

WAC 182-531-0950 Office and other outpatient physician-related services. (1) The medicaid agency pays eligible providers for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 182-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (1) of this section and follow the requirements in WAC 182-501-0169.

(3) See the agency's physician-related services billing instructions for procedures that are included in the office call and that cannot be billed separately.

(4) Using selected diagnosis codes, the agency reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) The agency may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and which was purchased by the provider from a pharmacy, drug manufacturer, or drug wholesaler.

(6) The agency does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) The agency does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; the agency does reimburse an administrative fee.

(8) The agency reimburses immunizations as follows:

(a) For immunizations that are not part of the vaccines for children program through the department of health, the agency reimburses for the immunization:

(i) At the medicare Part B drug file price; or

(ii) When a medicare Part B price is not available, the agency uses the point-of-sale actual acquisition cost (POS AAC) rate effective July 1st of each year; or

(iii) Invoice cost.

(b) The agency reimburses a separate administration fee for these immunizations.

(c) Covered immunizations are listed in the professional administered drugs and physician related/professional services fee schedules.

(d) Refer to WAC 182-531-0150 (1)(r) for vaccines recommended or required for the sole purpose of international travel.

(9) The agency reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) The agency does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. The agency does pay separately for the administration of these injections when they are provided on the same day as an E&M service. The agency does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. The agency reimburses separately for the drug(s).

(b) The agency does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same

day as an E&M service. If the injection is the only service provided, the agency pays an administrative fee. The agency reimburses separately for the drug.

(c) The agency reimburses injectable drugs at **acquisition cost**. The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by the agency. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing the agency for the following drugs:

(i) Classified drugs where the billed charge to the agency is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to the agency is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) The agency reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, the agency reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) The agency covers the antigen, the antigen preparation, and an administration fee.

(e) The agency reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) The agency reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) The agency reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on medicare Part B pricing, or POS AAC, maximum allowable cost (MAC), or invoice cost;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The National Drug Code (NDC).

(12) Notwithstanding the provisions of this section, the agency reserves the option of determining drug pricing for any particular drug based on the best evidence available to the agency, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) The agency may request an invoice as necessary.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-21-040, § 182-531-0950, filed 10/12/17, effective 11/12/17; WSR 15-20-057, § 182-531-0950, filed 10/1/15, effective 11/1/15; WSR 15-03-041, § 182-531-0950, filed 1/12/15, effective 2/12/15. WSR 11-14-075, recodified as § 182-531-0950, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0950, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]