

# Chapter 182-501 WAC

## ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

### WAC

182-501-0050	Healthcare general coverage.
182-501-0055	Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments.
182-501-0060	Healthcare coverage—Scope of covered categories of service.
182-501-0065	Healthcare coverage—Description of covered categories of service.
182-501-0070	Healthcare coverage—Noncovered services.
182-501-0100	Subrogation.
182-501-0125	Advance directives.
182-501-0135	Patient review and coordination (PRC).
182-501-0160	Exception to rule—Request for a noncovered healthcare service.
182-501-0163	Healthcare coverage—Process for submitting a valid request for authorization.
182-501-0165	Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment.
182-501-0169	Healthcare coverage—Limitation extension.
182-501-0175	Medical care provided in bordering cities.
182-501-0180	Healthcare services provided outside the state of Washington—General provisions.
182-501-0182	Healthcare provided in another state or U.S. territory—Nonemergency.
182-501-0184	Healthcare services provided outside of the United States and U.S. territories or in a foreign country.
182-501-0200	Third-party resources.
182-501-0213	Case management services.

### WAC 182-501-0050 Healthcare general coverage.

WAC 388-501-0050 through 388-501-0065 describe the healthcare services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 388-538-050). For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. WAC 388-501-0070 describes noncovered services.

(1) Healthcare service categories listed in WAC 388-501-0060 do not represent a contract for healthcare services.

(2) For the provider to receive payment, the client must be eligible for the covered healthcare service on the date the healthcare service is performed or provided.

(3) Under the department's fee-for-service programs, providers must be enrolled with the department and meet the requirements of chapter 388-502 WAC to be paid for furnishing healthcare services to clients.

(4) The department pays only for the healthcare services that are:

(a) Within the scope of the client's medical program;

(b) Covered - see subsection (9) of this section;

(c) Ordered or prescribed by a healthcare provider who meets the requirements of chapter 388-502 WAC;

(d) Medically necessary as defined in WAC 388-500-0005;

(e) Submitted for authorization, when required, in accordance with WAC 388-501-0163;

(f) Approved, when required, in accordance with WAC 388-501-0165;

(6/30/11)

(g) Furnished by a provider according to chapter 388-502 WAC; and

(h) Billed in accordance with department program rules and the department's current published billing instructions and numbered memoranda.

(5) The department does not pay for any healthcare service requiring prior authorization from the department, if prior authorization was not obtained before the healthcare service was provided; unless:

(a) The client is determined to be retroactively eligible for medical assistance; and

(b) The request meets the requirements of subsection (4) of this section.

(6) The department does not reimburse clients for healthcare services purchased out-of-pocket.

(7) The department does not pay for the replacement of department-purchased equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, or misuse unless:

(a) Extenuating circumstances exist that result in a loss or destruction of department-purchased equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or

(b) Otherwise allowed under chapter 388-500 WAC.

(8) The department's refusal to pay for replacement of equipment, device, or supplies will not extend beyond the limitations stated in specific department program rules.

### (9) Covered healthcare services

(a) Covered healthcare services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the healthcare service for medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the healthcare service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered healthcare services. Limitation extensions are authorized according to WAC 388-501-0169.

### (10) Noncovered healthcare services

(a) The department does not pay for any healthcare service:

(i) That federal or state laws or regulations prohibit the department from covering; or

(ii) Listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered healthcare service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When a noncovered healthcare service is recommended during the Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT) exam and then ordered by a provider, the department evaluates the healthcare service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[11-14-075, recodified as § 182-501-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-07-116, § 388-501-0050, filed 3/22/10, effective 4/22/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0050, filed 11/18/09, effective 12/19/09; 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

**WAC 182-501-0055 Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments.** (1) The department uses health technology assessments in determining whether a new technology, new indication, or existing technology approved by the Food and Drug Administration (FDA) is a covered service under department healthcare programs. The department only uses health technology assessments when coverage is not mandated by federal or state law. A health technology assessment may be conducted by or on behalf of:

- (a) The department; or
- (b) The health technology assessment clinical committee (HTACC) according to RCW 70.14.080 through 70.14.140.

(2) The department reviews available evidence relevant to a medical or dental service or healthcare-related equipment and uses a technology evaluation matrix, in order to:

- (a) Determine its efficacy, effectiveness, and safety;
- (b) Determine its impact on health outcomes;
- (c) Identify indications for use;
- (d) Identify potential for misuse or abuse; and
- (e) Compare to alternative technologies to assess benefit vs. harm and cost effectiveness.

(3) The department may determine the technology, device, or technology-related supply is:

- (a) Covered (See WAC 388-501-0060 for the scope of coverage for department medical assistance programs.);
- (b) Covered with authorization (See WAC 388-501-0165 for the process on how authorization is determined.);
- (c) Covered with limitations (See WAC 388-501-0169 for how limitations can be extended.); or
- (d) Noncovered (See WAC 388-501-0070 for the services determined to be noncovered.).

(4) The department may periodically review existing technologies, devices, or technology-related supplies and reassign authorization requirements as necessary according to the same provisions as outlined above for new technologies, devices, or technology-related supplies.

(5) The department evaluates the evidence and criteria presented by HTACC to determine whether a service is covered in accordance with WAC 388-501-0050 (9) and (10) and this section.

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**WAC 182-501-0060 Healthcare coverage—Scope of covered categories of service.** (1) This rule provides a list (see subsection (5)) of medical, dental, mental health, and substance abuse categories of service covered by the department under categorically needy (CN) medicaid, medically needy (MN) medicaid, Alien Emergency Medical (AEM), and medical care services (MCS) programs. MCS means the limited scope of care financed by state funds and provided to general assistance and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program clients.

(2) Not all categories of service listed in this section are covered under every medical program, nor do they represent a contract for services. Services are subject to the exclusions, limitations, and eligibility requirements contained in department rules.

(3) Services covered under each listed category:

(a) Are determined by the department after considering available evidence relevant to the service or equipment to:

- (i) Determine efficacy, effectiveness, and safety;
- (ii) Determine impact on health outcomes;
- (iii) Identify indications for use;
- (iv) Compare alternative technologies; and
- (v) Identify sources of credible evidence that use and report evidence-based information.

(b) May require prior authorization (see WAC 388-501-0165), or expedited authorization when allowed by the department.

(c) Are paid for by the department and subject to review both before and after payment is made. The department or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The department does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the department, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the department as required under chapter 388-502 WAC;

(c) Are included in a department waiver program identified in chapter 388-515 WAC; or

(d) Are covered by a third-party payer (see WAC 388-501-0200), including medicare, if the third-party payer has not made a determination on the claim or has not been billed by the provider.

(5) **Scope of covered service categories.** The following table lists the department's covered categories of healthcare services.

- Under the four program columns (CN, MN, MCS, and AEM), the letter "C" means a service category is covered for that program, subject to any limitations listed in the specific medical assistance program WAC and department issuances.

- The letter "N" means a service category is not covered under that program.

- The letter "E" means the service category is available only if it is necessary to treat the client's emergency medical condition and may require prior authorization from the department.

• Refer to WAC 388-501-0065 for a description of each service category and for the specific program WAC containing the limitations and exclusions to services.

