Chapter 182-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

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PROVIDER TYPES

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

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesiologists;

(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531-1410 through 182-531-1436:

(i) Certified agency-affiliated counselors;

(ii) Certified counselors; and

(iii) Certified counselor advisors.

(d) Audiologists;

(e) Chemical dependency professionals:

(i) Mental health care providers; and

(ii) Peer counselors.

(f) Chiropractors;

(g) Dentists;

(h) Dental hygienists;

(i) Denturists;

(j) Dietitians or nutritionists;

(k) Hearing aid fitters/dispensers;

(l) Marriage and family therapists;

(m) Mental health counselors;

(n) Mental health care providers;

(o) Midwives;

(p) Naturopathic physicians;

(q) Nurse anesthetist;

(r) Occularists;

(s) Occupational therapists;

(t) Ophthalmologists;

(u) Opticians;

(v) Optometrists;

(w) Orthodontists;

(x) Orthotist;

(y) Osteopathic physicians;

(z) Osteopathic physician assistants;

(aa) Peer counselors;

(bb) Podiatric physicians;

(cc) Pharmacists;

(dd) Physicians;

(ee) Physician assistants;

(ff) Physical therapists;

(gg) Prosthetist;

(hh) Psychiatrists;

(ii) Psychologists;

(jj) Radiologists;

(kk) Registered nurse delegators;

(ll) Registered nurse first assistants;

(mm) Respiratory therapists;

(nn) Social workers; and

(oo) Speech/language pathologists.

(2) Agencies, centers and facilities:

(a) Adult day health centers;

(b) Ambulance services (ground and air);

(c) Ambulatory surgery centers (medicare-certified);

(d) Birthing centers (licensed by the department of health);

(e) Cardiac diagnostic centers;

(f) Case management agencies;

(g) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of behavioral health and recovery (DBHR), and contracted through either:

(i) A county under chapter 388-810 WAC; or

(ii) DBHR to provide chemical dependency treatment services.

(h) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DBHR);

(i) Community AIDS services alternative agencies;

(j) Community mental health centers;

(k) Diagnostic centers;

(l) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;

(m) Family planning clinics;

(n) Federally qualified health centers (designated by the federal department of health and human services);

(o) Genetic counseling agencies;

(p) Health departments;

(q) Health maintenance organization (HMO)/managed care organization (MCO);

(r) HIV/AIDS case management;

(s) Home health agencies;

(t) Hospice agencies;

(u) Hospitals;

(v) Indian health service facilities/tribal 638 facilities;

(w) Tribal or urban Indian clinics;

(x) Inpatient psychiatric facilities;

(y) Intermediate care facilities for the mentally retarded (ICF-MR);

(z) Kidney centers;

(aa) Laboratories (CLIA certified);

(bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;

(cc) Neuromuscular and neurodevelopmental centers;

(dd) Nurse services/delegation;

(ee) Nursing facilities (approved by the DSHS aging and long-term support administration);

(ff) Pathology laboratories;

(gg) Pharmacies;

(hh) Private duty nursing agencies;

(ii) Radiology - Stand-alone clinics;

(jj) Rural health clinics (medicare-certified);

(kk) School districts and educational service districts;

(ll) Sleep study centers; and

(mm) Washington state school districts and educational service districts.

(3) Suppliers of:

(a) Blood, blood products, and related services;

(b) Durable and nondurable medical equipment and supplies;

(c) Complex rehabilitation technologies;

(d) Infusion therapy equipment and supplies;

(e) Prosthetics/orthotics;

(f) Hearing aids; and

(g) Respiratory care, equipment, and supplies.

(4) Contractors:

(a) Transportation brokers;

(b) Spoken language interpreter services agencies;

(c) Independent sign language interpreters; and

(d) Eyeglass and contact lens providers.

[Statutory Authority: RCW 41.05.021, 2013 c 178, and 2013 2nd sp.s. c 4. WSR 14-06-054, § 182-502-0002, filed 2/27/14, effective 3/30/14. WSR 11-14-075, recodified as § 182-502-0002, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0002, filed 5/9/11, effective 6/9/11.]

WAC 182-502-0003 Noneligible provider types. The medicaid agency does not enroll licensed or unlicensed health care practitioners not specifically listed in WAC 182-502-0002, including, but not limited to:

(1) Acupuncturists;

(2) Sanipractors;

(3) Homeopaths;

(4) Herbalists;

(5) Massage therapists;

(6) Christian science practitioners, theological healers, and spiritual healers;

(7) Chemical dependency professional trainee (CDPT); and

(8) Mental health trainee (MHT).

[Statutory Authority: RCW 41.05.021, 2013 c 178, and 2013 2nd sp.s. c 4. WSR 14-06-054, § 182-502-0003, filed 2/27/14, effective 3/30/14. WSR 11-14-075, recodified as § 182-502-0003, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0003, filed 5/9/11, effective 6/9/11.]

ENROLLMENT

WAC 182-502-0005 Core provider agreement (CPA). (1) The agency only pays claims submitted by or on behalf of a health care professional, health care entity, supplier or contractor of service that has an approved core provider agreement (CPA) with the agency, is a performing provider on an approved CPA with the agency, or has an approved agreement with the agency as a nonbilling provider in accordance with WAC 182-502-0006.

(2) Performing providers of services to a medical assistance client must be enrolled under the billing providers' CPA.

(3) Any ordering, prescribing, or referring providers must be enrolled in the agency's claims payment system in order for any services or supplies ordered, prescribed, or referred by them to be paid. The national provider identifier (NPI) of any referring, prescribing, or ordering provider must be included on the claim form. Refer to WAC 182-502-0006 for enrollment as a nonbilling provider.

(4) For services provided out-of-state, refer to WAC 182-501-0180, 182-501-0182, and 182-501-0184.

(5) The agency does not pay for services provided to clients during the CPA application process or application for nonbilling provider process, regardless of whether the agency later approves or denies the application, except as provided in subsection (6) of this section or WAC 182-502-0006(5).

(6) Enrollment of a provider applicant is effective on the date the agency approves the provider application.

(a) A provider applicant may ask for an effective date earlier than the agency's approval of the provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

(i) Earlier than the effective date of any required license or certification; or

(ii) More than three hundred sixty-five days prior to the agency's approval of the provider application.

(b) The chief medical officer or designee may approve exceptions as follows:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need as determined by the agency's chief medical officer or designee.

(c) For federally qualified health centers (FQHCs), see WAC 182-548-1200. For rural health clinics (RHCs), see WAC 182-549-1200.

