Chapter 182-546 WAC
TRANSPORTATION SERVICES

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WAC

WAC 182-546-0001 Definitions. The following definitions and abbreviations, and those found in WAC 388-500-0005, apply to this chapter unless otherwise specified.

"Advanced life support (ALS)" means that level of care that calls for invasive emergency medical services requiring advanced medical treatment skills.

"Advanced life support (ALS) assessment" means an assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service.

"Advanced life support (ALS) intervention" means a procedure that is beyond the scope of care of an emergency medical technician (EMT).

"Aid vehicle" means a vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedures.

"Air ambulance" means a helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide per-

sonnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service.

"Ambulance" means a ground or air vehicle designed and used to provide transportation to the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation; and licensed per RCW 18.73.140.

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

"Basic life support (BLS)" means that level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical procedures/services.

"Bed-confined" means the client is unable to perform all of the following actions:

(1) Get up from bed without assistance;

(2) Ambulate; and

(3) Sit in a chair or wheelchair.

"Bordering city hospital" means a licensed hospital in a designated bordering city (see WAC 388-501-0175).

"Broker" (see "transportation broker").

"Brokered transportation" means nonemergency transportation arranged by a broker, under contract with MAA, to or from covered medical services for an eligible client (also, see "transportation broker").

"By report" means a method of payment in which MAA determines the amount it will pay for a service that is covered but does not have an established maximum allowable fee. Providers must submit a report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

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

"Emergency medical transportation" means ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility.

"Ground ambulance" means a ground vehicle (including a water ambulance) designed and used to provide transportation to the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation.

"Invasive procedure" means a medical intervention that intrudes on the client's person or breaks the skin barrier.

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

"Loaded mileage" means the number of miles the client is transported in the ambulance vehicle.

"Medical control" means the medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan

by the approved medical program director of the region in which the service is provided.

"Nonemergency ambulance transportation" means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route, or the use of an air ambulance when prior authorized by MAA. Nonemergency ambulance transportation is usually scheduled or prearranged. See also "prone or supine transportation," and "scheduled transportation."

"Point of destination" means a facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved.

"Point of pickup" means the location of the client at the time he or she is placed on board the ambulance or transport vehicle.

"Prone or supine transportation" means transporting a client confined to a stretcher or gurney, with or without emergency medical services being provided en route.

"Scheduled transportation" means prearranged transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to or from a covered medical service.

"Specialty care transport (SCT)" means interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the paramedic.

"Standing order" means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or the ambulance provider's medical control.

"Transportation broker" means a person or organization contracted by MAA to arrange, coordinate and manage the provision of necessary but nonemergency transportation services for eligible clients to and from covered medical services.

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

[WSR 11-14-075, recodified as § 182-546-0001, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0001, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0001, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0100 The MAA ambulance transportation program. (1) The provisions of this chapter take precedence with respect to ambulance coverage in cases of ambiguity in, or conflict with, other rules governing eligibility for medical services.

(2) The medical assistance administration (MAA) covers medically necessary ambulance transportation to and from the provider of MAA covered services that is closest and most appropriate to meet the client's medical need. See WAC 388-546-0150 through 388-546-4000 for ambulance transportation and WAC 388-546-5000 through 388-546-5600 for brokered/nonemergency transportation.

[WSR 11-14-075, recodified as § 182-546-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0100, filed 8/17/04, effective 9/17/04. Stat-

utory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0100, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0150 Client eligibility for ambulance transportation. (1) Except for people in the Family Planning Only and TAKE CHARGE programs, fee-for-service clients are eligible for ambulance transportation to covered services with the following limitations:

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

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

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

(b) People in the apple health categorically needy/qualified medicare beneficiary (CN/QMB) and apple health medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 182-546-0400(5).

(2) People enrolled in an agency-contracted managed care organization (MCO) must coordinate:

(a) Ground ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter; and

(b) Air ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter.

(3) People enrolled in the agency's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with the agency's requirements. The agency pays for covered services for these people according to the agency's published billing guides and provider alerts.

(4) People under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to people who are being detained involuntarily for mental health treatment and being transported to or from bordering cities. See also WAC 182-546-4000.

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

(6) The agency does not pay for ambulance services for jail inmates and people living in a correctional facility, including people in work-release status. See WAC 182-503-0505(5).