Service Categories	CN*	MN	MCS	AEM
(a) Adult day health	C	C	N	E
(b) Ambulance (ground and air)	C	C	C	E
(c) Blood processing/administration	C	C	C	E
(d) Dental services	C	C	C	E
(e) Detoxification	C	C	C	E
(f) Diagnostic services (lab & x-ray)	C	C	C	E
(g) Family planning services	C	C	C	E
(h) Healthcare professional services	C	C	C	E
(i) Hearing care (audiology/hearing exams/aids)	C	C	C	E
(j) Home health services	C	C	C	E
(k) Hospice services	C	C	N	E
(l) Hospital services - inpatient/outpatient	C	C	C	E
(m) Intermediate care facility/services for mentally retarded	C	C	C	E
(n) Maternity care and delivery services	C	C	N	E
(o) Medical equipment, durable (DME)	C	C	C	E
(p) Medical equipment, nondurable (MSE)	C	C	C	E
(q) Medical nutrition services	C	C	C	E
(r) Mental health services	C	C	C	E
(s) Nursing facility services	C	C	C	E
(t) Organ transplants	C	C	C	N
(u) Out-of-state services	C	C	N	E
(v) Oxygen/respiratory services	C	C	C	E
(w) Personal care services	C	C	N	N
(x) Prescription drugs	C	C	C	E
(y) Private duty nursing	C	C	N	E
(z) Prosthetic/orthotic devices	C	C	C	E
(aa) School medical services	C	C	N	N
(bb) Substance abuse services	C	C	C	E
(cc) Therapy -occupational/physical/speech	C	C	C	E
(dd) Vision care (exams/lenses)	C	C	C	E

\*Clients enrolled in the State Children's Health Insurance Program and the Children's Health Program receive CN scope of medical care.

(6/30/11)

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**WAC 182-501-0065 Healthcare coverage—Description of covered categories of service.** This rule provides a brief description of the medical, dental, mental health, and substance abuse service categories listed in the table in WAC 388-501-0060. The description of services under each category is not intended to be all inclusive.

(1) For categorically needy (CN), medically needy (MN), and medical care services (MCS), refer to the WAC citations listed in the following descriptions for specific details regarding each service category. For Alien Emergency Medical (AEM) services, refer to WAC 388-438-0110.

(2) The following service categories are subject to the exclusions, limitations, and eligibility requirements contained in department rules:

(a) **Adult day health**—Skilled nursing services, counseling, therapy (physical, occupational, speech, or audiology), personal care services, social services, general therapeutic activities, health education, nutritional meals and snacks, supervision, and protection. [WAC 388-71-0702 through 388-71-0776]

(b) **Ambulance**—Emergency medical transportation and ambulance transportation for nonemergency medical needs. [WAC 388-546-0001 through 388-546-4000]

(c) **Blood processing/administration**—Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. [WAC 388-550-1400 and 388-550-1500]

(d) **Dental services**—Diagnosis and treatment of dental problems including emergency treatment and preventive care. [Chapters 388-535 and 388-535A WAC]

(e) **Detoxification**—Inpatient treatment performed by a certified detoxification center or in an inpatient hospital setting. [WAC 388-800-0020 through 388-800-0035; and 388-550-1100]

(f) **Diagnostic services**—Clinical testing and imaging services. [WAC 388-531-0100; 388-550-1400 and 388-550-1500]

(g) **Family planning services**—Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. [WAC 388-532-530]

(h) **Healthcare professional services**—Office visits, emergency room, nursing facility, home-based, and hospital-based care; surgery, anesthesia, pathology, radiology, and laboratory services; obstetric services; kidney dialysis and renal disease services; osteopathic care, podiatry services, physiatry, and pulmonary/respiratory services; and allergen immunotherapy. [Chapter 388-531 WAC]

(i) **Hearing care**—Audiology; diagnostic evaluations; hearing exams and testing; and hearing aids. [WAC 388-544-1200 and 388-544-1300; 388-545-700; and 388-531-0100]

(j) **Home health services**—Intermittent, short-term skilled nursing care, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. [WAC 388-551-2000 through 388-551-2220]

(k) **Hospice services**—Physician services, skilled nursing care, medical social services, counseling services for cli-

ent and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. [WAC 388-551-1210 through 388-551-1850]

(l) **Hospital services—Inpatient/outpatient**—Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. [Chapter 388-550 WAC]

(m) **Intermediate care facility/services for mentally retarded**—Habilitative training, health-related care, supervision, and residential care. [Chapter 388-835 WAC]

(n) **Maternity care and delivery services**—Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, and community health worker visits. [WAC 388-533-0330]

(o) **Medical equipment, durable (DME)**—Wheelchairs, hospital beds, respiratory equipment; prosthetic and orthotic devices; casts, splints, crutches, trusses, and braces. [WAC 388-543-1100]

(p) **Medical equipment, nondurable (MSE)**—Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, transcutaneous electrical nerve stimulators (TENS) supplies, and urological supplies. [WAC 388-543-2800]

(q) **Medical nutrition services**—Enteral and parenteral nutrition, including supplies. [Chapters 388-553 and 388-554 WAC]

(r) **Mental health services**—Inpatient and outpatient psychiatric services and community mental health services. [Chapter 388-865 WAC]

(s) **Nursing facility services**—Nursing, therapies, dietary, and daily care services. [Chapter 388-97 WAC]

(t) **Organ transplants**—Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. [WAC 388-550-1900 and 388-550-2000, and 388-556-0400]

(u) **Out-of-state services**—Emergency services; prior authorized care. Services provided in bordering cities are treated as if they were provided in state. [WAC 388-501-0175 and 388-501-0180; 388-531-1100; and 388-556-0500]

(v) **Oxygen/respiratory services**—Oxygen, oxygen equipment and supplies; oxygen and respiratory therapy, equipment, and supplies. [Chapter 388-552 WAC]

(w) **Personal care services**—Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). [WAC 388-106-0010, [388-106-]0300, [388-106-]0400, [388-106-]0500, [388-106-]0600, [388-106-]0700, [388-106-]0720 and [388-106-]0900]

(x) **Prescription drugs**—Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices

and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. [WAC 388-530-1100] Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(y) **Private duty nursing**—Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. [WAC 388-551-3000.] For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(z) **Prosthetic/orthotic devices**—Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. [WAC 388-543-1100]

(aa) **School medical services**—Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). [Chapter 388-537 WAC]

(bb) **Substance abuse services**—Chemical dependency assessment, case management services, and treatment services. [WAC 388-533-0701 through 388-533-0730; 388-556-0100 and 388-556-0400; and 388-800-0020]

(cc) **Therapy—Occupational/physical/speech**—Evaluations, assessments, and treatment. [WAC 388-545-300, 388-545-500, and 388-545-700]

(dd) **Vision care**—Eye exams, refractions, frames, lenses, ocular prosthetics, and surgery. [WAC 388-544-0250 through 388-544-0550]

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**Reviser's note:** The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

**WAC 182-501-0070 Healthcare coverage—Noncovered services.** (1) The department does not pay for any healthcare service not listed or referred to as a covered healthcare service under the medical programs described in WAC 388-501-0060, regardless of medical necessity. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. Circumstances in which clients are responsible for payment of healthcare services are described in WAC 388-502-0160.