(d) Exceptions granted under this subsection (6) do not supersede or otherwise change the agency's timely billing requirements under WAC 182-502-0150.

[Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-502-0005, filed 9/11/13, effective 10/12/13. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455 subpart E Provider Screening and Enrollment requirements. WSR 12-12-032, § 182-502-0005, filed 5/29/12, effective 7/1/12. WSR 11-14-075, recodified as § 182-502-0005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0005, filed 5/9/11, effective 6/9/11.]

WAC 182-502-0006 Enrollment for nonbilling individual providers. (1) The agency pays for health care services, drugs, supplies or equipment prescribed, ordered, or referred by a health care professional only when the health care professional has one of the following approved agreements with the agency and all other conditions of payment have been met (see WAC 182-501-0050):

(a) Core provider agreement, in accordance with WAC 182-502-0005; or

(b) Nonbilling provider agreement, in accordance with subsection (4) of this section.

(2) Only a licensed health care professional whose scope of practice under their licensure includes ordering, prescribing, or referring may enroll as a nonbilling provider.

(3) Nothing in this chapter obligates the agency to enroll any health care professional who requests enrollment as a nonbilling provider.

(4) **Enrollment.**

(a) To enroll as a nonbilling provider with the medicaid agency, a health care professional must, on the date of application:

(i) Not already be enrolled with the medicaid agency as a billing or servicing provider;

(ii) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules;

(iii) Be enrolled with medicare, when required in specific program rules;

(iv) Have current professional liability coverage, individually or as a member of a group;

(v) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(vi) Pass the agency's screening process, including license verifications, data base checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450. The agency uses the same screening level risk categories that apply under medicare. For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare;

(vii) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(viii) Sign, without modification, a Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002). The medicaid agency and each provider signing a Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002) will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of this agreement.

(b) The medicaid agency does not enroll a nonbilling provider for reasons which include, but are not limited to, the following:

(i) The agency determines that:

(A) There is a quality of care issue with significant risk factors that may endanger client health and/or safety (see WAC 182-502-0030 (1)(a)); or

(B) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 182-502-0030 (1)(b)).

(ii) The health care professional:

(A) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(B) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(C) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(D) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(E) Is noncompliant with the department of health's or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(F) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(G) Fails a background check, including a fingerprint-based criminal background check, performed by the agency. See WAC 182-502-0014, except that subsection (2) of this section does not apply to nonbilling providers;

(H) Does not have sufficient liability insurance according to (a)(i) of this subsection for the scope of practice; or

(I) Fails to meet the requirements of a site visit, as required by 42 C.F.R. 455.432.

(5) **Effective date of enrollment of nonbilling provider.** Enrollment of a nonbilling provider applicant is effective on the date the agency approves the nonbilling provider application.

(a) A nonbilling provider applicant may ask for an effective date earlier than the agency's approval of the nonbilling provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

(i) Earlier than the effective date of any required license or certification; or

(ii) More than three hundred sixty-five days prior to the agency's approval of the nonbilling provider application.

(b) The chief medical officer or designee may approve exceptions as follows:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need as determined by the agency's chief medical officer or designee.

(6) **Continuing requirements.** To continue eligibility, a nonbilling provider must:

(a) Only order, refer, or prescribe for clients consistent with the scope of their department of health (DOH) licensure and agency program rules;

(b) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(c) Document that the client was informed that the provider:

(i) May bill the client for any billable item or service. The rules in WAC 182-502-0160 do not apply; and

(ii) Is enrolled with the agency for the sole purpose of ordering, prescribing, or referring items or services for clients.

(d) Inform the agency of any changes to the provider's Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002) including, but not limited to, changes in:

(i) Address or telephone number;

(ii) Business name.

(e) Retain a current professional state license, registration, certification and applicable business license for the service being provided, and update the agency of all changes;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s) including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Maintain professional liability coverage requirements;

(h) Not surrender, voluntarily or involuntarily, his or her professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct;

(i) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.

(j) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information;

(ii) Submitting forms as required by the agency including, but not limited to, a new Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002); and

(iii) Passing the agency's screening process as specified in subsection (4)(a)(vi) of this section.

(k) Follow the laws and rules that govern the agency's programs. A nonbilling provider may contact the agency with questions regarding the agency's programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a nonbilling provider from this requirement.

(7) **Audit or investigation.**

(a) Audits or investigations may be conducted to determine compliance with the rule and regulations of the program.

(b) If an audit or investigation is initiated, the provider must retain all original records and supportive materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required six year period.

(8) **Inspection; maintenance of records.** For six years from the date of services, or longer if required specifically by law, the nonbilling provider must:

(a) Keep complete and accurate medical records that fully justify and disclose the extent of the services or items ordered, referred or prescribed.

(b) Make available upon request appropriate documentation, including client records, supporting material for review by the professional staff within the agency or the U.S. Department of Health and Human Services. The nonbilling provider understands that failure to submit or failure to retain adequate documentation may result in the termination of the nonbilling provider's enrollment.

(9) **Terminations.**

(a) The agency may immediately terminate a nonbilling provider's agreement, and refer the nonbilling provider to the appropriate state health professions quality assurance commission for:

(i) Any of the reasons in WAC 182-502-0030 termination for cause (except that subsection (1)(a)(ix) and (b)(i) do not apply); and

(ii) Failure to comply with the requirements of subsections (4), (6), and (8) of this section.

(b) Either the agency or the provider may terminate this agreement for convenience at any time with thirty calendar days' written notification to the other.

(c) If this agreement is terminated for any reason, the agency will pay for services ordered, referred, or prescribed by the provider only through the date of termination.

(10) **Termination disputes.**

(a) To dispute terminations of a nonbilling provider agreement under subsection (9)(a) of this section, the dispute process in WAC 182-502-0050 applies.

(b) Nonbilling providers cannot dispute terminations under subsection (9)(b) of this section.

[Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-502-0006, filed 9/11/13, effective 10/12/13.]

WAC 182-502-0010 When the medicaid agency enrolls. (1) Nothing in this chapter obligates the medicaid agency to enroll any eligible health care professional, health care entity, supplier or contractor of service who requests enrollment.

