

WSR 26-07-031

PERMANENT RULES

HEALTH CARE AUTHORITY

[Filed March 11, 2026, 9:28 a.m., effective April 11, 2026]

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

Purpose: The health care authority (agency) is adding references to early periodic screening, diagnosis, and treatment services to program rules to increase awareness, improve care, and for consistency with other agency rules. These revisions do not change current policy but further clarify existing policy.

Citation of Rules Affected by this Order: Amending WAC 182-531A-0900, 182-533-0600, 182-538-050, 182-538B-040, 182-538D-0200, 182-546-5100, 182-546-5500, 182-550-1100, 182-553-500, and 182-555-0300.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-04-019 on January 23, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 10, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 10, Repealed 0.

Date Adopted: March 11, 2026.

Wendy Barcus
Rules Coordinator

RDS-6703.2

AMENDATORY SECTION (Amending WSR 24-11-043, filed 5/9/24, effective 6/9/24)

WAC 182-531A-0900 Applied behavior analysis (ABA)—Covered services. (1) The medicaid agency covers only the following applied behavior analysis (ABA) services, delivered in settings described in WAC 182-531A-0600, for eligible clients:

- (a) The ABA assessments that determine the relationship between environmental events and the client's behaviors;
- (b) The direct provision of ABA services by the therapy assistant (TA) or lead behavior analysis therapist (LBAT);
- (c) Initial ABA assessment and development of a written, initial ABA therapy treatment plan, limited to one per year;
- (d) Up to four additional ABA assessments and revisions of the initial ABA therapy treatment plan per year, if necessary to meet client's needs;

- (e) One lifetime authorization of day treatment services. If a provider's request for covered services exceeds limitations in this section, the agency evaluates the request under WAC 182-501-0169.
- (f) Supervision of the TA;
- (g) Training and evaluation of family members or caregivers to carry out the approved ABA therapy treatment plans;
- (h) Observation of the client's behavior to determine the effectiveness of the approved ABA therapy treatment plan; and
- (i) On-site assistance in the event of a crisis.
- (2) The agency covers the following services, which may be provided in conjunction with ABA services under other agency programs:
- (a) Counseling;
- (b) Dietician services;
- (c) Interpreter services;
- (d) Occupational therapy;
- (e) Physical therapy;
- (f) Speech and language therapy; and
- (g) Transportation services.
- (3) The agency does not pay for ABA services:
- (a) That duplicate services provided in another setting; or
- (b) That are provided by a family member.
- (4) If a provider's request for covered services exceeds limitations in this section, the agency evaluates the request under WAC 182-501-0169.
- (5) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6704.3

AMENDATORY SECTION (Amending WSR 20-02-068, filed 12/26/19, effective 1/26/20)

- WAC 182-533-0600 Planned home births and births in birthing centers.** (1) **Client eligibility.** The medicaid agency covers planned home births and births in birthing centers for clients who choose to give birth at home or in an agency-approved birthing center and:
- (a) Are eligible for the alternative benefit package under WAC 182-501-0060, categorically needy or medically needy scope of care under WAC 182-533-0400(2);
- (b) Have an agency-approved medical provider who has accepted responsibility for the planned home birth or birth in birthing center under this section;
- (c) Are expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and
- (d) Pass the agency's risk screening criteria. The agency provides these risk-screening criteria to qualified medical services providers.
- (2) **Qualified providers.** Only the following provider types may be reimbursed for planned home births and births in birthing centers:
- (a) Physicians licensed under chapters 18.57 or 18.71 RCW;
- (b) Nurse midwives licensed under chapter 18.79 RCW; and
- (c) Midwives licensed under chapter 18.50 RCW.

(3) **Birth center requirements.**

(a) Each participating birthing center must:

(i) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-329 WAC;

(ii) Be specifically approved by the agency to provide birthing center services;

(iii) Have a valid core provider agreement with the agency; and

(iv) Maintain standards of care required by DOH for licensure.

(b) The agency suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in (a) of this subsection.

