Chapter 182-501 WAC
ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

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WAC 182-501-0050 Health care general coverage. WAC 182-501-0050 through 182-501-0065 describe the health care services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 182-538-050). For the purposes of this section, health care services includes treatment, equipment, related supplies, and drugs. WAC 182-501-0070 describes noncovered services.

(1) Health care service categories listed in WAC 182-501-0060 do not represent a contract for health care services.

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

(3) Under the agency's fee-for-service programs, providers must be enrolled with the agency or its designee and meet the requirements of chapter 182-502 WAC to be paid for furnishing health care services to clients.

(4) The agency or its designee pays only for the health care services that are:

(a) Included in the client's health care benefits package as described in WAC 182-501-0060;

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

(c) Ordered or prescribed by a health care provider who meets the requirements of chapter 182-502 WAC;

(d) Medically necessary as defined in WAC 182-500-0070;

(e) Submitted for authorization, when required, in accordance with WAC 182-501-0163;

(f) Approved, when required, in accordance with WAC 182-501-0165;

(g) Furnished by a provider according to chapter 182-502 WAC; and

(h) Billed in accordance with agency or its designee program rules and the agency's current published billing instructions.

(5) The agency does not pay for any health care service requiring prior authorization from the agency or its designee, if prior authorization was not obtained before the health care service was provided; unless:

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

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

(6) The agency does not reimburse clients for health care services purchased out-of-pocket.

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

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

(b) Otherwise allowed under specific agency program rules.

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

(9) **Covered health care services.**

(a) Covered health care services are either:

(i) "Federally mandated" - Means the state of Washington is required by federal regulation (42 C.F.R. 440.210 and 220) to cover the health care service for medicaid clients; or

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

(b) The agency may limit the scope, amount, duration, and/or frequency of covered health care services. Limitation extensions are authorized according to WAC 182-501-0169.

(10) **Noncovered health care services.**

(a) The agency does not pay for any health care service listed as noncovered in WAC 182-501-0070 or in any other agency program rule, unless the agency grants a request for an exception to rule allowing payment for the noncovered service. The agency evaluates a request for a noncovered health care service only if an exception to rule is requested according to the provisions in WAC 182-501-0160.

(b) When a noncovered health care service is recommended during the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam and then ordered by a provider, the agency evaluates the health care service according

to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-534-0100 for EPSDT rules).

[Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-501-0050, filed 7/11/13, effective 8/11/13. WSR 11-14-075, recodified as § 182-501-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-07-116, § 388-501-0050, filed 3/22/10, effective 4/22/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 09-23-112, § 388-501-0050, filed 11/18/09, effective 12/19/09; WSR 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. WSR 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

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

(a) The agency; or

(b) The health technology assessment clinical committee (HTACC) under RCW 70.14.080 through 70.14.140.

(2) The agency reviews available evidence relevant to a medical or dental service or health care-related equipment and uses a technology evaluation matrix to:

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

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Identify potential for misuse or abuse; and

(e) Compare to alternative technologies to assess benefit vs. harm and cost effectiveness.

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

(a) Covered (see WAC 182-501-0060 for the scope of coverage under Washington apple health (WAH) programs);

(b) Covered with authorization (see WAC 182-501-0165 for the process on how authorization is determined);

(c) Covered with limitations (see WAC 182-501-0169 for how limitations can be extended); or

(d) Noncovered (see WAC 182-501-0070 for noncovered services).

(4) The agency may periodically review existing technologies, devices, or technology-related supplies and reassign authorization requirements as necessary using the provisions in this section for new technologies, devices, or technology-related supplies.

(5) The agency evaluates the evidence and criteria from HTACC to determine whether a service is covered under WAC 182-501-0050 (9) and (10) and this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0055, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0055, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-07-116, § 388-501-0055, filed 3/22/10, effective 4/22/10. Statutory Authority: RCW 74.08.090 and 70.14.090. WSR 09-17-004, § 388-501-0055, filed 8/6/09, effective 9/6/09.]