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

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

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

(b) Medically necessary as defined in WAC 182-500-0005 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

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

(d) To one of the following destinations:

(i) The nearest appropriate agency-contracted medical provider of agency-covered services; or

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

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

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

(a) Report the third party determination on the claim; and

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

(4) The agency covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

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

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

(iii) Must be transported by stretcher or gurney.

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2017 c 273. WSR 19-19-090, § 182-546-0200, filed 9/18/19, effective 10/19/19. WSR 11-14-075, recodified as § 182-546-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-546-0200, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0200, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0200, filed 1/16/01, effective 2/16/01.]

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

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

(b) Refused by the client (see exception for ITA clients in WAC 182-546-4000(2));

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

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

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

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

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

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

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

(j) Not to the nearest appropriate medical facility.

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

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

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The agency approves such requests when medically necessary, according to the provisions of WAC 182-501-0165 and 182-501-0169.

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2017 c 273. WSR 19-19-090, § 182-546-0250, filed 9/18/19, effective 10/19/19. WSR 11-14-075, recodified as § 182-546-0250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-546-0250, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0250, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0250, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0300 General requirements for ambulance providers. (1) Ambulances must be licensed, operated, and equipped according to federal, state, and local statutes, ordinances and regulations.

(2) Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and 18.73.170.

(3) The medical assistance administration (MAA) requires providers of ambulance services to document medical justification for transportation and related services billed to MAA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of the transportation. MAA may review the client record to ensure MAA's criteria were met.

[WSR 11-14-075, recodified as § 182-546-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0300, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0300, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0400 General limitations on payment for ambulance services. (1) In accordance with WAC 182-502-0100(8), the agency pays providers the lesser of the provider's usual and customary charges or the maximum allowable rate established by the agency. The agency's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) The agency:

(a) Pays providers under fee-for-service for ground ambulance services provided to a client who is enrolled in an agency-contracted managed care organization (MCO).

(b) Pays providers under fee-for-service for air ambulance services provided to a client who is enrolled in an agency-contracted MCO.

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-546-0425 Ambulance coverage during inpatient hospitals stays. (1) The medical assistance administration (MAA) does not cover ambulance transportation services under fee-for-service when a client remains as an inpatient client in a hospital and the transportation to and/or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such services is the responsibility of the hospital, whether MAA pays the hospital under the diagnosis-related group (DRG) or ratio of costs-to-charges (RCC) method.

(2) Except as provided in subsections (3) and (5) of this section, MAA does not cover hospital to hospital transfers of clients under fee-for-service when ambulance transportation is requested solely to:

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

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

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

(3) MAA covers under fee-for-service ambulance transportation for a client being transferred from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required by the client. MAA covers air ambulance transportation for hospital transfers only if transportation by ground ambulance would endanger the client's life or health. The reason for transferring a client from one hospital to another, as well as the need for air ambulance transport, if applicable, must be clearly documented in the client's hospital chart and in the ambulance trip report.

(4) MAA does not cover under fee-for-service ambulance transportation for a client being transferred from a hospital providing a higher level of care to a hospital providing a lower level of care, except as allowed under subsection (5) of this section.

(5) MAA considers requests for fee-for-service ambulance coverage under the provisions of WAC 388-501-0160 (exception to rule) for transportation of a client from an intervening hospital to the discharging hospital. MAA evaluates such requests based on clinical considerations and cost-effectiveness. MAA's decision under the provisions of WAC 388-501-0160 is final. The reason for transferring a client from a hospital to another medical facility must be clearly docu-

mented in the client's hospital chart and in the ambulance trip record.

(6) Specialty care transport (SCT) is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. MAA pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport, provided:

(a) The criteria for covered hospital transfers under fee-for-service are met; and

(b) There is a written reimbursement agreement between the ambulance provider and SCT personnel. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, MAA pays the provider at the basic life support (BLS) rate.

[WSR 11-14-075, recodified as § 182-546-0425, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0425, filed 8/17/04, effective 9/17/04.]