(2) To enroll as a provider with the agency, a health care professional, health care entity, supplier or contractor of service must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules. Persons or entities outside of Washington state, see WAC 182-502-0120;

(b) Be enrolled with medicare, when required in specific program rules;

(c) Have current professional liability coverage, individually or as a member of a group;

(d) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(e) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(f) Sign, without modification, a core provider agreement (CPA) (HCA 09-015), disclosure of ownership form, and debarment form (HCA 09-016) or a contract with the agency;

(g) Agree to accept the payment from the agency as payment in full (in accordance with 42 C.F.R. § 447.15 acceptance of state payment as payment in full and WAC 182-502-0160 billing a client);

(h) Fully disclose ownership, employees who manage, and other control interests (e.g., member of a board of directors or office), as requested by the agency. Indian health services clinics are exempt from this requirement. If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and provide its national provider identifier (NPI) (if eligible for an NPI) to be used for submitting claims as the billing provider;

(i) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(j) Pass the agency's screening process, including license verifications, data base checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450. The agency uses the same screening level risk categories that apply under medicare. For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare; and

(k) Agree to pay an application fee, if required by CMS under 42 C.F.R. 455.460.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0010, filed 1/14/13, effective 2/14/13. Statutory Authority: RCW 41.05.021 and Affordable Care Act (ACA) - 76 Fed. Reg. 5862, 42 C.F.R. Parts 405, 424, 447, 455, 457, and 498. WSR 12-15-015, § 182-502-0010, filed 7/10/12, effective 9/1/12. WSR 11-14-075, recodified as § 182-502-0010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0010, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.09.521. WSR 08-12-030, § 388-502-0010, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.080, 74.09.120. WSR 03-14-106, § 388-502-0010, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. WSR 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; WSR 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

WAC 182-502-0012 When the medicaid agency does not enroll. (1) The medicaid agency does not enroll a health care professional, health care entity, supplier or contractor of service for reasons which include, but are not limited to, the following:

(a) The agency determines that:

(i) There is a quality of care issue with significant risk factors that may endanger client health and/or safety (see WAC 182-502-0030 (1)(a; or

(ii) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 182-502-0030 (1)(b.

(b) The health care professional, health care entity, supplier or contractor of service:

(i) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(ii) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(iii) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(iv) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(v) Is noncompliant with the department of health's or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(vi) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(vii) Fails a background check, including a fingerprint-based criminal background check, performed by the agency. See WAC 182-502-0014 and 182-502-0016;

(viii) Does not have sufficient liability insurance according to WAC 182-502-0016 for the scope of practice; or

(ix) Fails to meet the requirements of a site visit, as required by 42 C.F.R. 455.432.

(2) The agency may not pay for any health care service, drug, supply or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service whose application for a core provider agreement (CPA) has been denied or terminated.

(3) The agency may not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service who does not have a current CPA with the agency when the agency determines there is a potential danger to a client's health and/or safety.

(4) Nothing in this chapter precludes the agency from entering into other forms of written agreements with a health care professional, health care entity, supplier or contractor of service.

(5) If the agency denies an enrollment application, the applicant does not have any dispute rights within the agency.

(6) Under 42 C.F.R. 455.470, the agency:

(a) Will impose a temporary moratorium on enrollment when directed by CMS; or

(b) May initiate and impose a temporary moratorium on enrollment when approved by CMS.

[Statutory Authority: RCW 41.05.021. WSR 13-17-047, § 182-502-0012, filed 8/13/13, effective 10/1/13. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0012, filed 1/14/13, effective 2/14/13. WSR 11-14-075, recodified as § 182-502-0012, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0012, filed 5/9/11, effective 6/9/11.]

WAC 182-502-0014 Review and consideration of an applicant's history. (1) The medicaid agency may consider enrolling a health care professional, health care entity, supplier or contractor of service for reasons which include, but are not limited to, the following:

(a) The agency determines that:

(i) There is not a quality of care issue with significant risk factors that endanger client health or safety, or both;

(ii) There are not risk factors that affect the credibility, honesty, or veracity of the applicant; and

(iii) The applicant is not likely to repeat the violation that led to a restriction or sanction.

(b) The health care professional, health care entity, supplier or contractor of service has:

(i) Been excluded from participation in medicare, medicaid, or any other federally funded health care program but is not currently excluded; or

(ii) A history of probation, suspension, termination, revocation, or a surrendered professional license, certification, accreditation, or registration as defined under chapter 18.130 RCW but currently has an active license, certification, accreditation, or registration; or

(iii) A restricted or limited professional license, certification, accreditation, or registration as defined under RCW 18.130.160; or

(iv) A history of denial, limitation, suspension or termination of participation or privileges by any health care institution, plan, facility, clinic, or state agency for quality of care issues or inappropriate billing practices and the quality of care issue or inappropriate billing practices have been corrected to the agency's satisfaction.

(2) The agency conducts a screening process as specified in WAC 182-502-0010 (2)(j) on any applicant applying for a core provider agreement (CPA) or enrolling to provide services to eligible clients.

(3) The agency's response to a review of a request for enrollment is based on the information available to the agency at the time of application.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0014, filed 1/14/13, effective 2/14/13. WSR 11-14-075, recodified as § 182-502-0014, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0014, filed 5/9/11, effective 6/9/11.]

PROVIDER REQUIREMENTS

WAC 182-502-0016 Continuing requirements. (1) To continue to provide services for eligible clients and be paid for those services, a provider must:

(a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(b) Provide all services according to federal and state laws and rules, medicaid agency billing instructions, numbered memoranda issued by the agency, and other written directives from the agency;

(c) Inform the agency of any changes to the provider's application or contract, including but not limited to, changes in:

(i) Ownership (see WAC 182-502-0018);

(ii) Address or telephone number;

(iii) Professional practicing under the billing provider number; or

(iv) Business name.

(d) Retain a current professional state license, registration, certification and applicable business license for the service being provided, and update the agency of all changes;

(e) Inform the agency in writing within seven calendar days of changes applicable to the provider's clinical privileges;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s), including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Screen employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(h) Report immediately to the agency any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 182-502-0010 (2)(j);

(i) Pass any portion of the agency's screening process as specified in WAC 182-502-0010 (2)(j) when the agency requires such information to reassess a provider;

(j) Maintain professional and general liability coverage requirements, if not covered under agency, center, or facility, in the amounts identified by the medicaid agency;

(k) Not surrender, voluntarily or involuntarily, his or her professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct;

(l) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice; and

(m) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information including, but not limited to, disclosures;

(ii) Submitting forms as required by the agency including, but not limited to, a new core provider agreement; and

(iii) Passing the agency's screening process as specified in WAC 182-502-0010 (2)(j).

(2) A provider may contact the agency with questions regarding its programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the agency's programs.

(3) The agency may refer the provider to the appropriate state health professions quality assurance commission.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0016, filed 1/14/13, effective 2/14/13. WSR 11-14-075, recodified as § 182-502-0016, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0016, filed 5/9/11, effective 6/9/11.]