(2) This section does not apply to healthcare services provided as a result of the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter 388-534 WAC.

(3) The department does not pay for any ancillary healthcare service(s) provided in association with a noncovered healthcare service.

(4) The following list of noncovered healthcare services is not intended to be exhaustive. Noncovered healthcare services include, but are not limited to:

(a) Any healthcare service specifically excluded by federal or state law;

(b) Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, naturopathy, and sanopractice;

(c) Chiropractic care for adults;

(d) Cosmetic, reconstructive, or plastic surgery, and any related healthcare services, not specifically allowed under WAC 388-531-0100(4).

(e) Discography;

(f) Ear or other body piercing;

(g) Face lifts or other facial cosmetic enhancements;

(h) Fertility, infertility or sexual dysfunction testing, and related care, drugs, and/or treatment including but not limited to:

(i) Artificial insemination;

(ii) Donor ovum, sperm, or surrogate womb;

(iii) In vitro fertilization;

(iv) Penile implants;

(v) Reversal of sterilization; and

(vi) Sex therapy.

(i) Gender reassignment surgery and any surgery related to trans-sexualism, gender identity disorders, and body dysmorphism, and related healthcare services or procedures, including construction of internal or external genitalia, breast augmentation, or mammoplasty;

(j) Hair transplants, epilation (hair removal), and electrolysis;

(k) Marital counseling;

(l) Motion analysis, athletic training evaluation, work hardening condition, high altitude simulation test, and health and behavior assessment;

(m) Nonmedical equipment;

(n) Penile implants;

(o) Prosthetic testicles;

(p) Psychiatric sleep therapy;

(q) Subcutaneous injection filling;

(r) Tattoo removal;

(s) Transport of Involuntary Treatment Act (ITA) clients to or from out-of-state treatment facilities, including those in bordering cities;

(t) Upright magnetic resonance imaging (MRI); and

(u) Vehicle purchase - new or used vehicle.

(5) For a specific list of noncovered healthcare services in the following service categories, refer to the WAC citation:

(a) Ambulance transportation and nonemergent transportation as described in chapter 388-546 WAC;

(b) Dental services for clients twenty years of age and younger as described in chapter 388-535 WAC;

(c) Dental services for clients twenty-one years of age and older as described in chapter 388-535 WAC;

(d) Durable medical equipment as described in chapter 388-543 WAC;

(e) Hearing care services as described in chapter 388-547 WAC;

(f) Home health services as described in WAC 388-551-2130;

(g) Hospital services as described in WAC 388-550-1600;

(h) Physician-related services as described in WAC 388-531-0150;

(i) Prescription drugs as described in chapter 388-530 WAC; and

(j) Vision care services as described in chapter 388-544 WAC.

(6) A client has a right to request an administrative hearing, if one is available under state and federal law. When the

department denies all or part of a request for a noncovered healthcare service(s), the department sends the client and the provider written notice, within ten business days of the date the decision is made, that includes:

(a) A statement of the action the department intends to take;

(b) Reference to the specific WAC provision upon which the denial is based;

(c) Sufficient detail to enable the recipient to:

(i) Learn why the department's action was taken; and

(ii) Prepare a response to the department's decision to classify the requested healthcare service as noncovered.

(d) The specific factual basis for the intended action; and

(e) The following information:

(i) Administrative hearing rights;

(ii) Instructions on how to request the hearing;

(iii) Acknowledgement that a client may be represented at the hearing by legal counsel or other representative;

(iv) Instructions on how to request an exception to rule (ETR);

(v) Information regarding department-covered healthcare services, if any, as an alternative to the requested non-covered healthcare service; and

(vi) Upon the client's request, the name and address of the nearest legal services office.

(7) A client can request an exception to rule (ETR) as described in WAC 388-501-0160.

[11-14-075, recodified as § 182-501-0070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0070, filed 11/18/09, effective 12/19/09; 07-04-036, § 388-501-0070, filed 1/29/07, effective 3/1/07.]

**WAC 182-501-0100 Subrogation.** (1) For the purpose of this section, "**liable third party**" means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person, entity or program that is or may be liable to provide coverage for the illness or injuries for which the department is providing assistance or residential care.

(2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any liable third party for medical expenses, assistance, or residential care.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 74.09.180.

(4) The department is not responsible for medical care payment(s) for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, the department may provide the medical care required as a result of an injury or illness to the client if the client is otherwise eligible for medical care.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party or third party settlement or judgment as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.070, RCW 74.09.180 and 74.09.185.

(6) Notice to the department and determining the reimbursement amount:

(a) The client or the client's legal representative must notify the department in writing at the time of filing any claim against a third party, commencing an action at law, negotiating a settlement, or accepting an offer from the liable third party. Written notices to the department under this section should be sent to:

Health and Recovery Services Administration  
COB Casualty Unit  
PO Box 45561  
Olympia, WA 98504-5561  
Fax (360) 753-3077

(b) The client or the client's legal representative must provide the department with documentation proposing allocation of damages, if any, to be used for settlement or to be proven at trial.

(c) Where damages, including medical damages, have not been designated in the settlement or judgment, the client or the client's legal representative must contact the department to determine the appropriate reimbursement amount for payments the department made for the client's benefit.

(d) If the client and the department are unable to reach an agreement as to the appropriate reimbursement amount, any party may bring a motion in the superior court for a hearing to determine the amount of reimbursement to the department from settlement or judgment proceeds.

(7) The secretary of the department or the secretary's designee must consent in writing to any discharge or compromise of any settlement or judgment of a lien created under RCW 43.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(8) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[11-14-075, recodified as § 182-501-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: 42 U.S.C. §§ 1396a, 1396k, 1396p, chapter 43.20B RCW, RCW 74.08.090, 74.09.180, 74.09.185, 08-17-046, § 388-501-0100, filed 8/14/08, effective 12/1/08. Statutory Authority: RCW 74.08.090 and 74.09.185, 07-23-080 and 08-01-041, § 388-501-0100, filed 11/19/07 and 12/12/07, effective 12/1/08. Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

**WAC 182-501-0125 Advance directives.** In this section "advance directive" means a written instruction, recognized under state law, relating to the provision of health care when an individual is incapacitated.

(1) All agencies, health maintenance organizations (HMOs), and facilities including hospitals, critical access hospitals, skilled nursing and nursing facilities, and providers of in-home care services that serve medical assistance clients eighteen years of age or older must have written policies and procedures concerning advance directives.

(2) The agencies, HMOs, and facilities must give the following information to each adult client, in writing and orally, and in a language the client understands:

- (a) A statement about the client's right to:
  - (i) Make decisions concerning the client's medical care;
  - (ii) Accept or refuse surgical or medical treatment;
  - (iii) Execute an advance directive;
  - (iv) Revoke an advance directive at any time;

(b) The written policies of the agency, HMO, or facility concerning advance directives, including any policy that would preclude it from honoring the client's advance directive; and

(c) The client's rights under state law.

