WSR 26-17-080
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 17, 2026, 4:01 p.m., effective September 17, 2026]

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

Purpose: The health care authority (HCA) is amending these rules to ensure alignment with HCA's current billing practices. The amendments standardize billing policies while maintaining compliance with applicable federal guidelines.

Citation of Rules Affected by this Order: Amending WAC 182-531-0200, 182-531-0600, 182-531-0750, 182-531-0800, 182-531-1050, 182-531-1300, 182-531-1450, 182-531-1650, and 182-531-1900.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-10-083 on May 6, 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Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 9, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 9, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 9, Repealed 0.

Date Adopted: August 17, 2026.

Wendy Barcus
Rules Coordinator

RDS-7102.3

AMENDATORY SECTION (Amending WSR 24-03-049, filed 1/10/24, effective 2/10/24)

WAC 182-531-0200 Physician-related and health care professional services requiring prior authorization. (1) The medicaid agency requires **prior authorization** (PA) for certain services. ((~~Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 182-501-0165.~~

~~(2) EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to use that EPA number if a client meets the EPA criteria.~~

~~(a) The provider must create an authorization number using the process explained in the medicaid agency's physician-related billing instructions.~~

~~(b) Upon request, the provider must provide supporting clinical documentation to the medicaid agency showing how the authorization number was created.~~

~~(c) Selected nonemergency admissions to contract hospitals require EPA. These are identified in the medicaid agency billing instructions.~~

~~(d) Procedures allowing expedited prior authorization include, but are not limited to, the following:~~

~~(i) Reduction mammoplasties/mastectomy for gynecomastia;~~

~~(ii) Strabismus surgery for clients 18 years of age and older;~~

~~(iii) Meningococcal vaccine;~~

~~(iv) Placement of drug eluting stent and device;~~

~~(v) Cochlear implant devices;~~

~~(vi) Hyperbaric oxygen therapy;~~

~~(vii) Visual exam/refraction for clients 21 years of age and older;~~

~~(viii) Blepharoplasties; and~~

~~(ix) Neuropsychological testing for clients 16 years of age and older.~~

~~(3) The medicaid agency evaluates new technologies under the procedures in WAC 182-531-0550. These require prior authorization.~~

~~(4) Prior authorization is required for the following:~~

~~(a) Abdominoplasty;~~

~~(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R);**~~

~~(c) Cochlear implant devices (refer to WAC 182-531-0375);~~

~~(d) Diagnosis and treatment of eating disorders for clients 21 years of age and older;~~

~~(e) Osteopathic manipulative therapy in excess of the medicaid agency's published limits;~~

~~(f) Panniculectomy;~~

~~(g) Bariatric surgery (see WAC 182-531-1600);~~

~~(h) Vagus nerve stimulator insertion, which also:~~

~~(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and~~

~~(ii) For reimbursement, must have the invoice attached to the claim.~~

~~(i) Osseointegrated/bone anchored hearing aids (BAHA) for clients 20 years of age and younger;~~

~~(j) Removal or repair of previously implanted BAHA or cochlear implant devices for clients 21 years of age and older when medically necessary; and~~

~~(k) Gender reassignment surgery (see WAC 182-531-1675).~~

~~(5)~~)) (a) Procedures or services requiring PA are identified in applicable agency billing guides and fee schedules.

(b) When requesting PA, providers must follow WAC 182-501-0163 and 182-501-0169.

(c) The agency reviews PA requests according to WAC 182-501-0165.

(2) The agency evaluates experimental and investigational services under WAC 182-531-0550. Experimental and investigational services require PA.

(3) All hysterectomies performed for medical reasons may require ((~~prior authorization, as explained in subsection (2) of this section~~)) PA.

(a) Hysterectomies may be performed without ((~~prior authorization~~)) PA in either of the following circumstances:

(i) The client has been diagnosed with cancer(s) of the female reproductive organs; ((~~and/~~))or

(ii) A hysterectomy is needed due to trauma.

(b) The agency ((~~reimburses~~)) pays all attending providers for a hysterectomy procedure only when the provider submits an accurately completed agency-approved consent form with the claim for ((~~reimbursement~~)) payment.

((~~(6)~~)) (4) The ((~~medicaid~~)) agency may require a second opinion ((~~and/~~))or consultation before authorizing any elective surgical procedure.

((~~(7) Children six years of age and younger do not require authorization for hospitalization.~~))

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-0600 HIV/AIDS counseling and testing as physician-related services. The ((~~department~~)) medicaid agency covers one ((~~pre- and one post-HIV/AIDS~~)) presession and one postsession of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) counseling/testing ((~~session~~)) per client each time the client is tested for HIV/AIDS.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-0750 ((~~Inpatient hospital~~)) Physician-related services provided in a hospital inpatient observation setting. (1) The ((~~department~~)) medicaid agency separately ((~~reimburses the attending provider for inpatient hospital~~)) pays the physician or qualified health care professional (QHCP) for professional services ((~~rendered by the attending provider~~)) provided by the physician or QHCP in a hospital inpatient observation setting during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) The ((~~department reimburses for only one inpatient hospital call~~)) agency pays for one physician or QHCP service provided in a hospital inpatient observation setting per client, per day for the same or related diagnoses. If a ((~~call~~)) service is included in the **global surgery reimbursement,** the ((~~department~~)) agency does not ((~~reimburse~~)) pay separately.

