WSR 25-04-112
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed February 5, 2025, 8:19 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 24-20-066.

Title of Rule and Other Identifying Information: WAC 182-531-0050 Physician-related services definitions, and 182-531-2040 Enhanced reimbursement—Medication assisted treatment for opioid use disorder.

Hearing Location(s): On March 11, 2025, 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 at https://us02web.zoom.us/webinar/register/WN_s1pnm0KASVK81uTFRRtb2w.

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: Not sooner than March 12, 2025.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, beginning February 6, 2025, 8:00 a.m., by March 11, 2025, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication relay service 711, email Johanna.Larson@hca.wa.gov, by February 21, 2025.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending WAC 182-531-2040 Enhanced reimbursement—Medication assisted treatment for opioid use disorder, to change the title to Enhanced reimbursement—Medication for opioid use disorder (MOUD) and to clarify the requirements for receiving the enhanced reimbursement for MOUD. HCA is also amending WAC 182-531-0050 to remove MAT and add MOUD to the list of definitions.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Statute Being Implemented: RCW 41.05.021 and 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason R.P. Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Andrea Allen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9805.

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. HCA is only changing the name of the enhanced reimbursement and clarifying the requirements for receiving the enhanced reimbursement.

February 5, 2025
Wendy Barcus
Rules Coordinator

RDS-6125.2

AMENDATORY SECTION (Amending WSR 24-08-061, filed 3/29/24, effective 5/1/24)

WAC 182-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, apply to this chapter.

"Actual acquisition cost" - See WAC 182-530-1050.

"Acute care" - Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" - A comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at a medicaid agency-approved rehabilitation facility. The program provides 24-hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 182-550-2501).

"Add-on procedure(s)" - Secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" - The medical condition responsible for a hospital admission, as defined by the ICD diagnostic code.

"Advanced registered nurse practitioner (ARNP)" - A registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Allowed charges" - The maximum amount reimbursed for any procedure that is allowed by the medicaid agency.

"Anesthesia technical advisory group (ATAG)" - An advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" - Any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" - A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intraoperative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" - Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" - Supplies that are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)" - See WAC 182-500-0015.

"Call" - A face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" - A reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Center of excellence (COE)" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)" - See WAC 182-500-0020.

"Certified registered nurse anesthetist (CRNA)" - An advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the national certification and scope of practice.

"Children's health insurance plan (CHIP)" - See chapter ((~~182-542~~)) 182-505 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" - Regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" - Dollar amounts the medicaid agency uses to calculate the maximum allowable fee for physician-related services.

"Covered service" - A service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT" - See "current procedural terminology."

"Critical care services" - Physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Emergency medical condition(s)" - See WAC 182-500-0030.

"Emergency services" - Medical services required by and provided to a patient experiencing an emergency medical condition.

"Evaluation and management (E&M) codes" - Procedure codes that categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" - The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the medicaid agency which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness. A service is not "experimental" if the service:

(a) Is generally accepted by the medical profession as effective and appropriate; and

(b) Has been approved by the federal Food and Drug Administration or other requisite government body, if such approval is required.

"Federally approved hemophilia treatment center" - A hemophilia treatment center (HTC) that:

(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

(b) Is qualified to participate in 340B discount purchasing as an HTC. See WAC 182-530-7900;

(c) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC website;

(d) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and

(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

"Fee-for-service" - See WAC 182-500-0035.

"Flat fee" - The maximum allowable fee established by the agency for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" - As defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement" - See WAC 182-531-1700.

"HCPCS Level II" - Health care common procedure coding system, a coding system established by Centers for Medicare and Medicaid Services (CMS) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" - The name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" - A group of health care providers involved in the care of a client.

"Hospice" - A medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD" - See "International Classification of Diseases."

"Informed consent" - That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all the following:

(a) Disclosed and discussed the client's diagnosis;

(b) Offered the client an opportunity to ask questions about the procedure and to request information in writing;

(c) Given the client a copy of the consent form;

(d) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(e) Given the client oral information about all the following:

(i) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;

(ii) Alternatives to the procedure including potential risks, benefits, and consequences; and

(iii) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" - An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases (ICD)" - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumerical designations (coding).