WAC 182-546-0450 Payment for ground ambulance services. (1) The medical assistance administration (MAA) pays for two levels of service for ground ambulance transportation: Basic life support (BLS) and advanced life support (ALS):

(a) A BLS ambulance trip is one in which the client requires and receives basic medical services at the scene and/or en route from the scene of the acute and emergent illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are: Controlling bleeding, splinting fracture(s), treating for shock, and performing cardiopulmonary resuscitation (CPR).

(b) An ALS trip is one in which the client requires and receives more complex services at the scene and/or en route from the scene of the acute and emergent illness or injury to a hospital. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle as defined by chapter 18.83 RCW. Examples of complex medical services or ALS procedures are:

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

(ii) Airway intubation;

(iii) Cardiac pacing;

(iv) Chemical restraint;

(v) Chest decompression;

(vi) Creation of surgical airway;

(vii) Initiation of intravenous therapy;

(viii) Manual defibrillation/cardioversion;

(ix) Placement of central venous line; and

(x) Placement of intraosseous line.

(2) MAA pays for ambulance services (BLS or ALS) based on the client's actual medical condition and the level of medical services needed and provided during the trip.

(a) Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify a trip for MAA payment at the ALS level of service unless ALS services were provided.

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

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

(3) MAA's base rate includes: Necessary personnel and services; oxygen and oxygen administration; intravenous supplies and IV administration reusable supplies, disposable supplies, required equipment, and waiting time. MAA does not pay separately for chargeable items/services that are provided to the client based on standing orders.

(4) MAA pays ground ambulance providers the same mileage rate, regardless of the level of service. Ground ambulance mileage is paid when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

(5) MAA pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. Acceptable reasons for allowable extra mileage include, but are not limited to:

(a) A hospital was on "divert" status and not accepting patients; or

(b) A construction site caused a detour, or had to be avoided to save time.

(6) When multiple ambulance providers respond to an emergency call, MAA pays only the ambulance provider that actually furnishes the transportation.

(7) MAA pays for an extra attendant, when the ground ambulance provider documents in the client's file the justification for the extra attendant, and that the extra attendant is on-board for the trip because of one or more of the following:

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

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

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

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

(8) MAA pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting MAA clients. To be paid, providers must document the toll(s) by attaching the receipt(s) for the toll(s) to the claim.

[WSR 11-14-075, recodified as § 182-546-0450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0450, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0450, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0500 Payment for ground ambulance services in special circumstances. (1) When more than one client is transported in the same ground ambulance at the same time, the provider must bill the medical assistance administration (MAA):

(a) At a reduced base rate for the additional client, and

(b) No mileage charge for the additional client.

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

at the scene of the illness or injury but the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. See WAC 388-546-0450(1) for examples of medical interventions associated with each base rate. The intervention(s)/supplies provided must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies at the scene of the illness or injury after medical interventions/supplies are provided but before transport takes place.

(3) In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets MAA's fee schedule definition of an ALS intervention, the BLS provider may bill MAA the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists. The provider must give MAA a copy of the agreement upon request. If there is no written agreement between the BLS and ALS entities, MAA will pay only for the BLS level of service.

(4) In areas that distinguish between residents and nonresidents, MAA must be billed the same rate for ambulance services provided to a client in a particular jurisdiction as would be billed by that provider to the general public in the same jurisdiction.

[WSR 11-14-075, recodified as § 182-546-0500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0500, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0500, filed 1/16/01, effective 2/16/01.]

GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT)

WAC 182-546-0505 GEMT definitions. See WAC 182-546-0001 for additional definitions.

"Allowable costs" means an expenditure that meets the test of the appropriate Executive Office of the President of the United States Office of Management and Budget (OMB) Circular.

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

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

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

"Indirect costs" means the costs for a common or joint purpose benefiting more than one cost objective and allocated to each objec-

tive using an agency-approved indirect rate or an allocation methodology.

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0505, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0510 GEMT program overview. (1) The ground emergency medical transportation (GEMT) program permits publicly owned or operated providers to receive cost-based payments for emergency ground ambulance transportation of medicaid fee-for-service clients.

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

(a) Medicaid applicants; or

(b) Medicare/medicaid recipients with dual eligibility.

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

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

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

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

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

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

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

(b) Be publicly owned or operated as defined in WAC 182-546-0505.

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0515, filed 3/29/19, effective 5/1/19.]

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

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

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

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

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

(b) The participating provider must:

(i) Include the expenditure in its budget.