(3) The agencies, HMOs, and facilities must provide the information described in subsection (2) of this section to adult clients as follows:

(a) Hospitals at the time the client is admitted as an inpatient;

(b) Nursing facilities at the time the client is admitted as a resident;

(c) Providers of in-home care services before the client comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered;

(d) Hospice programs at the time the client initially receives hospice care from the program; and

(e) HMOs at the time the client enrolls with the organization.

(4) If the client is incapacitated at the time of admittance or enrollment and is unable to receive information or articulate whether or not the client has executed an advance directive, the agencies, HMOs, and facilities:

(a) May give information about advance directives to the person authorized by RCW 7.70.065 to make decisions regarding the client's health care;

(b) Must document in the client's file that the client was unable to communicate whether an advance directive exists if no one comes forward with a previously executed advance directive; and

(c) Must give the information described in subsection (2) to the client once the client is no longer incapacitated.

(5) The agencies, HMOs, and facilities must:

(a) Review each client's medical record prior to admittance or enrollment to determine if the client has an advance directive;

(b) Honor the directive or follow the process explained in subsection (6); and

(c) Not refuse, put conditions on care, or otherwise discriminate against a client based on whether or not the client has executed an advance directive.

(6) If an agency, HMO, or facility has a policy or practice that would keep it from honoring a client's advance directive, the facility or organization must:

(a) Tell the client prior to admission or enrollment or when the client executes the directive;

(b) Provide the client with a statement clarifying the differences between institution-wide conscience objections and those that may be raised by individual physicians and explaining the range of medical conditions or procedures affected;

(c) Prepare and keep a written plan of intended actions according to the requirements in RCW 70.122.060 if the client still chooses to retain the facility or organization; and

(d) Make a good faith effort to transfer the client to another health care practitioner who will honor the directive if the client chooses not to retain the facility or organization.

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility

or organization for refusing to withhold or withdraw life-sustaining treatment.

(8) The agencies, HMOs, and facilities must document, in a prominent place in each client's medical record, whether or not the client has executed an advance directive.

(9) The agencies, HMOs, and facilities must educate staff and the community on issues concerning advance directives.

(10) The agencies, HMOs, and facilities must comply with state and federal laws and regulations concerning advance directives, including but not limited to: 42 USC 1396a, subsection (w); 42 CFR 417.436; 42 CFR 489 Subpart I; and chapter 70.122 RCW.

[11-14-075, recodified as § 182-501-0125, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.035, 00-19-050, § 388-501-0125, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

**WAC 182-501-0135 Patient review and coordination (PRC).** (1) **Patient review and coordination (PRC)** program, formerly known as the patient review and restriction (PRR) program, coordinates care and ensures that clients selected for enrollment in PRC use services appropriately and in accordance with department rules and policies.

(a) PRC applies to medical assistance fee-for-service and managed care clients. PRC does not apply to clients eligible for the family planning only program.

(b) PRC is authorized under federal medicaid law by 42 USC 1396n (a)(2) and 42 CFR 431.54.

(2) **Definitions.** The following definitions apply to this section only:

**"Appropriate use"**—Use of healthcare services that are adapted to or appropriate for a client's healthcare needs.

**"Assigned provider"**—A department-enrolled healthcare provider or one participating with a department contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for a fee-for-service or managed care client in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a controlled substances prescriber, and a hospital for nonemergent hospital services.

**"At-risk"**—A term used to describe one or more of the following:

- (a) A client with a medical history of:
  - Indications of forging or altering prescriptions;
  - Seeking and/or obtaining healthcare services at a frequency or amount that is not medically necessary;
  - Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

(b) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

- Referrals from social services personnel about inappropriate behaviors or practices that places the client at risk;
- Noncompliance with treatment;
- Paying cash for controlled substances;
- Positive urine drug screen for illicit street drugs or non-prescribed controlled substances; or
- Unauthorized use of a client's services card or for an unauthorized purpose.

**"Care management"**—Services provided to clients with multiple health, behavioral, and social needs in order to improve care coordination, client education, and client self-management skills.

**"Client"**—A person enrolled in a department healthcare program and receiving service from fee-for-service provider(s) or a managed care organization (MCO), contracted with the department.

**"Conflicting"**—Drugs and/or healthcare services that are incompatible and/or unsuitable for use together because of undesirable chemical or physiological effects.

**"Contraindicated"**—To indicate or show a medical treatment or procedure is inadvisable or not recommended or warranted.

**"Controlled substances prescriber"**—Any of the following healthcare professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, Uniform Controlled Substance Act) for a legitimate medical purpose:

- A physician under chapter 18.71 RCW;
- A physician assistant under chapter 18.71A RCW;
- An osteopathic physician under chapter 18.57 RCW;
- An osteopathic physician assistant under chapter 18.57A RCW; and
- An advanced registered nurse practitioner under chapter 18.79 RCW.

**"Duplicative"**—Applies to the use of the same or similar drugs and healthcare services without due justification. Example: A client receives healthcare services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

**"Just cause"**—A legitimate reason to justify the action taken, including but not limited to, protecting the health and safety of the client.

**"Managed care organization" or "MCO"**—An organization having a certificate of authority or certificate of registration from the office of insurance commissioner, that contracts with the department under a comprehensive risk contract to provide prepaid healthcare services to eligible medical assistance clients under the department's managed care programs.

**"Managed care client"**—A medical assistance client enrolled in, and receiving healthcare services from, a department-contracted managed care organization (MCO).

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

(3) **Clients selected for PRC review.** The department or MCO selects a client for PRC review when either or both of the following occur:

- (a) A utilization review report indicates the client has not utilized healthcare services appropriately; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals to the department or MCO.

(4) **When a fee-for-service client is selected for PRC review** the prior authorization process as defined in chapter 388-530 WAC may be required:

- (a) Prior to or during a PRC review; or
- (b) When currently in the PRC program.

(5) **Review for placement in the PRC program.** When the department or MCO selects a client for PRC review, the department or MCO staff, with clinical oversight, reviews a client's medical and/or billing history to determine if the client has utilized healthcare services at a frequency or amount that is not medically necessary (42 CFR 431.54(e)).

(6) **Utilization guidelines for PRC placement.** Department or MCO staff use the following utilization guidelines to determine PRC placement. A client may be placed in the PRC program when medical and/or billing histories document any of the following:

(a) Any two or more of the following conditions occurred in a period of ninety consecutive calendar days in the previous twelve months. The client:

- (i) Received services from four or more different providers, including physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs);
- (ii) Had prescriptions filled by four or more different pharmacies;
- (iii) Received ten or more prescriptions;
- (iv) Had prescriptions written by four or more different prescribers;
- (v) Received similar services from two or more providers in the same day; or
- (vi) Had ten or more office visits.

(b) Any one of the following occurred within a period of ninety consecutive calendar days in the previous twelve months. The client:

- (i) Made two or more emergency department visits;
- (ii) Has a medical history that indicates "at-risk" utilization patterns;
- (iii) Made repeated and documented efforts to seek healthcare services that are not medically necessary; or
- (iv) Has been counseled at least once by a health care provider, or a department or MCO staff member, with clinical oversight, about the appropriate use of healthcare services.

(c) The client received prescriptions for controlled substances from two or more different prescribers in any one month in a period of ninety consecutive days in the previous twelve months.

