WSR 26-14-055
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 25, 2026, 12:18 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 26-11-014.

Title of Rule and Other Identifying Information: WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy), and 182-502-0002 Eligible provider types.

Hearing Location(s): On August 4, 2026, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. Virtual public hearings are held via Microsoft Teams webinar. To attend, you must register in advance at https://events.gcc.teams.microsoft.com/event/32d4231e-6e47-41ee-8ced-3a1f93bd02ee@11d0e217-264e-400a-8ba0-57dcc127d72d. After registering, you will receive a confirmation email containing information about joining the public hearing. You will be able to join the public hearing through most standard internet browsers; you do not need to install Microsoft Teams.

Date of Intended Adoption: Not sooner than August 5, 2026.

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 June 26, 2026, 8:00 a.m., by August 4, 2026, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Jessica Nguyen, phone 360-725-1174, fax 360-586-9727, telecommunication relay service 711, email Jessica.nguyen@hca.wa.gov, by July 17, 2026.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA added speech language pathology assistants (SLPAs), physical therapy assistants (PTAs), occupational therapy assistants (OTAs), and rural emergency hospitals (REHs) to the list of eligible providers in WAC 182-502-0002. OTAs and PTAs are already listed in WAC 182-545-200, but for consistency, HCA added these providers to the general eligible provider list in WAC 182-502-0002. HCA added REHs to the eligible providers list to support the rule making filed under WSR 26-10-052. HCA also added SLPAs to the list of providers who may enroll with the agency under WAC 182-545-200.

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: Governmental.

Name of Agency Personnel Responsible for Drafting: Blake O'Connor, 628 8th Avenue S.E., Olympia, WA 98501, 360-725-1344; Implementation and Enforcement: Lisa Little, 628 8th Avenue S.E., Olympia, WA 98501, 360-725-2033.

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.

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. This rule making only updates the list of eligible provider types and does not impose any new cost on small businesses.

June 25, 2026
Wendy Barcus
Rules Coordinator

RDS-7246.1

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

WAC 182-502-0002 Eligible provider types. The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include treatment, equipment, related supplies, and drugs.

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesia providers, as provided in WAC 182-531-0300:

(i) Physician anesthesiologists;

(ii) Anesthesiology residents;

(iii) Certified anesthesiologist assistants; and

(iv) Certified registered nurse anesthetists;

(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531A-0800:

(i) Licensed behavior analysts;

(ii) Licensed assistant behavior analysts; and

(iii) Certified behavior technicians;

(d) Audiologists;

(e) Birth doulas;

(f) Certified peer counselors;

(g) Certified behavioral health support specialists;

(h) Certified peer support specialists;

(i) Certified peer support specialist trainees;

(j) Chiropractors;

(k) Community health workers (CHWs);

(l) Dental health aide therapists, as provided in chapter 70.350 RCW;

(m) Dental hygienists;

(n) Dental therapists;

(o) Denturists;

(p) Dentists;

(q) Dietitians or nutritionists;

(r) Hearing aid fitters/dispensers;

(s) Home health aides credentialed with the department of health (DOH) as nursing assistants certified or nursing assistants registered;

(t) Licensed independent clinical social worker associates;

(u) Licensed independent clinical social workers;

(v) Licensed marriage and family therapists;

(w) Licensed marriage and family therapist associates;

(x) Licensed mental health counselors;

(y) Licensed mental health counselor associates;