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0520, filed 3/29/19, effective 5/1/19.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0525, filed 3/29/19, effective 5/1/19.]

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

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

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

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

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

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

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

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

(a) The agency:

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

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

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

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

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

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

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

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

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

WAC 182-546-0545 GEMT auditing. (1) Participating providers must follow the terms and conditions outlined in the agency's core provider agreement.

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2015 c 147. WSR 19-08-058, § 182-546-0545, filed 3/29/19, effective 5/1/19.]

WAC 182-546-0600 Procedure code modifiers. Ambulance providers must use procedure code modifiers published by MAA when billing MAA for ambulance trips. The appropriate modifiers must be used for all services related to the same trip for the same client.

[WSR 11-14-075, recodified as § 182-546-0600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0600, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0600, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0700 Payment limitations for air ambulance services. (1) MAA pays for air ambulance services only when all of the following apply:

(a) The necessary medical treatment is not available locally or the client's point of pick up is not accessible by ground ambulance;

(b) The vehicle and crew meet the provider requirements in WAC 388-546-0300 and 388-546-0800;

(c) The client's destination is an acute care hospital; and

(d) The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance; or

(e) The client's physical or medical condition is such that traveling on a commercial flight is not safe.

(2) MAA pays providers for one lift-off fee per client, per trip.

(3) Air mileage is based on loaded miles flown, as expressed in statute miles.

(4) Except as provided in WAC 388-546-0800(6), MAA pays for extra air mileage with sufficient justification. The reason for the added mileage must be documented in the client's record and the ambulance trip report. Acceptable reasons include, but are not limited to:

(a) Having to avoid a "no fly zone"; or

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

(5) MAA pays a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number

of clients transported and bill MAA for the mileage portion attributable to each eligible client.

(6) If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, MAA limits its payment as follows:

(a) If air ambulance is used and the trip involves more than one lift off, MAA pays only one lift-off fee per client and the total of air miles. If an air ambulance transport for the same client involves both rotary and fixed wing aircraft, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.

(b) If both air and ground ambulances are used, MAA pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided in WAC 388-546-0800(6).

(7) MAA does not pay separately for individual services or an extra attendant for air ambulance transportation. MAA's lift-off fee and mileage payment includes all personnel, services, supplies, and equipment related to the transport.

(8) MAA does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has MAA's prior authorization for the transportation services and fees. If authorized, MAA's payment is based on the actual cost to provide the service or at MAA's established rates, whichever is lower. MAA does not pay separately for items or services that MAA includes in the established rate(s).

(9) If MAA determines, upon review, that an air ambulance trip was not:

(a) Medically necessary, MAA may deny or recoup its payment and/or limit payment based on MAA's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or

(b) To the nearest available and appropriate hospital, MAA may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.

(10) Providers must have prior authorization from MAA for any nonemergency air transportation, whether by air ambulance or other mode of air transportation. Nonemergency air transportation includes scheduled transports to or from out-of-state treatment facilities.

(11) MAA uses commercial airline companies (i.e., MAA does not authorize air ambulance transports) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.

(12) MAA does not pay for air ambulance services if no transportation is provided.

[WSR 11-14-075, recodified as § 182-546-0700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0700, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0700, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0800 Payment for ambulance services provided in another state or U.S. territory. (1) The department pays for emergency ambulance transportation provided to eligible Washington state fee-for-service medical assistance clients who are in another state or U.S. territory when the emergency medical situation occurs according to the provisions of WAC 388-501-0180, 388-501-0182, and 388-502-0120.

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

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

(b) Have a signed agreement with the department.

(3) The department pays for emergency ambulance transportation provided out of state for an eligible Washington state medical assistance client under fee-for-service when the transport is:

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

(b) Medically necessary as defined in WAC 388-500-0005; and

(c) To the nearest appropriate treatment facility.

(4) The department does not pay for an ambulance transport provided in another state for a fee-for-service Washington state medical assistance client when:

(a) The client's medical eligibility program covers medical services within Washington state and/or designated bordering cities only. See WAC 388-546-0150 and 388-546-0200(5);

(b) The ambulance transport was nonemergent and was not prior authorized by the department.

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

(a) The provider's billed amount; or

(b) The rate established by the department.