WAC 182-502-0018 Change of ownership. (1) A provider must notify the department in writing within seven calendar days of ownership or control changes of any kind. An entity is considered to have an ownership or control interest in another entity if it has direct or indirect ownership of five percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or who directly or indirectly conducts day-to-day operations of the entity. The department determines whether a new core provider agreement (CPA) must be completed for the new entity.

(2) When a provider obtains a new federal tax identification (ID) following a change of ownership, the department terminates the provider's CPA as of the date of the change in federal tax ID. The provider may reapply for a new CPA.

(3) All new ownership enrollments are subject to the requirements in WAC 388-502-0010. In addition to those requirements, the applicant must:

(a) Complete a change of ownership form;

(b) Provide the department with a copy of the contract of sale identifying previous and current owners; and

(c) Provide the department with a list of all provider numbers affected by the change of ownership.

[WSR 11-14-075, recodified as § 182-502-0018, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0018, filed 5/9/11, effective 6/9/11.]

WAC 182-502-0020 Health care record requirements. This section applies to providers, as defined under WAC 182-500-0085 and under WAC 182-538-050. Providers must:

(1) Maintain documentation in the client's medical or health care records to verify the level, type, and extent of services provided to each client to fully justify the services and billing, including, but not limited to:

(a) Client's name and date of birth;

(b) Dates of services;

(c) Name and title of person performing the service;

(d) Chief complaint or reason for each visit;

(e) Pertinent past and present medical history;

(f) Pertinent findings on examination at each visit;

(g) Medication(s) or treatment prescribed and/or administered;

(h) Name and title of individual prescribing or administering medication(s);

(i) Equipment and/or supplies prescribed or provided;

(j) Name and title of individual prescribing or providing equipment and/or supplies;

(k) Detailed description of treatment provided;

(l) Subjective and objective findings;

(m) Clinical assessment and diagnosis;

(n) Recommendations for additional treatments, procedures, or consultations;

(o) Radiographs (X rays), diagnostic tests and results;

(p) Plan of treatment and/or care, and outcome;

(q) Specific claims and payments received for services;

(r) Correspondence pertaining to client dismissal or termination of health care practitioner/patient relationship;

(s) Advance directives, when required under WAC 182-501-0125;

(t) Patient treatment agreements (examples: Opioid agreement, medication and treatment compliance agreements); and

(u) Informed consent documentation.

(2) Keep legible, accurate, and complete charts and records;

(3) Meet any additional record requirements of the department of health (DOH);

(4) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(5) Make charts and records available to the medicaid agency, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if

required specifically by federal or state law or regulation. The agency does not separately reimburse for copying of health care records, reports, client charts and/or radiographs, and related copying expenses; and

(6) Permit the agency, DHHS, and its agents or designated contractors, access to its physical facilities and its records to enable the agency and DHHS to conduct audits, inspections, or reviews without prior announcement.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455. WSR 13-03-068, § 182-502-0020, filed 1/14/13, effective 2/14/13. WSR 11-14-075, recodified as § 182-502-0020, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0020, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. WSR 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; WSR 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

WAC 182-502-0022 Provider preventable conditions (PPCs)—Payment policy. (1) This section establishes the agency's payment policy for services provided to medicaid clients on a fee-for-service basis or to a client enrolled in a managed care organization (defined in WAC 182-538-050) by health care professionals and inpatient hospitals that result in provider preventable conditions (PPCs).

(2) The rules in this section apply to:

(a) All health care professionals who bill the agency directly; and

(b) Inpatient hospitals.

(3) Definitions. The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) **Agency -** See WAC 182-500-0010.

(b) **Health care-acquired conditions (HCAC) -** A condition occurring in any inpatient hospital setting (identified as a hospital acquired condition by medicare other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(c) **Other provider preventable conditions (OPPC) -** The list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 and published by the National Quality Forum.

(d) **Present on admission (POA) indicator -** A status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(e) **Provider preventable condition (PPC) -** An umbrella term for hospital and nonhospital acquired conditions identified by the agency for nonpayment to ensure the high quality of medicaid services. PPCs include two distinct categories: Health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

(4) **Health care-acquired condition (HCAC) -** The agency will deny or recover payment to health care professionals and inpatient hospitals for care related only to the treatment of the consequences of a HCAC.

(a) HCAC conditions include:

(i) Foreign object retained after surgery;

(ii) Air embolism;

(iii) Blood incompatibility;

(iv) Stage III and IV pressure ulcers;

(v) Falls and trauma:

(A) Fractures;

(B) Dislocations;

(C) Intracranial injuries;

(D) Crushing injuries;

(E) Burns;

(F) Other injuries.

(vi) Manifestations of poor glycemic control:

(A) Diabetic ketoacidosis;

(B) Nonketotic hyperosmolar coma;

(C) Hypoglycemic coma;

(D) Secondary diabetes with ketoacidosis;

(E) Secondary diabetes with hyperosmolarity.

(vii) Catheter-associated urinary tract infection (UTI);

(viii) Vascular catheter-associated infection;

(ix) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG);

(x) Surgical site infection following bariatric surgery for obesity:

(A) Laparoscopic gastric bypass;

(B) Gastroenterostomy; or

(C) Laparoscopic gastric restrictive surgery.

(xi) Surgical site infection following certain orthopedic procedures:

(A) Spine;

(B) Neck;

(C) Shoulder;

(D) Elbow.

(xii) Surgical site infection following cardiac implantable electronic device (CIED).

(xiii) Deep vein thrombosis/pulmonary embolism (DVT/PE) following certain orthopedic procedures:

(A) Total knee replacement; or

(B) Hip replacement.

(xiv) Latrogenic pneumothorax with venous catheterization.

(b) Hospitals must include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator is to be used according to the official coding guidelines for coding and reporting and the CMS guidelines. The POA indicator may prompt a review, by the agency or the agency's designee, of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines. The agency will identify professional claims using the information provided on the hospital claims.

(c) HCACs are based on current medicare inpatient prospective payment system rules with the inclusion of POA indicators. Health care professionals and inpatient hospitals must report HCACs on claims submitted to the agency for consideration of payment.