(d) The client's medical and/or billing history demonstrates a pattern of the following at any time in the previous twelve months:

- (i) The client has a history of using healthcare services in a manner that is duplicative, excessive, or contraindicated; or
- (ii) The client has a history of receiving conflicting healthcare services, drugs, or supplies that are not within acceptable medical practice.

(7) **PRC review results.** As a result of the PRC review, the department or MCO staff may take any of the following steps:

(a) Determine that no action is needed and close the client's file;

(b) Send the client and, if applicable, the client's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the PRC program; or

(c) Determine that the utilization guidelines for PRC placement establish that the client has utilized healthcare services at an amount or frequency that is not medically necessary, in which case the department or MCO will take one or more of the following actions:

(i) Refer the client for education on appropriate use of healthcare services;

(ii) Refer the client to other support services or agencies; or

(iii) Place the client into the PRC program for an initial placement period of twenty-four months.

(8) **Initial placement in the PRC program.** When a client is initially placed in the PRC program:

(a) The department or MCO places the client for twenty-four months with one or more of the following types of healthcare providers:

- (i) Primary care provider (PCP) (as defined in subsection (2) of this section);
- (ii) Pharmacy;
- (iii) Controlled substances prescriber;
- (iv) Hospital (for nonemergent hospital services); or
- (v) Another qualified provider type, as determined by department or MCO program staff on a case-by-case basis.

(b) The managed care client will remain in the same MCO for no less than twelve months unless:

(i) The client moves to a residence outside the MCO's service area and the MCO is not available in the new location; or

(ii) The client's assigned provider no longer participates with the MCO and is available in another MCO, and the client wishes to remain with the current provider.

(c) A managed care client placed in the PRC program must remain in the PRC program for the initial twenty-four month period regardless of whether the client changes MCOs or becomes a fee-for-service client.

(d) A care management program may be offered to a client.

(9) **Notifying the client about placement in the PRC program.** When the client is initially placed in the PRC program, the department or the MCO sends the client and, if applicable, the client's authorized representative, a written notice containing at least the following components:

(a) Informs the client of the reason for the PRC program placement;

(b) Directs the client to respond to the department or MCO within ten business days of the date of the written notice about taking the following actions:

(i) Select providers, subject to department or MCO approval;

(ii) Submit additional healthcare information, justifying the client's use of healthcare services; or

(iii) Request assistance, if needed, from the department or MCO program staff.

(c) Informs the client of hearing or appeal rights (see subsection (14) of this section).

(d) Informs the client that if a response is not received within ten days of the date of the notice, the client will be assigned a provider(s) by the department or MCO.

(10) **Selection and role of assigned provider.** A client may be afforded a limited choice of providers.

(a) The following providers are not available:

(i) A provider who is being reviewed by the department or licensing authority regarding quality of care;

(ii) A provider who has been suspended or disqualified from participating as a department-enrolled or MCO-contracted provider; or

(iii) A provider whose business license is suspended or revoked by the licensing authority.

(b) For a client placed in the PRC program, the assigned:

(i) Provider(s) must be located in the client's local geographic area, in the client's selected MCO, and/or be reasonably accessible to the client.

(ii) Primary care provider (PCP) supervises and coordinates healthcare services for the client, including continuity of care and referrals to specialists when necessary. The PCP must be one of the following:

(A) A physician who meets the criteria as defined in chapter 388-502 WAC;

(B) An advanced registered nurse practitioner (ARNP) who meets the criteria as defined in chapter 388-502 WAC; or

(C) A licensed physician assistant (PA), practicing with a supervising physician.

(iii) Controlled substances prescriber prescribes all controlled substances for the client.

(iv) Pharmacy fills all prescriptions for the client.

(v) Hospital provides all nonemergent hospital services.

(c) A client placed in the PRC program cannot change assigned providers for twelve months after the assignments are made, unless:

(i) The client moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's local geographic area and is no longer reasonably accessible to the client;

(iii) The provider refuses to continue to serve the client;

(iv) The client did not select the provider. The client may request to change an assigned provider once within thirty calendar days of the initial assignment;

(v) The client's assigned provider no longer participates with the MCO. In this case, the client may select a new provider from the list of available providers in the MCO or follow the assigned provider to the new MCO.

(d) When an assigned prescribing provider no longer contracts with the department:

(i) All prescriptions from the provider are invalid thirty calendar days following the date the contract ends; and

(ii) All prescriptions from the provider are subject to applicable prescription drugs (outpatient) rules in chapter 388-530 WAC or appropriate MCO rules.

(iii) The client must choose or be assigned another provider according to the requirements in this section.

(11) **PRC placement periods.** The length of time for a client's PRC placement includes:

(a) The initial period of PRC placement, which is a minimum of twenty-four consecutive months.

(b) The second period of PRC placement, which is an additional thirty-six consecutive months.

(c) The third period and each subsequent period of PRC placement, which is an additional seventy-two months.

(12) **Department review of a PRC placement period.**

The department or MCO reviews a client's use of healthcare services prior to the end of each PRC placement period described in subsection (11) of this section using the utilization guidelines in subsection (6) of this section.

(a) The department or MCO assigns the next PRC placement period if the utilization guidelines for PRC placement in subsection (6) apply to the client.

(b) When the department or MCO assigns a subsequent PRC placement period, the department or MCO sends the client and, if applicable, the client's authorized representative, a written notice informing the client:

(i) The reason for the subsequent PRC program placement;

(ii) The length of the subsequent PRC placement;

(iii) That the current providers assigned to the client continue to be assigned to the client during the subsequent PRC placement period;

(iv) That all PRC program rules continue to apply; and

(v) Of hearing or appeal rights (see subsection (14) of this section);

(vi) Of the rules that support the decision.

(c) The department may remove a client from PRC placement if the client:

(i) Successfully completes a treatment program that is provided by a chemical dependency service provider certified by the department under chapter 388-805 WAC;

(ii) Submits documentation of completion of the approved treatment program to the department; and

(iii) Maintains appropriate use of healthcare services within the utilization guidelines described in subsection (6) for six months after the date the treatment ends.

(d) The department or MCO determines the appropriate placement period for a client who has been placed back into the program.

(e) A client will remain placed in the PRC program regardless of change in eligibility program type or change in address.

(13) **Client financial responsibility.** A client placed in the PRC program may be billed by a provider and held financially responsible for healthcare services when the client obtains nonemergent services and the provider who renders the services is not assigned or referred under the PRC program.

(14) **Right to hearing or appeal.**

(a) A fee-for-service client who believes the department has taken an invalid action pursuant to this section may request a hearing.

(b) A managed care client who believes the MCO has taken an invalid action pursuant to this section or chapter 388-538 WAC must exhaust the MCO's internal appeal process set forth in WAC 388-538-110 prior to requesting a hearing. Managed care clients can not change MCOs until the appeal or hearing is resolved and there is a final ruling.

(c) A client must request the hearing or appeal within ninety calendar days after the client receives the written notice of placement in the PRC program.

(d) The department conducts a hearing according to chapter 388-02 WAC. Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 388-02-0010.

