal findings of fraudulent or abusive billing practices through an investigation or other review (e.g., audit or record review);

(iv) Exclusion from participation in medicare, medicaid, or any other federally funded health care program;

(v) Any conviction, no contest plea, or guilty plea relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(vi) Any conviction, no contest plea, or guilty plea of a criminal offense;

(vii) Failure to comply with a DOH request for information or an ongoing DOH investigation;

(viii) Noncompliance with a DOH or other state health care agency's stipulation to disposition, agreed order, final order, or other similar licensure restriction;

(ix) Misrepresentation or failure to disclose information to the agency during or after enrollment including on the application for a core provider agreement (CPA), a nonbilling provider agreement, or servicing providers enrolled under a core provider agreement;

(x) Failure to comply with an agency request for information;

(xi) Failure to submit adequate documentation to the agency or failure to retain adequate documentation as required by the agency;

(xii) Failure to cooperate with an agency investigation, audit, or review;

((~~(xii)~~)) (xiii) Providing health care services that are outside the provider's recognized scope of practice or the standard of practice in the state of Washington;

((~~(xiii)~~)) (xiv) Unnecessary medical, dental, or other health care procedures;

((~~(xiv)~~)) (xv) Discriminating in the furnishing of health care services, supplies, or equipment as prohibited by 42 U.S.C. § 2000d; and

((~~(xv)~~)) (xvi) Any other dishonest or discreditable act that the agency determines is contrary to the interest of the agency or its clients.

(2) If a provider's enrollment is terminated for cause, the agency pays only for authorized services provided up to the date of termination of enrollment if other program requirements are met including, but not limited to, the requirements in WAC 182-502-0016.

(3) When the agency terminates enrollment of a servicing provider who is also a full or partial owner of an enrolled group practice, the agency terminates the enrolled group practice and all enrolled servicing providers who are not linked to another enrolled group practice contracted with the agency. The remaining practitioners in the group practice may reapply for participation with the agency subject to WAC 182-502-0010.

(4) Effective date. The effective date of the termination of a provider's enrollment is the date stated in the notice. The filing of an appeal as provided in subsection (5) of this section does not stay the effective date of termination.

(5) Administrative hearing.

(a) The provider may appeal the agency decision to terminate the provider's enrollment for cause by submitting a written request to the address contained in the decision notice within 28 calendar days of the date on the notice and in a manner that provides proof of receipt by the agency. The agency does not allow good cause exception related to this subsection.

(b) If the agency receives a timely appeal, the presiding officer will schedule a prehearing conference in accordance with WAC 182-526-0195.

(c) The administrative hearing process is governed by the Administrative Procedure Act, chapter 34.05 RCW, and chapter 182-526 WAC.

(d) Burden of proof.

(i) The provider has the burden of proof.

(ii) The standard of proof in a provider termination hearing is "clear and convincing evidence" meaning the evidence is highly and substantially more likely to be true than untrue. This is a higher standard of proof than proof by a preponderance of the evidence, but it does not require proof beyond a reasonable doubt.

OTS-5657.3

AMENDATORY SECTION (Amending WSR 23-24-026, filed 11/29/23, effective 1/1/24)

WAC 182-502-0100 General conditions of payment. (1) The medicaid agency ((~~reimburses for medical~~)) pays for health care services furnished to an eligible client when the claim satisfies agency rules including all the following ((~~apply~~)):

(a) The service is within the scope of care of the client's Washington apple health program;

(b) The service is medically necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 182-502-0150;

(e) The provider bills according to agency rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The agency pays for health care services only when the services are provided by or on behalf of a provider that is enrolled with the agency.

(3) In order for any services or supplies ordered, prescribed, or referred by a provider to be paid:

(a) The provider must be enrolled with the agency under their national provider identifier (NPI); and

(b) The NPI for the referring, prescribing, or ordering provider must be included on the claim form.

(4) If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll with the agency and provide its national provider identifier (NPI) (if eligible for an NPI) to be used for submitting claims as the billing provider.

(5) The agency is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

((~~(3)~~)) (6) The agency does not ((~~reimburse~~)) pay providers for ((~~medical~~)) health care services identified by the agency as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (copays) (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met); and

(c) Spenddown (see WAC 182-519-0110).

((~~(4)~~)) (7) The agency does not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier, or contractor of service not currently enrolled with the agency.

(8) The agency does not pay for services provided to clients during the application process for provider enrollment, regardless of whether the agency later approves or denies the application, unless an exception for earlier enrollment is approved by the agency in accordance with WAC 182-502-0005.

(9) The agency does not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier, or contractor of services whose application for enrollment has been denied or terminated.

(10) The provider must accept medicare assignment for claims involving clients eligible for both medicare and Washington apple health before the agency makes any payment.

((~~(5)~~)) (11) The provider is responsible for verifying whether a client has Washington apple health coverage for the dates of service.

((~~(6)~~)) (12) The agency may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service when it was provided if:

(a) The agency considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the agency.

((~~(7)~~)) (13) The agency does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the agency.

((~~(8)~~)) (14) Information about ((~~medical care~~)) health care services for jail inmates is found in RCW 70.48.130.

((~~(9)~~)) (15) The agency pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the agency, whichever is lower.