WAC 182-501-0060 Health care coverage—Program benefit packages—Scope of service categories. (1) This rule provides a table that lists:

(a) The following Washington apple health (WAH) programs:

(i) The alternative benefits plan (ABP) medicaid;

(ii) Categorically needy (CN) medicaid;

(iii) Medically needy (MN) medicaid; and

(iv) Medical care services (MCS) programs (includes incapacity-based and aged, blind, and disabled medical care services), as described in WAC 182-508-0005; and

(b) The benefit packages showing what service categories are included for each program.

(2) Within a service category included in a benefit package, some services may be covered and others noncovered.

(3) Services covered within each service category included in a benefit package:

(a) Are determined in accordance with WAC 182-501-0050 and 182-501-0055 when applicable.

(b) May be subject to limitations, restrictions, and eligibility requirements contained in agency rules.

(c) May require prior authorization (see WAC 182-501-0165), or expedited authorization when allowed by the agency.

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

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

(a) Require prior authorization from the agency or its designee, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the agency as required under chapter 182-502 WAC;

(c) Are included in an agency or its designee waiver program identified in chapter 182-515 WAC; or

(d) Are covered by a third-party payor (see WAC 182-501-0200), including medicare, if the third-party payor has not made a determination on the claim or has not been billed by the provider.

(5) Programs not addressed in the table:

(a) Alien emergency medical (AEM) services (see chapter 182-507 WAC); and

(b) TAKE CHARGE program (see WAC 182-532-700 through 182-532-790);

(c) Postpartum and family planning extension (see WAC 182-523-0130(4) and 182-505-0115(5));

(d) Eligibility for pregnant minors (see WAC 182-505-0117); and

(e) Kidney disease program (see chapter 182-540 WAC).

(6) **Scope of service categories.** The following table lists the agency's categories of health care services.

(a) Under the ABP, CN, and MN headings there are two columns. One addresses clients twenty years of age and younger and the other addresses clients twenty-one years of age and older.

(b) The letter **"Y"** means a service category is included for that program. Services within each service category are

subject to limitations and restrictions listed in the specific medical assistance program rules and agency issuances.

(c) The letter **"N"** means a service category is not included for that program.

(d) Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services.

Service Categories	ABP 20-	ABP 21+	CN[1] 20-	CN 21+	MN 20-	MN 21+	MCS
Ambulance (ground and air)	Y		Y	Y	Y	Y	Y
Applied behavior analysis (ABA)	Y	N	Y	N	Y	N	N
Behavioral health services							
• Mental health (MH) inpatient care	Y	Y	Y	Y	Y	Y	Y
• MH outpatient community care	Y	Y	Y	Y	Y	Y	Y[2]
• MH psychiatric visits	Y	Y	Y	Y	Y	Y	Y[3]
• MH medication management	Y	Y	Y	Y	Y	Y	Y
• Substance use disorder (SUD) detoxification	Y	Y	Y	Y	Y	Y	Y
• SUD diagnostic assessment	Y	Y	Y	Y	Y	Y	Y
• SUD residential treatment	Y	Y	Y	Y	Y	Y	Y
• SUD outpatient treatment	Y	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y	Y
Dental services	Y	Y	Y	Y	Y	Y	Y
Diagnostic services (lab and X ray)	Y	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N	N
Habilitative services	Y	Y	N	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y	Y
Hearing evaluations	Y	Y	Y	Y	Y	Y	Y
Hearing aids	Y	N	Y	N	Y	N	N
Home health services	Y	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y	N
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y
Maternity care and delivery services	Y	Y	Y	Y	Y	Y	Y
Medical equipment, durable (DME)	Y	Y	Y	Y	Y	Y	Y
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y	Y	Y
Medical nutrition services	Y	Y	Y	Y	Y	Y	Y
Nursing facility services	Y	Y	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y	Y	Y
Orthodontic services	Y	N	Y	N	Y	N	N
Out-of-state services	Y	Y	Y	Y	Y	Y	N
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	N	Y
Personal care services	Y	Y	Y	Y	N	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y	N
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y	Y
Reproductive health services	Y	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N	N
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N	N

[1] Clients enrolled in the Washington apple health for kids and Washington apple health for kids with premium programs, which includes the children's health insurance program (CHIP), receive CN-scope of health care services.