(e) A client who requests a hearing or appeal within ten calendar days from the date of the written notice of an initial PRC placement period under subsection (11)(a) of this section will not be placed in the PRC program until the date an initial order is issued that supports the client's placement in the PRC program or otherwise ordered by an administrative law judge (ALJ).

(f) A client who requests a hearing or appeal more than ten calendar days from the date of the written notice under subsection (9) of this section will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(g) A client who requests a hearing or appeal within ninety days from the date of receiving the written notice under subsection (9) of this section and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(h) An administrative law judge (ALJ) may rule that the client be placed in the PRC program prior to the date the record is closed and prior to the date the initial order is issued based on a showing of just cause.

(i) The client who requests a hearing challenging placement into the PRC program has the burden of proving the department's or MCO's action was invalid. For standard of proof, see WAC 388-02-0485.

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**WAC 182-501-0160 Exception to rule—Request for a noncovered healthcare service.** A client and/or the client's provider may request the department to pay for a noncovered healthcare service. This is called an exception to rule.

(1) The department cannot approve an exception to rule if the requested service is excluded under state statute.

(2) The item or service(s) for which an exception is requested must be of a type and nature which falls within accepted standards and precepts of good medical practice;

(3) All exception requests must represent cost-effective utilization of medical assistance program funds as determined by the department;

(4) A request for an exception to rule must be submitted to the department in writing within ninety days of the date of the written notification denying authorization for the noncov-

ered service. For the department to consider the exception to rule request:

(a) The client and/or the client's healthcare provider must submit sufficient client-specific information and documentation to health and recovery services administration's medical director or designee which demonstrate the client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s).

(b) The client's healthcare professional must certify that medical treatment or items of service which are covered under the client's medical assistance program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:

(i) Medically ineffective in the treatment of the client's condition; or

(ii) Inappropriate for that specific client.

(5) Within fifteen business days of receiving the request, the department sends written notification to the provider and the client:

(a) Approving the exception to rule request;

(b) Denying the exception to rule request; or

(c) Requesting additional information.

(i) The additional information must be received by the department within thirty days of the date the information was requested.

(ii) The department approves or denies the exception to rule request within five business days of receiving the additional information.

(iii) If the requested information is insufficient or not provided within thirty days, the department denies the exception to rule request.

(6) The HRSA medical director or designee evaluates and considers requests on a case-by-case basis. The HRSA medical director has final authority to approve or deny a request for exception to rule.

(7) Clients do not have a right to a fair hearing on exception to rule decisions.

[11-14-075, recodified as § 182-501-0160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0160, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035, 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

**WAC 182-501-0163 Healthcare coverage—Process for submitting a valid request for authorization.** (1) The department requires providers to obtain authorization for certain healthcare services in accordance with this section, chapters 388-501 and 388-502 WAC, other applicable department rules, current published department billing instructions, and/or numbered memoranda. For the purposes of this section, healthcare services include treatment, equipment, related supplies, and drugs.

(a) For healthcare services that require prior authorization (PA), a provider (as defined in WAC 388-500-0005) must submit a written, electronic, or telephonic request to the department. To be a valid request for prior authorization, the provider must submit the request and conform to the department's current published program billing instructions, num-

bered memoranda, and any additional requirements in Washington Administrative Code (WAC) and/or Revised Code of Washington (RCW).

(b) For expedited prior authorization (EPA), a provider must certify that the client's clinical condition meets the appropriate EPA criteria outlined in the department's current published program billing instructions, numbered memoranda, and any additional requirements in WAC and/or RCW. The provider must use the department-assigned EPA number when submitting a claim for payment to the department.

(c) The department requires prior authorization for covered healthcare services when the applicable expedited prior authorization criteria are not met.

(d) Upon request, a provider must submit documentation to the department showing how the client's condition meets the required criteria for PA or EPA.

(2) Department authorization requirements for covered healthcare services are not a denial of service.

(3) The department returns invalid requests to the provider and takes no further action unless the request for authorization is resubmitted. The return of an invalid request is not a denial of service.

(4) Failure of a provider to request authorization for a healthcare service that requires it or a provider's failure to do so properly is not a denial of service.

(5) The department's authorization of healthcare service(s) does not guarantee payment. See WAC 388-501-0050 for other general requirements that must be satisfied before payment can be made for a healthcare service requested and authorized under this section.

(6) The department evaluates a request for an authorization of a healthcare service that exceeds identified limitations, on a case-by-case basis and in accordance with WAC 388-501-0169.

(7) The department may recoup any payment made to a provider if the department later determines the healthcare service was not properly authorized or did not meet EPA criteria. Refer to chapters 388-502 and 388-502A WAC.

[11-14-075, recodified as § 182-501-0163, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0163, filed 11/18/09, effective 12/19/09.]

**WAC 182-501-0165 Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment.** (1) This section applies to fee-for-service (FFS) requests for medical or dental services and medical equipment that:

(a) Are identified as covered services or EPSDT services; and

(b) Require prior authorization by the department.

(2) The following definitions and those found in WAC 388-500-0005 apply to this section:

**"Controlled studies"**—Studies in which defined groups are compared with each other to reduce bias.

**"Credible evidence"**—Type I-IV evidence or evidence-based information from any of the following sources:

- Clinical guidelines
- Government sources
- Independent medical evaluation (IME)
- Independent review organization (IRO)

- Independent technology assessment organizations
- Medical and hospital associations
- Policies of other health plans
- Regulating agencies (e.g., Federal Drug Administration or Department of Health)

• Treating provider

• Treatment pathways

**"Evidence-based"**—The ordered and explicit use of the best evidence available (see "hierarchy of evidence" in subsection (6)(a) of this section) when making health care decisions.

**"Health outcome"**—Changes in health status (mortality and morbidity) which result from the provision of health care services.

**"Institutional review board (IRB)"**—A board or committee responsible for reviewing research protocols and determining whether:

(1) The rights and welfare of human subjects are adequately protected;

(2) The risks to individuals are minimized and are not unreasonable;

(3) The risks to individuals are outweighed by the potential benefit to them or by the knowledge to be gained; and

(4) The proposed study design and methods are adequate and appropriate in the light of stated study objectives.

**"Independent review organization (IRO)"**—A panel of medical and benefit experts intended to provide unbiased, independent, clinical, evidence-based reviews of adverse decisions.

**"Independent medical evaluation (IME)"**—An objective medical examination of the client to establish the medical facts.

**"Provider"**—The individual who is responsible for diagnosing, prescribing, and providing medical, dental, or mental health services to department clients.

(3) The department authorizes, on a case-by-case basis, requests described in subsection (1) when the department determines the service or equipment is medically necessary as defined in WAC 388-500-0005. The process the department uses to assess medical necessity is based on:

(a) The evaluation of submitted and obtainable medical, dental, or mental health evidence as described in subsections (4) and (5) of this section; and

(b) The application of the evidence-based rating process described in subsection (6) of this section.

(4) The department reviews available evidence relevant to a medical, dental, or mental health service or equipment to:

(a) Determine its efficacy, effectiveness, and safety;

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Evaluate pertinent client information;

(e) Compare to alternative technologies; and

(f) Identify sources of credible evidence that use and report evidence-based information.