(5) **Other provider preventable condition (OPPC) -** The agency will deny or recoup payment to health care professionals and inpatient hospitals for care related only to the treatment of consequences of an OPPC when the condition:

(a) Could have reasonably been prevented through the application of nationally recognized evidence based guidelines;

(b) Is within the control of the hospital;

(c) Occurred during an inpatient hospital admission;

(d) Has a negative consequence for the beneficiary;

(e) Is auditable; and

(f) Is included on the list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 effective on the date the incident occurred. The list of serious reportable events in health care, as of the publishing of this rule, includes:

(i) Surgical or invasive procedure events:

(A) Surgical or other invasive procedure performed on the wrong site;

(B) Surgical or other invasive procedure performed on the wrong patient;

(C) Wrong surgical or other invasive procedure performed on a patient;

(D) Unintended retention of a foreign object in a patient after surgery or other invasive procedure;

(E) Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

(ii) Product or device events:

(A) Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the hospital;

(B) Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;

(C) Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a hospital.

(iii) Patient protection events:

(A) Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person;

(B) Patient death or serious injury associated with patient elopement;

(C) Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a hospital.

(iv) Care management events:

(A) Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);

(B) Patient death or serious injury associated with unsafe administration of blood products;

(C) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a hospital;

(D) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

(E) Patient death or serious injury associated with a fall while being cared for in a hospital;

(F) Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a hospital (not present on admission);

(G) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;

(H) Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results.

(v) Environmental events:

(A) Patient death or serious injury associated with an electric shock in the course of a patient care process in a hospital;

(B) Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances;

(C) Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a hospital;

(D) Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a hospital.

(vi) Radiologic events: Death or serious injury of a patient associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area.

(vii) Potential criminal event:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(B) Abduction of a patient of any age;

(C) Sexual abuse/assault on a patient within or on the grounds of a health care setting;

(D) Death or serious injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting.

(6) Reporting PPCs.

(a) The agency requires inpatient hospitals to report PPCs (as appropriate according to (d) and (e) of this subsection) to the agency by using designated present on admission (POA) indicator codes and appropriate HCPCs modifiers that are associated:

(i) With claims for medical assistance payment; or

(ii) With courses of treatment furnished to clients for which medical assistance payment would otherwise be available.

(b) Health care professionals and inpatient hospitals must report PPCs associated with medicaid clients to the agency even if the provider does not intend to bill the agency.

(c) Use of the appropriate POA indicator codes informs the agency of the following:

(i) A condition was present at the time of inpatient hospital admission or at the time the client was first seen by the health care professional or hospital; or

(ii) A condition occurred during admission or encounter with a health care professional either inpatient or outpatient.

(d) Hospitals must notify the agency of an OPPC associated with an established medicaid client within forty-five calendar days of the confirmed OPPC in accordance with RCW 70.56.020. If the client's medicaid eligibility status is not known or established at the time the OPPC is confirmed, the agency allows hospitals thirty days to notify the agency once the client's eligibility is established or known.

(i) Notification must be in writing, addressed to the agency's chief medical officer, and include the OPPC, date of service, client identifier, and the claim number if the facility submits a claim to the agency.

(ii) Hospitals must complete the appropriate portion of the HCA 12-200 form to notify the agency of the OPPC. Agency forms are available for download at: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(e) Health care professionals or designees responsible for or may have been associated with the occurrence of a PPC involving a medicaid client must notify the agency within forty-five calendar days of the confirmed PPC in accordance

with chapter 70.56 RCW. Notifications must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, and client identifier. Providers must complete the appropriate portion of the HCA 12-200 form to notify the agency of the PPC. Agency forms are available for download at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(f) Failure to report, code, bill or claim PPCs according to the requirements in this section will result in loss or denial of payments.

(7) Identifying PPCs. The agency may identify PPCs as follows:

(a) Through the department of health (DOH); or

(b) Through the agency's program integrity efforts, including:

(i) The agency's claims payment system;

(ii) Retrospective hospital utilization review process (see WAC 182-550-1700);

(iii) The agency's provider payment review process (see WAC 182-502-0230);

(iv) The agency's provider audit process (see chapter 182-502A WAC); and

(v) A provider or client complaint.

(8) Payment adjustment for PPCs. The agency or its designee conducts a review of the PPC prior to reducing or denying payment.

(a) The agency does not reduce, recoup, or deny payment to a provider for a PPC when the condition:

(i) Existed prior to the initiation of treatment for that client by that provider. Documentation must be kept in the client's clinical record to clearly support that the PPC existed prior to initiation of treatment; or

(ii) Is directly attributable to a comorbid condition(s).

(b) The agency reduces payment to a provider when the following applies:

(i) The identified PPC would otherwise result in an increase in payment; and

(ii) The portion of the professional services payment directly related to the PPC, or treatment of the PPC, can be reasonably isolated for nonpayment.

(c) The agency does not make additional payments for services on claims for covered health care services that are attributable to HCACs and/or are coded with POA indicator codes "N" or "U."

(d) Medicare crossover claims. The agency applies the following rules for these claims:

(i) If medicare denies payment for a claim at a higher rate for the increased costs of care under its PPC policies:

(A) The agency limits payment to the maximum allowed by medicare;

(B) The agency does not pay for care considered nonallowable by medicare; and

(C) The client cannot be held liable for payment.

(ii) If medicare denies payment for a claim under its national coverage determination agency from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(A) The agency does not pay the claim, any medicare deductible or any coinsurance related to the inpatient hospital and health care professional services; and

(B) The client cannot be held liable for payment.

(9) The agency will calculate its reduction, denial or recoupment of payment based on the facts of each OPPC or HCAC. Any overpayment applies only to the health care professional or hospital where the OPPC or HCAC occurred and does not apply to care provided by other health care professionals and inpatient hospitals, should the client subsequently be transferred or admitted to another hospital for needed care.

(10) Medicaid clients are not liable for payment of an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the agency, and must not be billed for any item or service related to a PPC.

(11) Provider dispute process for PPCs.

(a) A health care professional or inpatient hospital may dispute the agency's reduction, denial or recoupment of payment related to a PPC as described in chapter 182-502A WAC.

(b) The disputing health care professional or inpatient hospital must provide the agency with the following information:

(i) The health care professional or inpatient hospital's assessment of the PPC; and

(ii) A complete copy of the client's medical record and all associated billing records, to include itemized statement or explanation of charges.

[Statutory Authority: RCW 41.05.021. WSR 13-19-038, § 182-502-0022, filed 9/11/13, effective 10/12/13. Statutory Authority: 42 C.F.R. § 447.26. WSR 13-11-051, § 182-502-0022, filed 5/14/13, effective 7/1/13.]

WAC 182-502-0025 Electronic health records (EHR) incentive program. The purpose of this section is to establish the medicaid electronic health records (EHR) incentive program in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA). The medicaid EHR incentive program promotes the adoption and meaningful use of certified EHR technology by offering financial incentives to eligible professionals and hospitals. This program is administered by the department.