(4) **Home birth or birthing center providers.** Home birth or birthing center providers must:

(a) Obtain from the client a signed consent form in advance of the birth;

(b) Follow the agency's risk screening criteria and consult with, or refer the client or newborn to, a physician or hospital when medically appropriate;

(c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client or newborn to a hospital;

(d) Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care;

(e) Inform parents of required prophylactic eye ointment and newborn screening tests for heritable or metabolic disorders, and congenital heart defects, and send the newborn's blood sample to the DOH for testing. Parents may refuse these services for religious reasons under RCW 70.83.020. The provider must obtain the signature from the parent(s) on:

(i) The reverse side of the screening card to document refusal of screenings for heritable or metabolic disorders; and

(ii) A waiver form to document refusal of prophylactic eye ointment or a screening for congenital heart defects;

(f) Inform parents of the benefits and risks of Vitamin K injections for newborns; and

(g) Have evidence of current cardiopulmonary resuscitation (CPR) training for:

(i) Adult CPR; and

(ii) Neonatal resuscitation.

(5) **Planned home birth providers.** Planned home birth providers must:

(a) Provide medically necessary equipment, supplies, and medications for each client;

(b) Have arrangements for (~~twenty-four~~) 24 hour per day coverage;

(c) Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and

(d) Participate in a formal, state-sanctioned, quality assurance improvement program or professional liability review process.

(6) **Limitations.** The agency does not cover planned home births or births in birthing centers for women identified with any of the following conditions:

(a) Previous cesarean section;

(b) Current alcohol or drug addiction or abuse;

(c) Significant hematological disorders or coagulopathies;

(d) History of deep venous thrombosis or pulmonary embolism;

- (e) Cardiovascular disease causing functional impairment;
- (f) Chronic hypertension;
- (g) Significant endocrine disorders including preexisting diabetes (type I or type II);
- (h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy or abnormal liver function tests;
- (i) Isoimmunization, including evidence of Rh sensitization or platelet sensitization;
- (j) Neurologic disorders or active seizure disorders;
- (k) Pulmonary disease;
- (l) Renal disease;
- (m) Collagen-vascular diseases;
- (n) Current severe psychiatric illness;
- (o) Cancer affecting the female reproductive system;
- (p) Multiple gestation;
- (q) Breech presentation in labor with delivery not imminent; or
- (r) Other significant deviations from normal as assessed by the provider.

(7) **Clients age 20 and younger.** For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6707.1

AMENDATORY SECTION (Amending WSR 22-07-107, filed 3/23/22, effective 4/23/22)

WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Administrative hearing" means an evidentiary adjudicative proceeding before an administrative law judge or presiding officer that is available to an enrollee under chapter 182-526 WAC according to RCW 74.09.741.

"Adverse benefit determination" means one or more of the following:

- (a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- (b) The reduction, suspension, or termination of a previously authorized service;
- (c) The denial, in whole or in part, of payment for a service;
- (d) The failure to provide services in a timely manner, as defined by the state;
- (e) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. Sec. 438.408 (a), (b) (1) and (2) for standard resolution of grievances and appeals; or
- (f) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52 (b) (2) (ii).

"Agency" - See WAC 182-500-0010.

"Appeal" means a review by an MCO of an adverse benefit determination.

"Apple health foster care (AHFC)" means the managed care program developed by the agency and the department of social and health services to serve children and youth in foster care and adoption support and young adult alumni of the foster care program.

"Assign" or **"assignment"** means the agency selects an MCO to serve a client who has not selected an MCO.

"Auto enrollment" means the agency has automatically enrolled a client into an MCO in the client's area of residence.

"Behavioral health" - See WAC 182-538D-0200.

"Behavioral health administrative service organization (BH-ASO)" means an entity selected by the medicaid agency to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

"Behavioral health services only (BHSO)" means the program in which enrollees only receive behavioral health benefits through a managed care delivery system.

"Child or youth with special health care needs" means a client under age 19 who is:

- (a) Eligible for supplemental security income under Title XVI of the Social Security Act;
- (b) Eligible for medicaid under section 1902 (e)(3) of the Social Security Act;
- (c) In foster care or other out-of-home placement;
- (d) Receiving foster care or adoption assistance; or
- (e) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501 (a)(1)(D) of Title V of the Social Security Act.

