WSR 23-13-083
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 15, 2023, 2:05 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 22-17-048.

Title of Rule and Other Identifying Information: WAC 182-531-1850 Payment methodology for physician-related services——General and billing modifiers.

Hearing Location(s): On July 25, 2023, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. To attend the virtual public hearing, you must register in advance https://us02web.zoom.us/webinar/register/WN_QiArFJaqRvCj_rekiEBqoA. If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: No sooner than July 26, 2023.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 25, 2023, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email Johanna.Larson@hca.wa.gov, by July 14, 2023.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending this rule to explain how HCA updates the state-only composite rate, correct or remove outdated information, and clarify language throughout.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Wendy Steffens, P.O. Box 45500, Olympia, WA 98504-5500, 360-725-5145.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

Scope of exemption for rule proposal from Regulatory Fairness Act requirements:

Is not exempt.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The revised rule does not impose more-than-minor costs on small businesses.

June 15, 2023
Wendy Barcus
Rules Coordinator

OTS-4623.1

AMENDATORY SECTION (Amending WSR 21-23-050, filed 11/10/21, effective 12/11/21)

WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(1) The medicaid agency bases the payment methodology for most physician-related services on medicare's resource-based relative value scale (RBRVS). The agency obtains information used to update the agency's RBRVS from the ((~~MPFSPS~~)) centers for medicare and medicaid services (CMS) relative value unit (RVU) file.

(2) The agency updates and revises the ((~~following~~)) RBRVS ((~~areas each January prior to~~)) calculations during the agency's annual update.

(3) The agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by doing the following:

(a) First, determining the units of service and expenditures for a base period((~~. Then,~~));

(b) Second, applying the latest medicare RVU obtained from the medicare physician fee schedule database (MPFSDB), as published in the ((~~MPFSPS~~)) CMS RVU file, and blended Washington (WA) geographic practice cost indices (GCPI) ((~~changes~~)) to obtain projected units of service for the new period((~~. Then,~~));

(c) Third, multiplying the projected units of service by conversion factors to obtain estimated expenditures((~~. Then,~~));

(d) Fourth, comparing expenditures obtained in (c) of this subsection with base period expenditure levels((~~. Then,~~)); and

(e) Fifth, adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the ((~~three components (practice, malpractice, and work) of the RVU are~~)) agency determines RBRVS RVUs by:

(i) ((~~Each multiplied~~)) First, multiplying the medicare RVU by the blended statewide geographic practice cost index (GPCI)((~~. Then,~~)); and

(ii) Second, multiplying the sum of these products ((~~is multiplied~~)) by the applicable conversion factor. ((~~The resulting RVUs are known as RBRVS RVUs.~~))

(b) ((~~For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:~~

~~(i) When there are three RSC RVU components (practice, malpractice, and work):~~

~~(A) Each component is multiplied by the statewide GPCI. Then,~~

~~(B) The sum of these products is multiplied by the applicable conversion factor.~~

~~(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.~~

~~(c)~~)) For procedure codes with no RBRVS ((~~or RSC~~)) RVUs, the agency establishes maximum allowable fees, also known as "flat" fees.

(i) The agency does not use the conversion factor for these codes.

(ii) The agency updates flat fee reimbursement ((~~only~~)) based on market research or when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) ((~~Immunization~~)) The agency reimburses for professional administered drug codes ((~~are reimbursed~~)) at the medicare Part B drug file price or using point-of-sale (POS) ((~~AAC~~)) pricing methodology, described in WAC 182-530-7000, when there is no Part B rate. ((~~(See WAC 182-530-1050 for explanation of POS AAC.)~~)) When the provider receives immunization materials from the department of health, the agency pays only a flat administrative fee for ((~~administering the immunization~~)) storage.

(B) ((~~A cast material maximum allowable fee is set using an average of wholesale or distributor prices for cast materials~~)) The agency uses established medicare contractor rates.

(iii) For information regarding the agency's reimbursement of other supplies ((~~are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs))~~)), see WAC 182-543-9000.

((~~(d)~~)) (c) For procedure codes with no RVU or maximum allowable fee, the agency reimburses "by report." The agency reimburses for by report codes ((~~are reimbursed~~)) at a percentage of the amount billed for the service.

((~~(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.~~

~~(f) The agency reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established~~)) (d) The agency adjusts composite rates annually when the codes that make up the composite rates are updated.

(5) The ((~~technical advisory group~~)) agency reviews RBRVS changes.

(6) The agency also makes fee schedule changes when:

(a) The legislature grants a vendor rate increase ((~~and the effective date of that increase is not the same as~~)) outside of the agency's annual update;

(b) There are coverage changes due to policy updates; or

(c) CMS adds or deletes procedure codes.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the agency applies the increase after calculating budget-neutral fees. The agency pays providers a higher reimbursement rate for primary health care evaluation and management (E&M) services that are provided to children age 20 and ((~~under~~)) younger.

(8) The agency may adjust rates to maintain or increase access to health care services as directed by the legislature.

(9) The agency does not allow separate reimbursement for CMS bundled services. ((~~However, the agency allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.~~))

(10) Variations of payment methodology which are specific to particular services, and which differ from the general payment methodolo-

gy described in this section, are included in the sections dealing with those particular services.

((~~CPT/HCFA~~)) CURRENT PROCEDURAL TERMINOLOGY (CPT)/HEALTHCARE FINANCING ADMINISTRATION (HCFA) MODIFIERS

(11) ((~~A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.~~

~~(12)~~)) Certain services and procedures require modifiers ((~~in order~~)) for the agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-23-050, § 182-531-1850, filed 11/10/21, effective 12/11/21; WSR 17-21-040, § 182-531-1850, filed 10/12/17, effective 11/12/17; WSR 17-04-039, § 182-531-1850, filed 1/25/17, effective 2/25/17. WSR 11-14-075, recodified as § 182-531-1850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]