(3) The ((~~department reimburses~~)) agency pays for a hospital admission related to a planned surgery through the global fee for surgery, if applicable.

AMENDATORY SECTION (Amending WSR 15-03-041, filed 1/12/15, effective 2/12/15)

WAC 182-531-0800 Laboratory and pathology ((~~physician-related~~)) services. (1) The medicaid agency pays providers for laboratory services only when the provider:

(a) ((~~The provider~~)) Is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) ((~~The provider~~)) Has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The agency ((~~includes a~~)) considers the cost for the handling, packaging, and mailing fee to be included in the ((~~reimbursement~~)) payment for lab tests and does not ((~~reimburse~~)) pay these separately.

(3) The agency pays for one blood drawing fee per client, per day. The agency allows additional ((~~reimbursement~~)) units for an independent laboratory when ((~~it~~)) the laboratory goes to a nursing facility or a private home to obtain a specimen.

(4) The agency pays for only one catheterization for collection of a urine specimen per client, per day.

(5) The agency pays for automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not ((~~all tests are~~)) every test in a panel is performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the agency ((~~reimburses~~)) pays for the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) The agency allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The agency pays for STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order((~~, the physician~~)). Physicians must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The agency pays for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) ((~~The agency does not pay for drug screens for clients in the division of behavioral health and recovery (DBHR) within the department of social and health services (DSHS)-contracted methadone treatment programs. These are reimbursed through a contract issued by DBHR DSHS.~~

~~(9) The agency does not pay for drug screens to monitor for program compliance in either a residential or outpatient drug or alcohol treatment program.~~

~~(10)~~)) The agency may require a drug or alcohol screen ((~~in order~~)) to determine a client's suitability for a specific test.

((~~(11)~~)) (9) An independent laboratory must bill the agency directly. The agency does not pay a medical practitioner for services referred to or performed by an independent laboratory.

AMENDATORY SECTION (Amending WSR 15-03-041, filed 1/12/15, effective 2/12/15)

WAC 182-531-1050 Osteopathic manipulative therapy. (1) The medicaid agency pays for osteopathic manipulative therapy only when:

(a) Provided by an osteopathic physician licensed under chapter 18.57 RCW or naturopathic physicians licensed under chapter 18.36A RCW; and

(b) Billed using the appropriate current procedural terminology (CPT) codes that involve the number of body regions involved.

(2) The agency allows an osteopathic physician or naturopathic physician to bill the agency for an evaluation and management (E&M) service in addition to the osteopathic manipulative therapy when one of the following apply:

(a) The physician diagnoses the condition requiring osteopathic manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to osteopathic manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the osteopathic manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require osteopathic manipulative therapy.

(3) The agency pays for ((~~ten~~)) 10 osteopathic manipulations per client, per calendar year. The agency evaluates a request for osteopathic manipulations that is in excess of the limitations or restrictions according to WAC 182-501-0169. Payment for each osteopathic manipulation includes a brief evaluation as well as the osteopathic manipulation.

(4) The agency does not pay for physical therapy services performed by osteopathic physicians or naturopathic physicians.

AMENDATORY SECTION (Amending WSR 24-21-163, filed 10/23/24, effective 11/23/24)

WAC 182-531-1300 Foot care services for clients 21 years of age and older. (1) This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients 21 years of age and older.

(2) The ((~~department~~)) medicaid agency covers ((~~the~~)) foot care services listed in this section when those services are provided by any of the following health care providers and billed to the ((~~department~~)) agency using procedure codes and diagnosis codes that are within their scope of practice:

(a) Physicians ((~~or~~)), surgeons, and physician assistants, including osteopathic and podiatric specialties; or

(b) ((~~Osteopathic physicians, surgeons, or physician assistants;~~

~~(c) Podiatric physicians and surgeons; or~~

~~(d)~~)) Advanced registered nurse practitioners (ARNP).

(3) The ((~~department~~)) agency covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the ((~~department~~)) agency covers treatment if the criteria in subsection (4) of this section are met.

(4) The ((~~department~~)) agency pays for:

(a) Treatment of the following conditions of the lower extremities only when there is an acute condition, an exacerbation of a chronic condition, or presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain resulting in the inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified:

(i) Acute inflammatory processes such as, but not limited to tendonitis;

(ii) Circulatory compromise such as, but are not limited to:

(A) Lymphedema;

(B) Raynaud's disease;

(C) Thromboangiitis obliterans; and

(D) Phlebitis.