"Client" - See WAC 182-500-0020.

"Disenrollment" - See "end enrollment."

"Early periodic screening, diagnosis, and treatment (EPSDT)" - See WAC 182-534-0050.

"Emergency medical condition" means a condition meeting the definition in 42 C.F.R. Sec. 438.114(a).

"Emergency services" means services defined in 42 C.F.R. Sec. 438.114(a).

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 182-538-130.

"Enrollee" means a person eligible for any Washington apple health program enrolled in managed care with an MCO or PCCM provider that has a contract with the state.

"Enrollee's representative" means a person with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs" means enrollees having chronic and disabling conditions and the conditions:

- (a) Have a biologic, psychologic, or cognitive basis;
- (b) Have lasted or are virtually certain to last for at least one year; and
- (c) Produce one or more of the following conditions stemming from a disease:
 - (i) Significant limitation in areas of physical, cognitive, or emotional function;

(ii) Dependency on medical or assistive devices to minimize limitation of function or activities; or

(iii) In addition, for children, any of the following:

(A) Significant limitation in social growth or developmental function;

(B) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

(C) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means agency approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 182-538-130.

"Fully integrated managed care (FIMC)" - See integrated managed care.

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination.

"Grievance and appeal system" means the processes the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

"Health care service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Integrated managed care (IMC)" means the program under which a managed care organization provides:

(a) Physical health services funded by medicaid; and

(b) Behavioral health services funded by medicaid, and other available resources provided for in chapters 182-538B, 182-538C, and 182-538D WAC.

"Managed care" means a comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract" means the agreement between the agency and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the agency under a comprehensive risk contract to provide prepaid health care services to enrollees under the agency's managed care programs.

"Mandatory enrollment" means the agency's requirement that a client enroll in managed care.

"Mandatory service area" means a service area in which eligible clients are required to enroll in an MCO.

"Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity acting within their scope of practice and licensure that:

(a) Provides health care services to enrollees; and

(b) Does not have a written agreement with the managed care organization (MCO) to participate in the MCO's provider network.

"Participating provider" means a person, health care provider, practitioner, or entity acting within their scope of practice and licensure with a written agreement with the MCO to provide services to enrollees.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the

patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for 90 days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"Primary care case management" or "PCCM" means the health care management activities of a provider that contracts with the agency to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or "PCP" means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), naturopath, or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Regional service area (RSA)" means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

"Timely" concerning the provision of services, means an enrollee has the right to receive medically necessary health care as expeditiously as the enrollee's health condition requires. Concerning authorization of services and grievances and appeals, "timely" means according to the agency's managed care program contracts and the time frames stated in this chapter.

"Wraparound with intensive services (WISE)" is a program that provides comprehensive behavioral health services and support to:

- (a) Medicaid-eligible people age 20 or younger with complex behavioral health needs; and
- (b) Their families.

RDS-6708.2

AMENDATORY SECTION (Amending WSR 19-24-063, filed 11/27/19, effective 1/1/20)

WAC 182-538B-040 Behavioral health wraparound services. (1)

This chapter governs nonmedicaid funded behavioral health services provided under the medicaid agency's behavioral health services wrap-around contract. See also chapter 182-538D WAC for rules applicable to nonmedicaid behavioral health services.

(2) Washington apple health integrated managed care (IMC) behavioral health wraparound services are available only through a managed care organization (MCO) contracted to provide IMC services.

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an IMC regional service area:

- (a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) When nonmedicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

(5) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6944.2

AMENDATORY SECTION (Amending WSR 25-22-061, filed 10/30/25, effective 1/1/26)

WAC 182-538D-0200 Behavioral health services—Definitions. The following definitions and those found in chapters 182-500, 182-538, and 182-538C WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Adult" means a person age 18 or older.

"Assessment" means the process of obtaining all pertinent biopsychosocial information, as identified by the person, and family and collateral sources, for determining a diagnosis and to plan individualized services and supports.