(6) To receive payment from the department for a nonemergency transport, an ambulance provider, who transports a Washington state medical assistance client to a facility that is out of state or brings a client into the state from a location that is out of state, must obtain prior authorization from the department.

(7) The department pays a negotiated rate for a medically necessary nonemergency interstate ambulance transport that the department has prior authorized. The ambulance provider is responsible for ensuring that all medical services necessary for the client's safety during the transport are available on-board the vehicle or aircraft. The contractual amount for a nonemergency air ambulance transport may include:

(a) The cost of medically necessary ground ambulance transport from the discharging facility to the point-of-pickup (airstrip); and

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

(8) The department does not pay to transport clients under the Involuntary Treatment Act (ITA) program to or from locations outside the state of Washington. For ITA purposes, transports to or from designated bordering cities are not covered. See WAC 388-546-4000.

(9) The department requires out-of-state ground ambulance providers who transport a Washington state medical assistance client into, within, or outside the state of Washington, to comply with RCW 18.73.180 regarding stretcher transportation.

[WSR 11-14-075, recodified as § 182-546-0800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-0800, filed

3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0800, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-0800, filed 1/16/01, effective 2/16/01.]

WAC 182-546-0900 Ambulance coverage in Canada, Mexico, and other countries. The department does not cover ambulance transportation for eligible medical assistance clients traveling outside of the United States and U.S. territories. See WAC 388-501-0184 for ambulance coverage in British Columbia, Canada.

[WSR 11-14-075, recodified as § 182-546-0900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-0900, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-0900, filed 8/17/04, effective 9/17/04.]

WAC 182-546-1000 Coverage for nonemergency ground ambulance transportation. (1) The medical assistance administration (MAA) pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

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

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

(2) MAA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation as follows:

(a) For nonemergency, scheduled ambulance services that are repetitive in nature, the ambulance provider must obtain a written physician certification statement (PCS) from the client's attending physician certifying that the ambulance services are medically necessary. The PCS must specify the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services. The PCS must be dated no earlier than sixty days before the first date of service. A PCS for repetitive, nonemergency ambulance services is valid for sixty days as long as the client's medical condition does not improve. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.

(b) For nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider must obtain from the client's attending physician a signed PCS within forty-eight hours after the transport. The PCS must certify that the ambulance services are medically necessary.

(c) If the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed certificate of medical necessity form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where

the client is being treated and who has personal knowledge of the client's medical condition at the time the ambulance service was furnished. In lieu of the attending physician, one of the following may sign the certification form: a physician assistant, a nurse practitioner, a registered nurse, a clinical nurse specialist, or a hospital discharge planner. The signed certificate must be obtained from the alternate provider no later than twenty-one calendar days from the date of service.

(d) If, after twenty-one days, the ambulance provider is unable to obtain the signed PCS from the attending physician or alternate provider for nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider may submit a claim to MAA, as long as the provider is able to show acceptable documentation of the attempts to obtain the PCS.

(e) In addition to the signed certification statement of medical necessity, all other program criteria must be met in order for MAA to pay for the service.

(3) Ground ambulance providers may choose to enter into contracts with MAA's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs MAA would incur under subsection (1) of this section.

[WSR 11-14-075, recodified as § 182-546-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-1000, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-03-084, § 388-546-1000, filed 1/16/01, effective 2/16/01.]

WAC 182-546-1500 Coverage for nonemergency air ambulance transportation. (1) The medical assistance administration (MAA) pays for a nonemergency air ambulance transport only when the transport is prior authorized by MAA.

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

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

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

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

(3) MAA requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical justification must be submitted to MAA prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation.

[WSR 11-14-075, recodified as § 182-546-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-1500, filed 8/17/04, effective 9/17/04.]

WAC 182-546-2500 Transportation to or from out-of-state treatment facilities—Coordination of benefits. (1) The medical assistance

administration (MAA) does not pay for a client's transportation to or from an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

(2) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

(a) Denies the client's request for medical services out-of-state for lack of medical necessity; or

(b) Denies the client's request for transportation for lack of medical necessity.

(3) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not consider requests for transportation to or from out-of-state treatment facilities unless the client has tried all of the following:

(a) Requested coverage of the benefit from his/her primary insurer and been denied;

(b) Appealed the denial of coverage by the primary insurer; and

(c) Exhausted his/her administrative remedies through the primary insurer.