(z) Licensed practical nurses;
(aa) Licensed social workers advanced;
(bb) Licensed social worker associates advanced;
(cc) Midwives;
(dd) Naturopathic physicians;
(ee) Nurse anesthetists;
(ff) Ocularists;
(gg) Occupational therapists;
(hh) Occupational therapy assistants;
(ii) Ophthalmologists;
((~~(ii)~~)) (jj) Opticians;
((~~(jj)~~)) (kk) Optometrists;
((~~(kk)~~)) (ll) Orthodontists;
((~~(ll)~~)) (mm) Orthotists;
((~~(mm)~~)) (nn) Osteopathic physicians;
((~~(nn)~~)) (oo) Osteopathic physician assistants;
((~~(oo)~~)) (pp) Podiatric physicians;
((~~(pp)~~)) (qq) Pharmacists;
((~~(qq)~~)) (rr) Physicians;
((~~(rr)~~)) (ss) Physician assistants;
((~~(ss)~~)) (tt) Physical therapists;
((~~(tt)~~)) (uu) Physical therapy assistants;
(vv) Prosthetists;
((~~(uu)~~)) (ww) Psychiatrists;
((~~(vv)~~)) (xx) Psychological associates;
((~~(ww)~~)) (yy) Psychologists;
((~~(xx)~~)) (zz) Radiologists;
((~~(yy)~~)) (aaa) Registered nurses;
((~~(zz)~~)) (bbb) Registered nurse delegators;
((~~(aaa)~~)) (ccc) Registered nurse first assistants;
((~~(bbb)~~)) (ddd) Respiratory therapists;
((~~(ccc) Speech/language~~)) (eee) Speech-language pathologists;
((~~and~~
~~(ddd)~~)) (fff) Speech-language pathology assistants; and
(ggg) Substance use disorder professionals.

(2) Agencies, centers, and facilities:
(a) Adult day health centers;
(b) Ambulance services (ground and air);
(c) Ambulatory surgery centers (medicare-certified);
(d) Birthing centers (licensed by DOH);
(e) Cardiac diagnostic centers;
(f) Case management agencies;
(g) Substance use disorder treatment facilities certified by DOH;
(h) Withdrawal management treatment facilities certified by DOH;
(i) Community acquired immune deficiency syndrome (AIDS) services alternative agencies;
(j) Community behavioral health support services provider facilities;
(k) Community mental health centers;
(l) Diagnostic centers;
(m) Family planning clinics;
(n) Federally qualified health centers (designated by the federal department of health and human services);
(o) Genetic counseling agencies;
(p) Health departments;
(q) Health maintenance organizations (HMOs)/managed care organizations (MCOs);

(r) Human immunodeficiency virus (HIV)/AIDS case management agencies;
(s) Home health agencies;
(t) Hospice agencies;
(u) Hospitals;
(v) Independent diagnostic testing facilities;
(w) Indian health service facilities/tribal 638 facilities;
(x) Inpatient psychiatric facilities;
(y) Intermediate care facilities for individuals with intellectual disabilities (ICF-IID);
(z) Kidney centers;
(aa) Laboratories (clinical laboratory improvement amendments (CLIA) certified);
(bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;
(cc) Neuromuscular and neurodevelopmental centers;
(dd) Nurse services/delegation;
(ee) Nursing facilities (approved by the department of social and health services home and community living administration);
(ff) Pathology laboratories;
(gg) Pharmacies;
(hh) Private duty nursing agencies;
(ii) Radiology - Stand-alone clinics;
(jj) Rural emergency hospitals;
(kk) Rural health clinics (medicare-certified);
((~~(kk)~~)) (ll) School districts and educational service districts;
((~~(ll)~~)) (mm) Sleep study centers; and
((~~(mm)~~)) (nn) Tribal or urban Indian clinics.
(3) Suppliers of:
(a) Blood, blood products, and related services;
(b) Complex rehabilitation technologies;
(c) Durable and nondurable medical equipment and supplies;
(d) Hearing aids;
(e) Infusion therapy equipment and supplies;
(f) Prosthetics/orthotics; and
(g) Respiratory care, equipment, and supplies.
(4) Contractors:
(a) Eyeglass and contact lens providers;
(b) Independent sign language interpreters;
(c) Spoken language interpreter services agencies; and
(d) Transportation brokers.

RDS-7247.1

AMENDATORY SECTION (Amending WSR 24-24-058, filed 11/27/24, effective 1/1/25)

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the medicaid agency, as defined in WAC 182-500-0010, to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible clients:

(a) A physiatrist;
(b) A licensed occupational therapist;
(c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
(d) A licensed physical therapist;
(e) A physical therapist assistant supervised by a licensed physical therapist;
(f) A licensed speech-language pathologist; ((~~and~~))
(g) A speech-language pathology assistant (SLPA) supervised by a licensed speech-language pathologist; and
(h) A licensed optometrist to provide vision occupational therapy only.

(2) Clients covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter.

(3) Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through their agency-contracted MCO.