(1) The department provides incentive payments to eligible providers and hospitals that adopt and meaningfully use certified EHR technology in accordance with the provisions of 42 C.F.R. Parts 412, 413, 422, and any other federal regulations that apply.

(2) Providers and hospitals eligible to participate in EHR incentive program are identified in 42 C.F.R. Part 495.304 and other applicable rules.

(3) As authorized by 42 C.F.R. Parts 412, 413, 422, chapters 43.20B and 74.09 RCW, and any other federal or state rules that apply, the department monitors and reviews all providers and hospitals participating in the EHR incentive program. By the same authority, the department reviews all practices, documentation, and/or data related to EHR technology to determine whether professionals and hospitals participating in the EHR incentive program are eligible and complying with state and federal rules and regulations.

(4) The department may determine that a participating professional or hospital has not met the eligibility or performance requirements to receive an EHR incentive payment, or should receive an incentive payment in an amount less than the amount anticipated by the provider or hospital. Areas of

possible dispute in the EHR incentive program include, at a minimum, any of the following:

(a) Patient volume thresholds and calculations, as outlined in 42 C.F.R. Part 495.304 and 495.306.

(b) Eligibility criteria and payment limitations, as outlined in 42 C.F.R. Part 495.10, 495.304, 495.306, and 495.310.

(c) Attestations and compliance demonstrations including, at a minimum:

(i) Attestations that certified EHR technology has been adopted, implemented, or upgraded; and

(ii) Demonstrations of meaningful use, as outlined in 42 C.F.R. Part 495.6, 495.8, 495.306, 495.310, and in any future published federal regulations and requirements, as applicable.

(d) The payment process and incentive payment amounts, as outlined in 42 C.F.R. Part 495.310, 495.312, and 495.314.

(e) Additional issues regarding EHR incentive program eligibility, participation, documentation, and compliance as outlined in 42 C.F.R. Parts 412, 413, 422 et al. and in any future published federal regulations and requirements, as applicable.

(5) All matters of dispute are subject to the administrative procedure act (APA) appeal process per chapter 34.05 RCW. A provider who disagrees with a department action under this section may request a hearing. The hearing request must:

(a) Be in writing;

(b) Be received by the agency, at the address identified in the notice of action, within twenty-eight days of the date of the notice of action by certified mail (return receipt); and

(c) State the reason(s) why the provider thinks the action is incorrect.

[WSR 11-14-075, recodified as § 182-502-0025, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-13-053, § 388-502-0025, filed 6/10/11, effective 7/11/11.]

TERMINATION OF PROVIDER

WAC 182-502-0030 Termination of a provider agreement—For cause. (1) The department may immediately terminate a provider's core provider agreement (CPA) for any one or more of the following reasons, each of which constitutes cause:

(a) Provider exhibits significant risk factors that endanger client health and/or safety. These factors include, but are not limited to:

(i) Moral turpitude;

(ii) Sexual misconduct as defined in WAC 246-934-100 or in profession specific rules of the department of health (DOH);

(iii) A statement of allegations or statement of charges by DOH;

(iv) Restrictions placed by DOH on provider's current practice such as chaperone required for rendering treatment, preceptor required to review practice, or prescriptive limitations;

(v) Limitations, restrictions, or loss of hospital privileges or participation in any health care plan and/or failure to disclose the reasons to the department;

(vi) Negligence, incompetence, inadequate or inappropriate treatment, or lack of appropriate follow-up treatment;

(vii) Patient drug mismanagement and/or failure to identify substance abuse/addiction or failure to refer the patient for substance abuse treatment once abuse/addiction is identified;

(viii) Use of health care providers or health care staff who are unlicensed to practice or who provide health care services which are outside their recognized scope of practice or the standard of practice in the state of Washington;

(ix) Failure of the health care provider to comply with the requirements of WAC 388-502-0016;

(x) Failure of the health care practitioner with an alcohol or chemical dependency to furnish documentation or other assurances as determined by the department to adequately safeguard the health and safety of medical assistance clients that the provider:

(A) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(B) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.

(xi) Infection control deficiencies;

(xii) Failure to maintain adequate professional malpractice coverage;

(xiii) Medical malpractice claims or professional liability claims that constitute a pattern of questionable or inadequate treatment, or contain any gross or flagrant incident of malpractice; or

(xiv) Any other act which the department determines is contrary to the health and safety of its clients.

(b) Provider exhibits significant risk factors that affect the provider's credibility or honesty. These factors include, but are not limited to:

(i) Failure to meet the requirements in WAC 388-502-0010 and WAC 388-502-0020;

(ii) Dishonesty or other unprofessional conduct;

(iii) Investigatory (e.g. audit), civil, or criminal finding of fraudulent or abusive billing practices;

(iv) Exclusion from participation in medicare, medicaid, or any other federally-funded health care program;

(v) Any conviction, no contest plea, or guilty plea relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(vi) Any conviction, no contest plea, or guilty plea of a criminal offense;

(vii) Failure to comply with a DOH request for information or an on-going DOH investigation;

(viii) Noncompliance with a DOH or other state health care agency's stipulation to disposition, agreed order, final order, or other similar licensure restriction;

(ix) Misrepresentation or failure to disclose information on the enrollment application for a core provider agreement (CPA), failure to supply requested information, or failure to update CPA as required;

(x) Failure to comply with a department request for information;

(xi) Failure to cooperate with a department investigation, audit or review;

(xii) Providing health care services which are outside the provider's recognized scope of practice or the standard of practice in the state of Washington;

(xiii) Unnecessary medical/dental or other health care procedures;

(xiv) Discriminating in the furnishing of health care services, supplies, or equipment as prohibited by 42 U.S.C. § 2000d; and

(xv) Any other dishonest or discreditable act which the department determines is contrary to the interest of the department or its clients.

(2) If a provider is terminated for cause, the department pays for authorized services provided up to the date of termination only.

(3) If the department terminates a provider who is also a full or partial owner of a group practice, the department also terminates all providers linked to the group practice. The remaining practitioners in the group practice may reapply for participation with the department subject to WAC 388-502-0010(2).

(4) A provider who is terminated for cause may dispute a department decision under the process in WAC 388-502-0050.

[WSR 11-14-075, recodified as § 182-502-0030, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0030, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. WSR 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

WAC 182-502-0040 Termination of a provider agreement—For convenience. (1) Either the department or the provider may terminate the provider's participation with the department for convenience with thirty calendar days written notice served upon the other party in a manner which provides proof of receipt or proof of valid attempt to deliver.

(2) Terminations for convenience are not eligible for the dispute resolution process described in WAC 388-502-0050.