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

(5) For clients eligible for out-of-state coverage but have other third-party insurance, MAA considers requests for transportation to or from out-of-state treatment facilities under the provisions of WAC 388-501-0165.

[WSR 11-14-075, recodified as § 182-546-2500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-2500, filed 8/17/04, effective 9/17/04.]

WAC 182-546-3000 Transporting qualified trauma cases. The department does not pay ambulance providers who meet department of health (DOH) criteria for participation in the statewide trauma network an additional amount for transports involving qualified trauma cases described in WAC 388-550-5450. Subject to the availability of trauma care fund (TCF) monies allocated for such purpose, the department may make supplemental payments to these ambulance providers, also known as verified prehospital providers.

[WSR 11-14-075, recodified as § 182-546-3000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. WSR 10-12-013, § 388-546-3000, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-3000, filed 8/17/04, effective 9/17/04.]

WAC 182-546-4000 Transportation coverage under the Involuntary Treatment Act (ITA). (1) For purposes of this section, the following definitions apply:

(a) "Nearest and most appropriate destination" means the nearest facility able and willing to accept the involuntarily detained individual for treatment, not the closest facility based solely on driving distance.

(b) "County-designated mental health professional (CD-MHP)" means a person who, under the guidelines specified by the Involuntary Treatment Act (ITA):

(i) Assesses a client's level of need for transportation according to procedures established by the county in which the client being assessed resides; and

(ii) Decides, following the assessment, how a client should be transported to an inpatient psychiatric treatment facility.

(c) "Involuntary Treatment Act" means, for adults, chapter 71.05 RCW; for juveniles, chapter 71.34 RCW. See also chapter 388-865 WAC.

(d) "Regional support network (RSN)" means a county authority or group of county authorities recognized by the secretary of the department of social and health services (DSHS) and which contracts with DSHS to implement a locally managed community mental health program.

(2) The medical assistance administration (MAA) covers transportation under ITA for an individual who is being involuntarily detained for mental health treatment, after that individual has been assessed by a CD-MHP and found to be:

(a) A danger to self;

(b) A danger to others; or

(c) Gravely disabled.

(3) Transportation under ITA may be provided to an eligible individual by an organization designated as an ITA provider by the local community mental health center and/or RSN. Designated ITA providers must comply with the department's requirements for drivers, driver training, vehicle and equipment standards and maintenance.

(4) Transportation under the ITA for an individual described in subsection (2) is covered from:

(a) The site of the initial detention;

(b) An evaluation and treatment facility designated by the department; or

(c) A court hearing.

(5) Transportation under the ITA for an individual described in subsection (2) is covered when provided to:

(a) An evaluation and treatment facility;

(b) A less restrictive alternative setting, except when ambulance transport to a client's home is not covered; or

(c) A court hearing.

(6) The CD-MHP authorizes the level of transportation provided under ITA to and from covered facilities based on the individual's need. A copy of the authorization by the CD-MHP must be kept in the individual's file.

(7) MAA pays for ITA transports to the nearest and most appropriate destination. The reason for the diversion to a more distant facility must be clearly documented in the individual's file.

(8) The department's mental health division (MHD) establishes payment for ITA transports. Providers must clearly identify ITA transports on the claim form when submitting claims to MAA.

[WSR 11-14-075, recodified as § 182-546-4000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. WSR 04-17-118, § 388-546-4000, filed 8/17/04, effective 9/17/04.]

WAC 182-546-4600 Ambulance transportation—Involuntary substance use disorder treatment—Ricky Garcia Act. (1) Definitions. For the purposes of this section, the following definitions and those found in chapter 182-500 WAC apply:

(a) **"Behavioral health organization (BHO)"** - See WAC 182-500-0015.

(b) **"Chemical dependency professional"** means a person certified as a chemical dependency professional by the department of health (DOH) under chapter 18.205 RCW.

(c) **"Designated crisis responder (DCR)"** means a mental health professional appointed by the behavioral health organization (BHO) to perform the duties described in chapter 71.05 RCW.

(d) **"Detention"** or **"detain"** means the lawful confinement of a person, under chapter 71.05 RCW.