(5) The department considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition, including but not limited to:

- (a) A client-specific physiological description of the disease, injury, impairment, or other ailment;
  - (b) Pertinent laboratory findings;
  - (c) Pertinent X-ray and/or imaging reports;
  - (d) Individual patient records pertinent to the case or request;
  - (e) Photographs and/or videos when requested by the department; and
  - (f) Objective medical/dental/mental health information such as medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.
- (6) The department uses the following processes to determine whether a requested service described in subsection (1) is medically necessary:

(a) **Hierarchy of evidence—How defined.** The department uses a hierarchy of evidence to determine the weight given to available data. The weight of medical evidence depends on objective indicators of its validity and reliability including the nature and source of the evidence, the empirical characteristics of the studies or trials upon which the evidence is based, and the consistency of the outcome with comparable studies. The hierarchy (in descending order with Type I given the greatest weight) is:

- (i) Type I: Meta-analysis done with multiple, well-designed controlled studies;
- (ii) Type II: One or more well-designed experimental studies;
- (iii) Type III: Well-designed, quasi-experimental studies such as nonrandomized controlled, single group pre-post, cohort, time series, or matched case-controlled studies;
- (iv) Type IV: Well-designed, nonexperimental studies, such as comparative and correlation descriptive, and case studies (uncontrolled); and
- (v) Type V: Credible evidence submitted by the provider.

(b) **Hierarchy of evidence—How classified.** Based on the quality of available evidence, the department determines if the requested service is effective and safe for the client by classifying it as an "A," "B," "C," or "D" level of evidence:

(i) **"A" level evidence:** Shows the requested service or equipment is a proven benefit to the client's condition by strong scientific literature and well-designed clinical trials such as Type I evidence or multiple Type II evidence or combinations of Type II, III or IV evidence with consistent results (An "A" rating cannot be based on Type III or Type IV evidence alone).

(ii) **"B" level evidence:** Shows the requested service or equipment has some proven benefit supported by:

- (A) Multiple Type II or III evidence or combinations of Type II, III or IV evidence with generally consistent findings of effectiveness and safety (A "B" rating cannot be based on Type IV evidence alone); or
- (B) Singular Type II, III, or IV evidence in combination with department-recognized:
  - (I) Clinical guidelines; or
  - (II) Treatment pathways; or
  - (III) Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

(iii) **"C" level evidence:** Shows only weak and inconclusive evidence regarding safety and/or efficacy such as:

(A) Type II, III, or IV evidence with inconsistent findings; or

(B) Only Type V evidence is available.

(iv) **"D" level evidence:** Is not supported by any evidence regarding its safety and efficacy, for example that which is considered investigational or experimental.

(c) **Hierarchy of evidence—How applied.** After classifying the available evidence, the department:

(i) Approves "A" and "B" rated requests if the service or equipment:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is not more costly than an equally effective alternative treatment.

(ii) Approves a "C" rated request only if the provider shows the requested service is the optimal intervention for meeting the client's specific condition or treatment needs, and:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is less costly to the department than an equally effective alternative treatment; and

(C) Is the next reasonable step for the client in a well-documented tried-and-failed attempt at evidence-based care.

(iii) Denies "D" rated requests unless:

(A) The requested service or equipment has a humanitarian device exemption from the Food And Drug Administration (FDA); or

(B) There is a local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the department and the requesting provider.

(7) Within fifteen days of receiving the request from the client's provider, the department reviews all evidence submitted and:

(a) Approves the request;

(b) Denies the request if the requested service is not medically necessary; or

(c) Requests the provider submit additional justifying information. The department sends a copy of the request to the client at the same time.

(i) The provider must submit the additional information within thirty days of the department's request.

(ii) The department approves or denies the request within five business days of the receipt of the additional information.

(iii) If the provider fails to provide the additional information, the department will deny the requested service.

(8) When the department denies all or part of a request for a covered service(s) or equipment, the department sends the client and the provider written notice, within ten business days of the date the information is received, that:

(a) Includes a statement of the action the department intends to take;

(b) Includes the specific factual basis for the intended action;

(c) Includes reference to the specific WAC provision upon which the denial is based;

(d) Is in sufficient detail to enable the recipient to:

- (i) Learn why the department's action was taken; and
- (ii) Prepare an appropriate response.
- (e) Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;
- (f) Includes the client's administrative hearing rights;
- (g) Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and
- (h) Includes examples(s) of "lesser cost alternatives" that permit the affected party to prepare an appropriate response.
- (9) If an administrative hearing is requested, the department or the client may request an independent review organization (IRO) or independent medical examination (IME) to provide an opinion regarding whether the requested service or equipment is medically necessary. The department will pay for the independent assessment if the department agrees that it is necessary, or an administrative law judge orders the assessment.

[11-14-075, recodified as § 182-501-0165, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 05-23-031, § 388-501-0165, filed 11/8/05, effective 12/9/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035, 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

**WAC 182-501-0169 Healthcare coverage—Limitation extension.** This section addresses requests for limitation extensions regarding scope, amount, duration and/or frequency of a covered healthcare service. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. The department does not authorize or pay for any covered healthcare services exceeding identified limitations unless authorization is obtained prior to client receiving the service.

- (1) No limitation extension of covered healthcare services will be authorized when prohibited by specific program rules.
- (2) When a limitation extension is not prohibited by specific program rules, the client's provider may request a limitation extension.
- (3) The department evaluates requests for limitation extensions as follows:
  - (a) For a fee-for-service client, the process described in WAC 388-501-0165.
  - (b) For a managed care enrollee, the client's managed care organization (MCO) evaluates requests for limitation extensions according to the MCO's prior authorization process.
  - (c) Both the department and MCO consider the following in evaluating a request for a limitation extension:
    - (i) The level of improvement the client has shown to date related to the requested healthcare service and the reasonably calculated probability of continued improvement if the requested healthcare service is extended; and
    - (ii) The reasonably calculated probability the client's condition will worsen if the requested healthcare service is not extended.

[11-14-075, recodified as § 182-501-0169, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 09-23-112, § 388-501-0169, filed 11/18/09, effective 12/19/09; 06-24-036, § 388-501-0169, filed 11/30/06, effective 1/1/07.]

(6/30/11)

**WAC 182-501-0175 Medical care provided in bordering cities.** (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

- (a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and
- (b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[11-14-075, recodified as § 182-501-0175, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

**WAC 182-501-0180 Healthcare services provided outside the state of Washington—General provisions.** WAC 388-501-0180 through 388-501-0184 apply only to services payable on a fee-for-service basis for Washington state medical assistance clients.

(1) Subject to the exceptions and limitations in this section, WAC 388-501-0182 and 388-501-0184, the department covers emergency and nonemergency out-of-state healthcare services provided to eligible Washington state medical assistance clients when the services are:

- (a) Within the scope of the client's healthcare program as specified under chapter 388-501 WAC;
- (b) Allowed to be provided outside the state of Washington by specific program WAC; and
- (c) Medically necessary as defined in WAC 388-500-0005.

(2) The department does not cover services provided outside the state of Washington under the Involuntary Treatment Act (chapter 71.05 RCW and chapter 388-865 WAC), including designated bordering cities.