"Investigational" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness for a particular condition. A service is not "investigational" if the service:

(a) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(b) Is supported by an overall balance of objective scientific evidence, that examines the potential risks and potential benefits and demonstrates the proposed service to be of greater overall benefit to the client in the particular circumstance than another generally available service.

"Life support" - Mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension" - See WAC 182-501-0169.

"Long-acting reversible contraceptive (LARC)" - Subdermal implants and intrauterine devices (IUDs).

"Maximum allowable fee" - The maximum dollar amount that the medicaid agency will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary" - See WAC 182-500-0070.

((~~**"Medication assisted treatment (MAT)" - The use of Food and Drug Administration-approved medications that have published evidence of effectiveness, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.**~~))

"Medicare clinical diagnostic laboratory fee schedule" - The fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Medicare physician fee schedule database (MPFSDB)" - The official CMS publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" - The official CMS publication of the medicare fees for physician services.

"Medication for opioid use disorder (MOUD)" - The use of Food and Drug Administration-approved medications that have published evidence of effectiveness, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

"Mentally incompetent" - A client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" - A two-digit alphabetic or numeric, or both, identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient" - See WAC 182-500-0080.

"Peer-reviewed medical literature" - A research study, report, or findings regarding a medical treatment that is published in one or more reputable professional journals after being critically reviewed by appropriately credentialed experts for scientific validity, safety, and effectiveness.

"Physician care plan" - A written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" - Physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology" - See "current procedural terminology (CPT)."

"PM&R" - See acute physical medicine and rehabilitation.

"Podiatric service" - The diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the medicaid agency's fee schedules that is not routinely covered.

"Preventive" - Medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization" - See WAC 182-500-0085.

"Professional component" - The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" - The probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" - Face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider" - See WAC 182-500-0085.

"Radioallergosorbent test" or **"RAST"** - A blood test for specific allergies.

"RBRVS" - See resource based relative value scale.

"RBRVS RVU" - A measure of the resources required to perform an individual service or intervention. It is set by medicare based on

three components - Physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"Reimbursement" - Payment to a provider or other agency-approved entity who bills according to the provisions in WAC 182-502-0100.

"Reimbursement steering committee (RSC)" - An interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the medicaid agency and the department of labor and industries.

"Relative value guide (RVG)" - A system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" - A unit that is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RSC RVU" - A unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"RVU" - See relative value unit.

"Stat laboratory charges" - Charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" - A tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by CMS to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" - An advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Technical component" - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

AMENDATORY SECTION (Amending WSR 23-16-058, filed 7/26/23, effective 8/26/23)

WAC 182-531-2040 Enhanced reimbursement—Medication ((~~assisted treatment~~)) for opioid use disorder. (1) The medicaid agency pays an enhanced reimbursement using the medicare rate when medication ((~~assisted treatment (MAT)~~)) for opioid use disorder (MOUD) is part of the visit for selected evaluation and management (E/M) codes and the provider meets the criteria in this section.

(2) The purpose of this enhanced reimbursement is to increase client access to evidence-based treatment using medications for opioid use disorder.

(3) To receive the enhanced reimbursement for ((~~MAT~~)) MOUD, a provider must:

(a) Bill using the agency's expedited prior authorization process;

(b) Bill for treating a client with a qualifying primary or secondary diagnosis for opioid use disorder; ((~~and~~))

(c) Ensure the client was offered, administered, or received a prescription for a federal Food and Drug Administration-approved medication for the treatment of opioid use disorder at the time the service was provided; and

(d) Provide opioid-related counseling during the visit.

(4) The agency payment for ((~~MAT~~)) MOUD under this section is limited to one enhanced reimbursement, per client, per day.

(5) The agency does not pay an enhanced reimbursement for services a client receives for opioid use disorder through an opioid treatment program facility licensed by the department of health.