(iii) Injuries, fractures, sprains, and dislocations;

(iv) Gout;

(v) Lacerations, ulcerations, wounds, blisters;

(vi) Neuropathies (e.g., reflex sympathetic dystrophy, secondary to diabetes, charcot arthropathy);

(vii) Osteomyelitis;

(viii) Post-op complications;

(ix) Warts, corns, or calluses in the presence of an acute condition such as infection and pain ((~~effecting~~)) affecting the client's ability to ambulate as a result of the warts, corns, or calluses and meets the criteria in this subsection ((~~(4) of this section~~));

(x) Soft tissue conditions, such as, but are not limited to:

(A) Rashes;

(B) Infections (fungal, bacterial);

(C) Gangrene;

(D) Cellulitis of lower extremities;

(E) Soft tissue tumors; and

(F) Neuroma.

(xi) Nail bed infections (paronychia); and

(xii) Tarsal tunnel syndrome.

(b) Trimming ((~~and/~~))or debridement, or both, of nails to treat, as applicable, conditions from the list in ((~~subsection (4)~~))(a) of this ((~~section~~)) subsection. The ((~~department~~)) agency pays for one treatment in a 60-day period. The ((~~department~~)) agency covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) A surgical procedure to treat one of the conditions in this subsection ((~~(4) of this section~~)) performed on the lower extremities, and performed by a qualified provider;

(d) Impression casting to treat one of the conditions in this subsection ((~~(4) of this section~~)). The ((~~department~~)) agency includes 90-day follow-up care in the ((~~reimbursement~~)) payment;

(e) Custom fitted and/or custom molded orthotic devices to treat one of the conditions in this subsection ((~~(4) of this section~~)).

(i) The ((~~department's~~)) agency's fee for the orthotic device includes ((~~reimbursement~~)) payment for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) ((~~The department includes an evaluation and management (E&M) fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical~~

~~record~~)) For further information on orthotic devices, see WAC 182-543-5000.

(5) The ((~~department~~)) agency does not pay for:

(a) The following radiology services:

(i) Bilateral X-rays for a unilateral condition; or

(ii) X-rays in excess of three views; or

(iii) X-rays that are ordered before the client is examined.

(b) Podiatric physicians or surgeons for X-rays for any part of the body other than the foot or ankle.

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

WAC 182-531-1450 Radiology physician-related services. (1) The medicaid agency ((~~reimburses~~)) pays for radiology services subject to the limitations in this section and ((~~under~~)) in WAC 182-531-0300.

(2) The agency does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; ((~~and/~~))or

(g) Other clinical situations where the use of any media except LOCM would constitute a danger to the health of the client.

(3) The agency ((~~reimburses separately~~)) pays for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures when listed on the appropriate agency fee schedule as covered. ((~~Providers must submit invoices for these procedures when requested by the agency, and reimbursement is at actual acquisition cost.~~))

(4) The agency ((~~reimburses~~)) pays for general anesthesia for radiology procedures. See WAC 182-531-0300.

(5) The agency ((~~reimburses~~)) pays for radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 182-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The agency ((~~reimburses~~)) pays for consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate professional component modifier.

(7) The agency ((~~reimburses~~)) pays for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contrast media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column, or skull.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-1650 ((~~Substance abuse detoxification~~)) Withdrawal management physician-related services. (1) The ((~~department~~)) medicaid agency covers physician-related services for ((~~three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in a department-enrolled hospital-based detoxification center~~)) withdrawal management when determined to be medically necessary and when provided in an inpatient hospital setting in a hospital certified under chapter 246-320 WAC.

(2) ((~~The department covers treatment in programs certified under chapter 388-805 WAC or its successor.~~

~~(3) The department covers detoxification~~)) The agency pays for physician-related services for withdrawal management and medical stabilization services ((~~to chemically~~)) for people enrolled in the substance-using pregnant ((~~(CUP) women for up to twenty-seven days in an inpatient hospital setting~~)) people (SUPP) program as described in WAC 182-533-0730.

AMENDATORY SECTION (Amending WSR 15-17-066, filed 8/14/15, effective 9/14/15)

WAC 182-531-1900 Payment—General requirements for physician-related services. (1) The medicaid agency pays physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) To receive payment, physicians must bill the agency according to the conditions of payment ((~~under~~)) listed in WAC 182-502-0100.

(3) The agency does not pay separately ((~~reimburse~~)) for certain administrative costs or services. The agency considers these costs to be included in the payment. These costs and services include the following:

(a) Delinquent payment fees;

(b) Educational supplies;

(c) Mileage;

(d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, and copying expenses;

(f) Service charges;

(g) Take home drugs except as noted in published agency billing guides; and

(h) ((~~Telephoning (e.g.,~~)) Requests for prescription refills((~~)~~)).

(4) The agency does not routinely pay for procedure codes ((~~which have a "#" or "NC" indicator in~~)) not listed on the fee schedule. ((~~The agency reviews these codes for conformance to medicaid program policy only as an exception to policy or as a limitation extension. See WAC 182-501-0160 and 182-501-0165~~)) Providers may submit a prior authorization request for unlisted services for review by the agency in accordance with WAC 182-501-0163.