"Behavioral health" means the prevention, treatment of, and recovery from substance use disorders, mental health disorders or problem and pathological gambling disorders.

"Behavioral health administrative service organization (BH-ASO)" - See WAC 182-538-050.

"Behavioral health agency" means an entity licensed by the department of health (DOH) to provide behavioral health services, including services for mental health disorders and substance use disorders.

"Certified behavioral health support specialist (BHSS)" means a person who delivers brief behavioral health services under the supervision of a provider outlined in WAC 246-821-410. To provide services as a BHSS, this person must have a bachelor's degree and have completed the BHSS educational program recognized by DOH.

"Certified peer counselor" - See chapter 182-115 WAC.

"Certified peer support specialist" or "CPSS" - See chapter 246-929 WAC.

"Certified peer support specialist trainee" or "CPSST" - See chapter 246-929 WAC.

"Child" means the same as in RCW 71.24.025. For clients age 20 and younger, (~~providers must follow the rules for~~) see the early periodic screening, diagnosis, and treatment (EPSDT) program(~~;~~ see) described in chapter 182-534 WAC.

"Clinical record" means a paper or electronic file that is maintained by the provider and contains pertinent psychological, medical, and clinical information for each person served.

"Community support services" means the same as in RCW 71.24.025.

"Complaint" - See "grievance" in WAC 182-538-050.

"Consent" means agreement given by a person after the person is provided with a description of the nature, character, anticipated results of proposed treatments and the recognized serious possible risks, complications, and anticipated benefits, including alternatives and nontreatment. Informed consent must be provided in a terminology that the person can reasonably be expected to understand.

"Consultation" means the clinical review and development of recommendations regarding activities, or decisions of, clinical staff, contracted employees, volunteers, or students by people with appropriate knowledge and experience to make recommendations.

"Crisis" means an actual or perceived urgent or emergent situation that occurs when a person's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the person's mental or physical health, or to prevent the need for referral to a significantly higher level of care.

"Cultural competence" or **"culturally competent"** means the ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which people from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging people to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.

"Designated crisis responder (DCR)" means a mental health professional appointed by the county, or an entity appointed by the county, to perform the duties described in chapter 71.05 RCW.

"Disability" means a physical or mental impairment that substantially limits one or more major life activities of a person and the person:

- (a) Has a record of such an impairment; or
- (b) Is regarded as having such impairment.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

- (a) African American;
- (b) An American Indian or Alaskan native, which includes:
 - (i) A person who is a member or considered to be a member in a federally recognized tribe;
 - (ii) A person determined eligible to be found Indian by the secretary of interior;
 - (iii) An Eskimo, Aleut, or other Alaskan native; and
 - (iv) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off-reservation Indian/Alaskan native community organization.
- (c) Asian/Pacific Islander; or
- (d) Hispanic.

"Housing services" means the active search and promotion of individual access to, and choice in, safe and affordable housing that is appropriate to the person's age, culture, and needs.

"Integrated managed care (IMC)" - See WAC 182-538-050.

"Less restrictive alternative (LRA)" - See WAC 182-538C-050.

"Mental health professional" means a person who meets the following:

- (a) A psychiatrist, psychologist, psychological associate, physician assistant working with a supervising psychiatrist, psychiatric

advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate; or

(c) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of people with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by DOH or attested to by the licensed behavioral health agency.

"Mental health specialist" means:

(a) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(i) A minimum of 100 actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(ii) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(b) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(i) A minimum of 100 actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of people age 60 and older; and

(ii) The equivalent of one year of full-time experience in the treatment of people age 60 and older, under the supervision of a geriatric mental health specialist.

(c) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including:

(i) Evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(ii) One of the following:

(A) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(B) A minimum of 100 actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minorities.

(d) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means a person with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(i) If the consumer is deaf, the specialist must be a mental health professional with:

(A) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(B) Ability to communicate fluently in the preferred language system of the consumer.

(ii) The specialist for people with developmental disabilities must be a mental health professional who:

(A) Has at least one year experience working with people with developmental disabilities; or

(B) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Quality plan" means an overarching system or process, or both, whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of a BH-ASO's or MCO's operations.

"Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for people who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

"Resource management services" means the same as in RCW 71.24.025.

"Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that a person continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

"Substance use disorder professional" or **"SUDP"** - See WAC ((182-500-010)) 182-500-0100.

"Substance use disorder professional trainee" or **"SUDPT"** - See WAC 246-811-010.

"Supervision" means the regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give direction and require change.

"Youth" means a person age 13 through age 17. For clients age 20 and younger, ((providers must follow the rules for)) see the early periodic screening, diagnosis, and treatment (EPSDT) program((; see)) described in chapter 182-534 WAC.

RDS-6709.2

AMENDATORY SECTION (Amending WSR 23-17-118, filed 8/18/23, effective 9/18/23)

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.

"Against medical advice (AMA)" - When a client elects to discharge from a health care facility against the advice of medical professionals.

"Ambulance" - See WAC 182-546-0125.

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

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

"Early periodic screening, diagnosis, and treatment (EPSDT)" - See WAC 182-534-0050.

"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.

"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;
- Public bus;
- Commercial bus;
- 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.

"Service animal" - An animal individually trained to work or perform tasks for an individual with a disability. The work or task an animal has been trained to provide must be directly related to the individual's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the American with Disabilities Act.

"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.

AMENDATORY SECTION (Amending WSR 16-06-053, filed 2/24/16, effective 4/1/16)

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.

(3) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6710.2

AMENDATORY SECTION (Amending WSR 23-19-018, filed 9/8/23, effective 10/9/23)

WAC 182-550-1100 Hospital care—General. (1) The medicaid agency:

(a) Pays for an eligible Washington apple health client's admission to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered under WAC 182-501-0050, 182-501-0060 and 182-501-0065;

(ii) Are medically necessary as defined in WAC 182-500-0070;

(iii) Are determined according to WAC 182-501-0165 when prior authorization is required;

(iv) Are authorized when required under this chapter; and

(v) Meet applicable state and federal requirements.

(b) For hospital admissions, defines "attending physician" as the client's primary care provider, or the primary provider of care to the client at the time of admission.

(2) Medical record documentation of hospital services must meet the requirements in WAC 182-502-0020.

(3) The agency pays for a hospital covered service provided to an eligible apple health client enrolled in an agency-contracted managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the agency and meets prior authorization requirements. (See WAC 182-550-2600 for inpatient psychiatric services.)

(4) The agency pays up to 26 days of inpatient hospital care for hospital-based withdrawal management, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the substance-using pregnant people (SUPP) program.

See WAC 182-533-0701 through 182-533-0730.

(5) The agency pays for inpatient hospital withdrawal management of acute alcohol or other drug intoxication when the services are provided to an eligible client:

(a) In a withdrawal management unit in a hospital that has a withdrawal management provider agreement with the agency to perform these services and the services are approved by the division of behavioral health and recovery (DBHR) within the health care authority (HCA); or

(b) In an acute hospital and all the following criteria are met:

(i) The hospital does not have a withdrawal management specific provider agreement with DBHR;

(ii) The hospital provides the care in a medical unit;

(iii) Nonhospital-based withdrawal management is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from the agency or the agency's designee as an inpatient stay is not indicated;

(v) The client's stay qualifies as an inpatient stay;

(vi) The client is not participating in the agency's substance-using pregnant people (SUPP) program; and

(vii) The client's principal diagnosis meets the agency's medical inpatient withdrawal management criteria listed in the agency's published billing instructions.

(6) The agency covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

(a) Are provided under chapter 182-535 WAC; and

(b) Are billed on the American Dental Association (ADA) or health care financing administration (HCFA) claim form.

(7) The agency pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room, when:

(a) The covered dental-related services are medically necessary and provided under chapter 182-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least one of the following is true:

(i) The dental-related service(s) is provided to an eligible apple health client on an emergency basis;

(ii) The client is eligible under the division of developmental disability program;

(iii) The client is age eight or younger; or

(iv) The dental service is prior authorized by the agency.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 182-550-2600.