(3) If a provider is terminated for convenience, the department pays for authorized services provided up to the date of termination only.

[WSR 11-14-075, recodified as § 182-502-0040, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0040, filed 5/9/11, effective 6/9/11.]

INFORMAL DISPUTE RESOLUTION PROCESS

WAC 182-502-0050 Provider dispute of an agency action. The process described in this section applies only when agency rules allow a provider to dispute an agency decision under this section.

(1) In order for the agency to review a decision previously made by the agency, a provider must submit the request to review the decision:

(a) Within twenty-eight calendar days of the date on the agency's decision notice;

(b) To the address listed in the decision notice; and

(c) In a manner that provides proof of receipt.

(2) A provider's dispute request must:

(a) Be in writing;

(b) Specify the agency decision that the provider is disputing;

(c) State the basis for disputing the agency's decision; and

(d) Include documentation to support the provider's position.

(3) The agency may request additional information or documentation. The provider must submit the additional information or documentation to the agency within twenty-eight calendar days of the date on the agency's request.

(4) The agency closes the dispute without issuing a decision and with no right to further review under subsection (6) of this section when the provider:

(a) Fails to comply with any requirement of subsections (2), (3), and (4) of this section;

(b) Fails to cooperate with, or unduly delays, the dispute process; or

(c) Withdraws the dispute request in writing.

(5) The agency will send the provider a written notice of dispute closure or written dispute decision.

(6) The provider may request the director of the health care authority or designee to review the written dispute decision according to the process in WAC 182-502-0270.

(7) This section does not apply to disputes regarding overpayment. For disputes regarding overpayment, see WAC 182-502-0230.

[Statutory Authority: RCW 41.05.021. WSR 13-17-047, § 182-502-0050, filed 8/13/13, effective 10/1/13. WSR 11-14-075, recodified as § 182-502-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0050, filed 5/9/11, effective 6/9/11.]

REAPPLYING FOR PARTICIPATION

WAC 182-502-0060 Reapplying for participation. (1) Providers who are denied enrollment or removed from participation are not eligible to reapply for participation with the agency for five years from the date of denial or termination.

(2) Providers who are denied enrollment or removed from participation more than once are not eligible to reapply for participation with the agency.

[Statutory Authority: RCW 41.05.021. WSR 13-17-047, § 182-502-0060, filed 8/13/13, effective 10/1/13. WSR 11-14-075, recodified as § 182-502-0060, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0060, filed 5/9/11, effective 6/9/11.]

PAYMENT

WAC 182-502-0100 General conditions of payment. (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 388-502-0150;

(e) The provider bills according to department rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The department does not reimburse providers for medical services identified by the department as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (co-pays) (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(c) Emergency medical expense requirements (EMER) (see WAC 388-550-1050 and 388-865-0217); and

(d) Spenddown (see WAC 388-519-0110).

(4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and medical assistance before the department makes any payment.

(5) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(6) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

(a) The department considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the department.

(7) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[WSR 11-14-075, recodified as § 182-502-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-014, § 388-502-0100, filed 5/9/11, effective 6/9/11; WSR 10-19-057, § 388-502-0100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. WSR 06-13-042, § 388-502-0100, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. WSR 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WAC 182-502-0110 Conditions of payment—Medicare deductible and coinsurance. (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the medicare DRG as payment in full until the medicaid outlier threshold is reached. After the medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If medicare and medicaid cover the service, the department pays only the deductible and/or coinsurance up to medicare or medicaid's allowed amount, whichever is less. If only medicare and not medicaid covers the service, the department pays only the deductible and/or coinsurance up to medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for medicaid covered services when the client exhausts medicare benefits.

[WSR 11-14-075, recodified as § 182-502-0110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. WSR 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

WAC 182-502-0120 Payment for health care services provided outside the state of Washington. (1) The department pays for health care services provided outside the state of Washington only when the service meets the provisions set forth in WAC 388-501-0180, 388-501-0182, 388-501-0184, and specific program WAC.

(2) With the exception of hospital services and nursing facilities, the department pays the provider of service in designated bordering cities as if the care was provided within the state of Washington (see WAC 388-501-0175).

(3) With the exception of designated bordering cities, the department does not pay for health care services provided to clients in medical care services (MCS) programs outside the state of Washington (see WAC 388-556-0500).

(4) With the exception of hospital services (see subsection (5) of this section), the department pays for health care services provided outside the state of Washington at the lower of:

(a) The billed amount; or

(b) The rate established by the Washington state medical assistance programs.

(5) The department pays for hospital services provided in designated bordering cities and outside the state of Washington in accordance with the provisions of WAC 388-550-3900, 388-550-4000, 388-550-4800 and 388-550-6700.

(6) The department pays nursing facilities located outside the state of Washington when approved by the aging and disability services administration (ADSA) at the lower of the billed amount or the adjusted statewide average reimbursement rate for in-state nursing facility care, only in the following limited circumstances:

(a) Emergency situations; or

(b) When the client intends to return to Washington state and the out-of-state stay is for:

(i) Thirty days or less; or

(ii) More than thirty days if approved by ADSA.

(7) To receive payment from the department, an out-of-state provider must:

(a) Have a signed agreement with the department;

(b) Meet the functionally equivalent licensing requirements of the state or province in which care is rendered;

(c) Meet the conditions in WAC 388-502-0100 and 388-502-0150;

(d) Satisfy all medicaid conditions of participation;

(e) Accept the department's payment as payment in full according to 42 C.F.R. 447.15; and

(f) If a Canadian provider, bill at the U.S. exchange rate in effect at the time the service was provided.

(8) For covered services for eligible clients, the department reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX medicaid program.

[WSR 11-14-075, recodified as § 182-502-0120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0120, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-502-0120, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

INTEREST PENALTIES

WAC 182-502-0130 Interest penalties—Providers. (1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[WSR 11-14-075, recodified as § 182-502-0130, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

TIME LIMITS FOR BILLING

WAC 182-502-0150 Time limits for providers to bill the department. Providers must bill the department for covered services provided to eligible clients as follows:

(1) The department requires providers to submit initial claims and adjust prior claims in a timely manner. The department has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims and claims for major trauma services, see subsections (7) and (8) of this section;

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to the department as described in the department's current published billing instructions.

(3) Providers must submit the initial claim to the department and have a transaction control number (TCN) assigned by the department within three hundred sixty-five calendar days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) The department may grant exceptions to the time limit of three hundred sixty-five calendar days for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to the department's satisfaction that there are other extenuating circumstances.

(5) The department requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to the department's billing limits.