(e) **"Gravely disabled"** means a condition in which a person, as a result of a mental disorder, or as the result of the use of alcohol or other psychoactive chemicals:

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

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

(f) **"Less restrictive alternative treatment"** means a program of individualized treatment in a less restrictive setting than inpatient treatment and that includes the services described in RCW 71.05.585.

(g) **"Nearest and most appropriate destination"** means the nearest facility able and willing to accept the involuntarily detained person for treatment, not the closest facility based solely on driving distance.

(h) **"Secure detoxification facility"** means a facility operated by either a public or private agency that:

(i) Provides for intoxicated people:

(A) Evaluation and assessment by certified chemical dependency professionals;

(B) Acute or subacute detoxification services;

(C) Discharge assistance by certified chemical dependency professionals, including assistance with transitions to appropriate voluntary or involuntary inpatient services, or to less-restrictive alternatives appropriate for the client;

(ii) Includes security measures sufficient to protect the patients, staff, and community; and

(iii) Is certified as a secure withdrawal management and stabilization facility by the department of health (DOH).

(2) For a client involuntarily detained for substance use disorder (SUD) treatment, the agency covers transportation services under the ITA when the client has been assessed by a DCR and found to be one of the following:

(a) A danger to self;

(b) A danger to others;

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

(d) Gravely disabled as a result of SUD.

(3) The agency pays for transportation under this section only when the transportation is:

(a) From one of the following locations:

(i) The site of the initial detention;

(ii) A local emergency room department;
(iii) A court hearing; or
(iv) A secure detoxification facility or crisis response center.
(b) To one of the following locations:
(i) A less restrictive alternative setting, except when ambulance transportation to a client's home is not covered;
(ii) A local emergency room department;
(iii) A court hearing; or
(iv) A secure detoxification facility or crisis response center.
(c) Provided by an ambulance transportation provider or law enforcement. The ambulance transportation provider must have an active core provider agreement (CPA) with the agency.
(d) To the nearest and most appropriate destination. The reason for a diversion to a more distant facility must be clearly documented in the client's file.
(4) The DCR authorizes the treatment destination based on the client's legal status.
(5) A copy of the agency's authorization of ambulance/secure transportation services under the Involuntary Treatment Act (ITA) form (HCA 42-0003) must be completed and signed by the DCR and kept in the client's file.
(6) The agency establishes payment for SUD-related transportation services when the transportation provider complies with the agency's requirements for drivers, driver training, vehicle and equipment standards and maintenance. Providers must clearly identify ITA transportation on the claim when billing the agency.

[Statutory Authority: 2016 c 29 1st sp. sess., RCW 41.05.021, and 41.05.160. WSR 18-21-042, § 182-546-4600, filed 10/8/18, effective 11/8/18.]

WAC 182-546-5000 Nonemergency transportation—General. (1) The medicaid agency covers nonemergency nonambulance transportation to and from covered health care services, as provided by the Code of Federal Regulations (42 C.F.R. 431.53 and 42 C.F.R. 440.170) subject to the limitations and requirements under WAC 182-546-5000 through 182-546-6200. See WAC 182-546-1000 for nonemergency ground ambulance transportation.
(2) The agency pays for nonemergency transportation for clients covered under state-funded medical programs subject to funding appropriated by the legislature.
(3) Clients may not select the transportation provider or the mode of transportation.
(4) A client's right to freedom of choice does not require the agency to cover transportation at unusual or exceptional cost in order to meet a client's personal choice of provider.

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

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

"Ambulance" - See WAC 182-546-0001.

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

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

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

"Extended stay" - A period of time spanning seven consecutive days or longer for which a client receives health care services outside of his or her local community and for which he or she may request assistance with meals and lodging.

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

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

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

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

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

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

"Noncompliance or noncompliant" - When a client:

- Fails to appear at the pickup point of the trip at the scheduled pickup time;
- Misuses or abuses agency-paid medical, transportation, or other services;
- Fails to comply with the rules, procedures, or policies of the agency or those of the agency's transportation brokers, the brokers'

subcontracted transportation providers, or health care service providers;

• Poses a direct threat to the health or safety of self or others; or

• Engages in violent, seriously disruptive, or illegal conduct.