(4) The agency pays for outpatient rehabilitation when the services are:
(a) Covered;
(b) Medically necessary;
(c) Within the scope of the eligible person's medical care program;
(d) Ordered by:
(i) A physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP); or
(ii) An optometrist, if the ordered services are for occupational therapy only.
(e) Within currently accepted standards of evidence-based medical practice;
(f) Authorized, as required within this chapter, under chapters 182-501 and 182-502 WAC and the agency's published billing instructions;
(g) Begun within 30 calendar days of the date ordered;
(h) Provided by one of the health professionals listed in subsection (1) of this section;
(i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions; and
(j) Provided as part of an outpatient treatment program:
(i) In an office or outpatient hospital setting;
(ii) In the home, by a home health agency as described in chapter 182-551 WAC;
(iii) In a neurodevelopmental center, as described in WAC 182-545-900;
(iv) For children with disabilities, age six or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child; or
(v) When provided by licensed and certified behavioral health agencies as part of a mental health or substance use disorder treatment program.

(5) For eligible clients age 20 and younger, the agency covers unlimited outpatient rehabilitation.

(6) For clients age 21 and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for clients age 21 and older must:

(a) Restore, improve, or maintain the person's level of function that has been lost due to a clinically documented condition; and

(b) Include an ongoing management plan for the client or the client's caregiver to support timely discharge and continued progress.

(8) For eligible clients age 21 and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per person, per year:

(i) Without authorization:

(A) For clients needing occupational therapy to treat physical conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours; and

(B) For clients needing occupational therapy to treat behavioral health conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of occupational therapy to treat either the client's physical or behavioral health conditions may be available to continue treatment initiated under the original 24 units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The client's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Behavioral health conditions;

(III) Brain injury, which occurred within the past 24 months, with residual cognitive or functional deficits;

(IV) Burns - Second or third degree only;

(V) Cerebral vascular accident, which occurred within the past 24 months, with residual cognitive or functional deficits;

(VI) Lymphedema;

(VII) Major joint surgery - Partial or total replacement only;

(VIII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(IX) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(X) Reflex sympathetic dystrophy;

(XI) Swallowing deficits due to injury or surgery to the face, head, or neck;

(XII) Spinal cord injury that occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XIII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per person, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of physical therapy may be available to continue treatment initiated under the original 24 units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past 24 months, with residual functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past 24 months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(c) Speech therapy, per person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Brain injury, which occurred within the past 24 months, with residual cognitive or functional deficits;

(II) Burns of internal organs such as nasal oral mucosa or upper airway;

(III) Burns of the face, head, and neck - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past 24 months, with residual functional deficits;

(V) Muscular-skeletal disorders such as complex fractures that require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;

(VI) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre));

(VII) Speech deficit due to injury or surgery to the face, head, or neck;

(VIII) Speech deficit that requires a speech generating device;

(IX) Swallowing deficit due to injury or surgery to the face, head, or neck; or

(X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(d) Durable medical equipment (DME) needs assessments, two per person, per year.

(e) Orthotics management and training of upper or lower extremities, or both, two program units, per person, per day.

(f) Orthotic or prosthetic use, two program units, per person, per year.

(g) Muscle testing, one procedure, per person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.

(h) Wheelchair needs assessment, one per person, per year.

(9) For the purposes of this chapter:

(a) Each 15 minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(10) For expedited prior authorization (EPA):

(a) A provider must establish that:

(i) The person's condition meets the clinically appropriate EPA criteria outlined in this section; and

(ii) The services are expected to result in a reasonable improvement in the person's condition and achieve the person's therapeutic individual goal within 60 calendar days of initial treatment;

(b) The appropriate EPA number must be used when the provider bills the agency;

(c) Upon request, a provider must provide documentation to the agency showing how the person's condition met the criteria for EPA; and

(d) A provider may request expedited prior authorization once per year, per person, per each therapy type.

(11) If the client does not meet the EPA clinical criteria in this section, the agency uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

(12) The agency evaluates limitation extension (LE) requests regarding scope, amount, duration, and frequency of covered health care services under WAC 182-501-0169. Providers may submit LE requests for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) A new qualifying condition arises after the initial six visits are used.

(13) Duplicate services for outpatient rehabilitation are not allowed for the same person when both providers are performing the same or similar procedure(s).

(14) The agency does not pay separately for outpatient rehabilitation that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(15) The agency does not reimburse a health care professional for outpatient rehabilitation performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.