(6) When a client is covered by both medicare and medicaid, the provider must bill medicare for the service before billing the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, the department requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, with a timely TCN. This applies to any claim, other than a prescription drug claim or a

claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. The department does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(8) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) The department allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within fifteen months of the date the service was provided to the client. After fifteen months, the department does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

[WSR 11-14-075, recodified as § 182-502-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-502-0150, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. WSR 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

BILLING A CLIENT

WAC 182-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 182-500-0085) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a medicaid agency-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050 (4)(a) and 182-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable medicaid agency or agency-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the agency or agency-contracted MCO for medical assistance services furnished to clients. See 42 C.F.R. § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the agency or the client's MCO.

(c) A covered service when the agency or its designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC 182-501-0050(9), or a noncovered service, defined in WAC 182-501-0050(10) and 182-501-0070. The client and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at http://hrsa.

dshs.wa.gov/mpforms.shtml. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for agency or the agency's designee review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency or its designee). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is under the agency's or an agency-contracted MCO's patient review and coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or health care facilities other than those to whom the client is assigned or referred under the PRC program;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 182-530-7700 (2)(a)(iii) are met;

(f) The service is within a service category excluded from the client's benefits package. See WAC 182-501-0060;

(g) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the agency or its designee after being informed by the provider that he or she is not contracted with the agency or its designee

and that the services offered will not be paid by the client's health care program; and

(i) An agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

(7) Under chapter 182-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on health care expenses to become eligible for coverage under the medically needy program. An individual must incur health care expenses greater than or equal to the amount that he or she must spend down. The provider is prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the agency for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the agency or its designee or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the agency or its designee makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 182-500-0025; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 C.F.R. § 435.914(a) and defined in WAC 182-500-0095.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the agency or its designee for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

[Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-502-0160, filed 7/11/13, effective 8/11/13. Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act. WSR 12-18-062, § 182-502-0160, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-502-0160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0160, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.15. WSR 10-10-022, § 388-502-0160, filed 4/26/10, effective 5/27/10. Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. WSR 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090. WSR 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; WSR 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

PROVIDER REPORTS

WAC 182-502-0210 Statistical data-provider reports. (1) At the request of the department, all providers enrolled with department programs must submit full reports, as specified by the department, of goods and services furnished to eligible medical assistance clients. The department furnishes the provider with a standardized format to report these data.

(2) The department analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to the department's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with the department, and any other interested organizations or individuals.

[WSR 11-14-075, recodified as § 182-502-0210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0210, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.035. WSR 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

APPEAL—RATE REIMBURSEMENT

WAC 182-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the department reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with the department.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for the department to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, the department may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, the department may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) The department issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When the department requests additional information, the contractor/provider has forty-five calendar days from the date of the department's request to submit the additional information.

(ii) The department issues a decision within thirty calendar days of receipt of the completed information.

(e) The department may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate

increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from the department. The department does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) The department may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that the department grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with the department. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to the department within thirty calendar days after the contractor/provider receives the rate review decision. The department does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) The department conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) The department considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[WSR 11-14-075, recodified as § 182-502-0220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-502-0220, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.730. WSR 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

PROVIDER PAYMENT REVIEWS AND DISPUTE RIGHTS

WAC 182-502-0230 Provider overpayment disputes—General. (1) This section applies to provider overpayment disputes with providers who furnish health care services to Washington apple health clients, except those overpayment disputes to which chapter 182-502A WAC applies. For the purposes of this section:

(a) "Agency" means the health care authority and its designees.

(b) "Provider" has the same meaning as vendor in RCW 41.05A.010(5).

(2) If the medicaid agency determines that a provider was overpaid, the agency may take any of the following actions:

(a) Review claims, encounters, or payments;

(b) Refer the provider to the agency's office of program integrity;

(c) Refer the provider to the Washington state medicaid fraud control unit;

(d) Refer the provider to the appropriate state health care professional discipline authority;

(e) Terminate the provider's participation in Washington apple health;

(f) Assess a civil penalty against the provider, per RCW 74.09.210;

(g) In the event of a prepay review, suspend some or all payments;

(h) Adjust or void an improper claim, encounter, or payment;

(i) Recover any moneys that the provider received as a result of overpayments as authorized under chapter 41.05A RCW; and

(j) Any other action authorized by Title 182 WAC.

(3) A provider may contest an overpayment by requesting a hearing.

(4) The hearing request must:

(a) Be in writing;

(b) Identify each overpayment being contested;

(c) State each reason why the provider thinks the overpayment is incorrect;

(d) Include documentation to support the provider's position; and

(e) Include a copy of the overpayment notice.

(5) The hearing request must be served on the agency at the address specified in the overpayment notice, in a manner which provides proof of receipt, no later than twenty-eight calendar days after the provider received the overpayment notice.

(6) The hearing is conducted under the Administrative Procedure Act and chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-01-056, § 182-502-0230, filed 12/10/14, effective 1/10/15. WSR 11-14-075, recodified as § 182-502-0230, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0230, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220. WSR 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 182-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements. (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[WSR 11-14-075, recodified as § 182-502-0260, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.290. WSR 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

WAC 182-502-0270 Review of agency's provider dispute decision. (1) This section applies only when agency rules allow review of an agency dispute decision under this section. The director of the health care authority or designee conducts the review.

(2) Providers and former providers may request a review of an agency dispute decision. The request must be in writing and sent to: Health Care Authority, Attn: Appeals Administrator, P.O. Box 45504, Olympia, WA 98504-5504. The agency must receive the written dispute review request within twenty-eight calendar days of the date on the agency's written dispute decision.

(3) When the agency receives a timely dispute review request, the director or designee may schedule a dispute review conference. "Dispute review conference" means an informal conference for the purpose of resolving disagreements between the agency and a provider or former provider who is dissatisfied with an agency decision. The dispute review conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW. If the director or designee chooses to schedule a dispute review conference, the director or designee will conduct the conference within ninety calendar days of the dispute review request unless the director or designee and the party requesting review agree to an extension.

(4) The director or designee will issue a dispute review decision to the provider or former provider requesting review within thirty calendar days of receiving the dispute review request or within thirty calendar days of the dispute review conference, whichever is later, unless both parties agree to an extension.

(5) The director review is the final level of agency review for disputes to which this section applies.

[Statutory Authority: RCW 41.05.021. WSR 13-17-047, § 182-502-0270, filed 8/13/13, effective 10/1/13. WSR 11-14-075, recodified as § 182-502-0270, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 08-12-012, § 388-502-0270, filed 5/27/08, effective 6/27/08.]