(3) When the department pays for covered healthcare services furnished to an eligible Washington state medical assistance client outside the state of Washington, its payment is payment in full according to 42 CFR 447.15.

(4) The department determines coverage for transportation services provided out of state, including ambulance services, according to chapter 388-546 WAC.

(5) With the exception of designated bordering cities (see WAC 388-501-0175), if the client travels out of state expressly to obtain healthcare, the service(s) must be prior authorized by the department. See WAC 388-501-0182 for requirements related to out-of-state nonemergency treatment and WAC 388-501-0165 for the department's medical necessity determination process.

(6) The department does not cover healthcare services provided outside the United States and U.S. territories, with the exception of British Columbia, Canada. See WAC 388-501-0184 for limitations on coverage of, and payment for, healthcare provided to medical assistance clients in British Columbia, Canada.

(7) See WAC 388-502-0120 for provider requirements for payment of healthcare provided outside the state of Washington.

[11-14-075, recodified as § 182-501-0180, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.057 and 74.09.510, 11-14-054, § 388-501-0180, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035, 08-08-064, §

388-501-0180, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0180, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

**WAC 182-501-0182 Healthcare provided in another state or U.S. territory—Nonemergency.** (1) This rule applies to nonemergency treatment situations occurring in another state or U.S. territory. Applicable situations include, but are not limited to:

(a) Healthcare services that the department has prior authorized for a client; and

(b) Healthcare services obtained by the client, independent of the department, while traveling or visiting.

(2) In accordance with the prior authorization process described in WAC 388-501-0165, except as specified in subsection (3) of this section, the department pays for covered nonemergency healthcare services provided to an eligible Washington state medical assistance client in another state or U.S. territory to the same extent that it pays for covered non-emergency services provided within the state of Washington when the department determines that:

(a) Services are medically necessary and the client's health will be endangered if the client is required to travel to the state of Washington to receive the needed care;

(b) Medically necessary services are not available in Washington state or designated bordering cities (see WAC 388-501-0175) and are more readily available in another state; or

(c) It is general practice for clients in a particular Washington state locality to use medically necessary resources in a bordering state.

(3) The department pays for covered nonemergency healthcare services furnished to an eligible Washington state medical assistance client in another state or U.S. territory, unless the out-of-state provider is unwilling to accept the department's payment as payment in full according to 42 CFR 447.15. The department does not pay when the provider refuses to accept the department's payment as payment in full.

(4) The department does not pay for medically necessary, nonsymptomatic treatment (i.e., preventive care) furnished outside the state of Washington unless it is furnished in a designated bordering city, which is considered the same as an in-state city for the purposes of healthcare coverage (see WAC 388-501-0175). Covered nonemergency services requiring prior authorization, when provided in the state of Washington, also require prior authorization, when provided in a designated bordering city (see WAC 388-501-0165 for the department's medical necessity determination process).

(5) See WAC 388-501-0180 for additional information regarding healthcare services provided outside the state of Washington.

(6) The department's health and recovery services administration's (HRSA) assistant secretary or designee reviews all exception to rule (ETR) requests.

[11-14-075, recodified as § 182-501-0182, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-501-0182, filed 3/31/08, effective 5/1/08.]

**WAC 182-501-0184 Healthcare services provided outside of the United States and U.S. territories or in a foreign country.** For the purposes of this section the term "healthcare services" does not include the diagnosis and treatment for alcohol and/or substance abuse and mental health services.

(1) The provisions of WAC 388-501-0182 apply to this section.

(2) The department does not pay for healthcare services furnished in a foreign country, except for medical services furnished in the province of British Columbia, Canada, under the conditions specified in this section. The department pays for medical services furnished in British Columbia, Canada to the following Washington state medical assistance clients only:

(a) Those who reside in Point Roberts, Washington;

(b) Those who reside in Washington communities along the border with British Columbia, Canada (see subsection (3) of this section for further clarification); and

(c) Members of the Canadian First Nations who live in Washington state.

(3) For those medical assistance clients identified in subsection (2) of this section, the department covers emergency and nonemergency medical services provided in British Columbia, Canada, when the services are:

(a) Within the scope of the client's healthcare program as specified in chapter 388-501 WAC;

(b) Allowed to be provided outside the United States and U.S. territories by specific program WAC; and

(c) Medically necessary as defined in WAC 388-500-0005.

(4) For those medical assistance clients identified in subsection (2) of this section, the department covers nonemergency medical services in British Columbia, Canada, only when:

(a) It is general practice for Washington state medical assistance clients residing in these particular localities to use medically necessary resources across the Canadian border; or

(b) The medical services in British Columbia, Canada are closer or more readily accessible to the client's Washington state residence. As applied to nonemergency medical services, the phrase "closer or more readily accessible to the client's Washington state residence" means:

(i) There is not a United States provider for the same service within twenty-five miles of the client's Washington state residence; and

(ii) The closest Canadian provider of service is closer than the closest U.S. provider of the service.

(5) The department does not cover services provided in British Columbia, Canada under the Involuntary Treatment Act (chapter 71.05 RCW and chapter 388-865 WAC).

(6) When the department pays for covered medical services furnished to a Washington state medical assistance client in British Columbia, Canada, its payment is payment in full according to 42 CFR 447.15.

(7) A British Columbia, Canada provider who furnished healthcare services and/or covered items to a medical assistance client will receive payment from the department only when:

(a) Such reimbursement is made to a financial institution or entity located within the United States in U.S. dollars; and

(b) The participating British Columbia, Canada provider:

- (i) Has signed a core provider agreement with the department;
- (ii) Satisfies all medicaid conditions of participation;
- (iii) Meets functionally equivalent licensing requirements; and
- (iv) Complies with the same utilization control standards as in-state providers.

[11-14-075, recodified as § 182-501-0184, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.057 and 74.09.510. 11-14-054, § 388-501-0184, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-501-0184, filed 3/31/08, effective 5/1/08.]

**WAC 182-501-0200 Third-party resources.** (1) The department requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) The department pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

- (a) Prenatal care;
  - (b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or
  - (c) Preventive pediatric services as covered under the EPSDT program.
- (3) The department pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to the department documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

- (i) Is not complying with an existing court order; or
- (ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the department or the client for a covered service when a third party pays a provider the same amount as or more than the department rate.

(5) When the provider receives payment from the third party after receiving reimbursement from the department, the provider must refund to the department the amount of the:

- (a) Third-party payment when the payment is less than the department's maximum allowable rate; or
- (b) The department payment when the third-party payment is equal to or greater than the department's maximum allowable rate.

(6) The department is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills the department, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) The department considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the department is responsible for providing medical services as described under WAC 388-501-0100.

[11-14-075, recodified as § 182-501-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 10-19-057, § 388-501-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00; 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

**WAC 182-501-0213 Case management services.** (1) The department shall provide case management services to medical assistance recipients:

- (a) By contract with providers of case management services.
- (b) Limited to target groups of clients as determined by the contract.
- (c) Limited to services as determined by the contract.

(2) Case management services are services which will assist clients in gaining access to needed medical, social, educational, and other services.

[11-14-075, recodified as § 182-501-0213, filed 6/30/11, effective 7/1/11. 00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]