(9) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6711.2

AMENDATORY SECTION (Amending WSR 19-01-024, filed 12/10/18, effective 2/1/19)

WAC 182-553-500 Home infusion therapy and parenteral nutrition program—Coverage, services, limitations, prior authorization, and reimbursement. (1) The home infusion therapy and parenteral nutrition program covers the following for eligible clients, subject to the limitations and restrictions listed:

(a) A one-month supply of home infusion, per client, per calendar month.

(b) A one-month supply of parenteral nutrition solution, per client, per calendar month.

(c) One type of infusion pump, one type of parenteral pump, and one type of insulin pump per client, per calendar month and as follows:

(i) All rent-to-purchase infusion, parenteral, and insulin pumps must be new equipment at the beginning of the rental period.

(ii) The agency covers the rental payment for each type of infusion, parenteral, or insulin pump for up to (~~twelve~~) 12 months. The agency considers a pump purchased after (~~twelve~~) 12 months of rental payments.

(iii) The agency covers only one purchased infusion pump or parenteral pump per client in a five-year period.

(iv) The agency covers only one purchased insulin pump per client in a four-year period.

(2) Covered supplies and equipment that are within the described limitations listed in subsection (1) of this section do not require prior authorization for reimbursement.

(3) The agency pays for FDA-approved continuous glucose monitoring systems and related monitoring equipment and supplies using the expedited prior authorization process when the client meets the following criteria:

(a) Is age (~~eighteen~~) 18 and younger;

(b) Is age (~~nineteen~~) 19 and older with Type 1 diabetes;

(c) Is age (~~nineteen~~) 19 and older with Type 2 diabetes who is:

(i) Unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan after six months of intensive insulin therapy and testing blood glucose four or more times per day;

(ii) Suffering from one or more severe episodes of hypoglycemia despite adherence to an appropriate glycemic management plan; or

(iii) Unable to recognize, or communicate about, symptoms of hypoglycemia.

(d) Is pregnant with:

(i) Type 1 diabetes; or

(ii) Type 2 diabetes and on insulin prior to pregnancy;

(iii) Type 2 diabetes and whose blood glucose does not remain well controlled on diet or oral medication during pregnancy and requires insulin; or

(iv) Gestational diabetes with blood glucose that is not well controlled (HbA1C above target or experiencing episodes of hyperglycemia or hypoglycemia) and requires insulin.

(4) Requests for supplies or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on a case-by-case basis under WAC 182-501-0165 and 182-501-0169.

(5) The agency may adopt policies, procedure codes, and rates inconsistent with those set by medicare.

(6) Agency reimbursement for equipment rentals and purchases includes the following:

(a) Instructions to a client, a caregiver, or both, on the safe and proper use of equipment provided;

(b) Full service warranty;

(c) Delivery and pickup; and

(d) Setup, fitting, and adjustments.

(7) For clients residing in a state-owned facility (i.e., state school, developmental disabilities facility, mental health facility, Western State Hospital, and Eastern State Hospital) payment for home infusion supplies, equipment, and parenteral nutrition solutions are the responsibility of the state-owned facility to provide.

(8) For clients who are eligible for and have elected to receive the agency's hospice benefit, the agency pays for home infusion or parenteral nutrition supplies and equipment separately from the hospice per diem rate when:

(a) The client has a preexisting diagnosis that requires parenteral support; and

(b) The preexisting diagnosis is not related to the diagnosis that qualifies the client for hospice.

(9) For clients residing in a nursing facility, infusion pumps, parenteral nutrition pumps, insulin pumps, solutions, and insulin infusion supplies are not included in the nursing facility per diem rate. The agency pays for these items separately.

(10) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

RDS-6859.1

AMENDATORY SECTION (Amending WSR 23-07-132, filed 3/22/23, effective 4/22/23)

WAC 182-555-0300 Eligibility. (1) The medicaid agency covers medical nutrition therapy for clients who are referred to a registered dietitian for medical nutrition therapy by a physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP).

(2) For clients age 20 and younger, see the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.