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

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

"Short stay" - A period of time spanning one to six days for which a client receives health care services outside of his or her local community and for which he or she may request assistance with meals and lodging.

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

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

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

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

"Urgent care" - An unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day or the following day.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-12-022, § 182-546-5100, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5100, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5100, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5100, filed 7/12/11, effective 8/12/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-546-5100, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. WSR 01-06-029, § 388-546-5100, filed 3/2/01, effective 4/2/01.]

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

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

(b) Brokers to:

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

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

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

(2) Brokers:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The health care services are:

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

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

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

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

(c) The health care service is being provided:

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

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

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

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

(A) A medicare enrolled provider;

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, except for complex rehabilitation technology (CRT) and DME equipment that needs to be fitted to the client.

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

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

(h) Mental health services:

(i) Nonemergency transportation brokers generally provide one round trip per day to or from a mental health service. The broker must request agency approval for additional trips for off-site activities.

(ii) Nonemergency transportation of an involuntarily detained person under the Involuntary Treatment Act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider. See WAC 182-546-4000.

(i) Chemical dependency services - Nonemergency transportation is not provided through the brokers to or from the following:

(i) Residential treatment, intensive inpatient, or long-term treatment at certified facilities which are institutes for mental diseases (IMDs), as defined in WAC 182-500-0050;

(ii) Recovery house; and

(iii) Information and assistance services which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(2) Transportation may be provided to facilities identified by the agency as non-IMDs, and therefore eligible to receive medicaid funds (refer to the Catalog of Federal Domestic Assistance (CFDA) program number 93.778).

(3) The state-funded medical care services (MCS) program has a limitation on trips. Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The medicaid agency does pay for nonemergency transportation to and from medical services listed in WAC 182-501-0060, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-12-022, § 182-546-5550, filed 5/20/16, effective 6/20/16; WSR 15-03-050, § 182-546-5550, filed 1/14/15, effective 2/14/15. WSR 11-17-059, recodi-

fied as § 182-546-5550, filed 8/15/11, effective 8/15/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5550, filed 7/12/11, effective 8/12/11.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) If requested by the broker, the client or the client's provider must provide documentation from the client's primary care provider (PCP), specialist, or other appropriate provider verifying the

medical necessity for the client to be served by a health care provider outside of the client's local community.

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

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

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

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

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

(A) Active cancer treatment;

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

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

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

(E) Third trimester of pregnancy;

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

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

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

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

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

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

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

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

(i) Transit bus fare;

(ii) Commercial bus or train fare;
(iii) Gas voucher/gas card; or
(iv) Mileage reimbursement.

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

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

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

WAC 182-546-5800 Nonemergency transportation—Trips out-of-state/out-of-country. (1) The medicaid agency reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered health care services, including WAC 182-501-0180, 182-501-0182 and 182-501-0184.

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

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

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

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

(3) Brokers follow the agency's guidelines in determining the reasonable costs of meals and lodging. The agency's guidelines are:

(a) The reasonable cost of lodging for short and extended stays is measured against state per diem rates.

(b) For short stays, the cost of meals is measured against the state per diem rate.

(c) For extended stays, the reasonable cost of meals is measured against the state's basic food program. The maximum monthly allowable

meal cost for extended stays is not to exceed the client's calculated monthly food benefit or state per diem rates.

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-03-050, § 182-546-5900, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-5900, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-5900, filed 7/12/11, effective 8/12/11.]

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-546-6200 Nonemergency transportation—Reimbursement. (1) To be reimbursed for trips, meals, or lodging, the requestor must receive prior authorization from the broker at least two business days in advance of the client's travel.

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

(3) To be reimbursed for mileage, fuel, parking, bridge tolls, or ferry fees, the requestor must provide the broker with legible copies of:

(a) Receipt(s);

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

(c) Valid vehicle registration; and

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

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

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

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

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

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

(e) The request for retroactive reimbursement is made within sixty days from the date of eligibility notification (award letter), not

to exceed eight months from the date(s) of service for which reimbursement is requested.

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

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

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

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-03-050, § 182-546-6200, filed 1/14/15, effective 2/14/15. WSR 11-17-032, recodified as § 182-546-6200, filed 8/9/11, effective 8/9/11. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.500. WSR 11-15-029, § 388-546-6200, filed 7/12/11, effective 8/12/11.]