[2] Restricted to incapacity-based MCS clients enrolled in managed care.

[3] Incapacity-based MCS clients can receive one psychiatric diagnostic evaluation per year and eleven monthly visits per year for medication management.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-07-083, § 182-501-0060, filed 3/17/15, effective 4/17/15. Statutory Authority: RCW 41.05.021, 2013 2nd sp.s. c 4, and Patient Protection and Affordable Care Act (P.L. 111-148). WSR 14-06-045, § 182-501-0060, filed 2/26/14, effective 3/29/14. Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-501-0060, filed 7/11/13, effective 8/11/13. WSR 11-14-075, recodified as § 182-501-0060, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-501-0060, filed 11/30/06, effective 1/1/07.]

WAC 182-501-0065 Health care coverage—Description of service categories. This rule provides a brief description of the medical, dental, mental health, and substance use disorder (SUD) service categories listed in the table in WAC 182-501-0060. The description of services under each category is not intended to be all inclusive.

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

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

(a) **Ambulance -** Emergency medical transportation and ambulance transportation for nonemergency medical needs. (WAC 182-546-0001 through 182-546-4000.)

(b) **Applied behavior analysis (ABA)** - (WAC 182-531-1410 through 182-531-1434).

(c) **Behavioral health services -**

(i) Mental health inpatient care - Voluntary and involuntary admissions for psychiatric services. (WAC 182-550-2600.)

(ii) Mental health outpatient (community mental health) services - Nonemergency, psychological evaluation, nonurgent counseling. (WAC 182-531-1400, 388-865-0215, 388-865-0230, and 388-865-0610 (1)(d)(i).)

(iii) Psychiatric visits. (WAC 182-531-1400 and 388-865-0230.)

(iv) Mental health medication management. (WAC 182-531-1400.)

(v) Substance use disorder (SUD) detoxification. (WAC 388-877B-0100 through 388-877B-0130 and 182-550-1100; WAC 182-556-0400(3).)

(vi) SUD diagnostic assessment. (WAC 388-877B-0500 through 388-877B-0550.)

(vii) SUD residential treatment. (WAC 388-877B-0200 through 388-877B-0280.)

(viii) SUD outpatient treatment. (WAC 388-877B-0300 through 388-877B-0370; WAC 182-533-0701 through 182-533-0730.)

(d) **Blood, blood products, and related services -** Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. (WAC 182-550-1400 and 182-550-1500.)

(e) **Dental services -** Diagnosis and treatment of dental problems including emergency treatment and preventive care. (Chapters 182-535 and 182-535A WAC.)

(f) **Diagnostic services -** Clinical testing and imaging services. (WAC 182-531-0100; WAC 182-550-1400 and 182-550-1500.)

(g) **Early and periodic screening, diagnosis, and treatment (EPSDT)** - (Chapter 182-534 WAC and WAC 182-501-0050(10).)

(h) **Habilitative services** - (Chapter 182-545 WAC).

(i) **Health care professional services -** Office visits, vaccinations, screening/brief intervention/referral to treatment (SBIRT), emergency room, nursing facility, home-based, and hospital-based care; surgery, anesthesia, pathology, radiology, and laboratory services; obstetric services; kidney dialysis and renal disease services; osteopathic care, podiatry services, physiatry, and pulmonary/respiratory services; and allergen immunotherapy. (Chapter 182-531 WAC.)

(j) **Hearing evaluations -** Audiology; diagnostic evaluations; hearing exams and testing. (WAC 182-531-0100 and 182-531-0375.)

(k) **Hearing aids -** (Chapter 182-547 WAC).

(l) **Home health services -** Intermittent, short-term skilled nursing care, occupational therapy, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. (WAC 182-551-2000 through 182-551-2220.)

(m) **Hospice services -** Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. (WAC 182-551-1210 through 182-551-1850.)

(n) **Hospital services—Inpatient/outpatient -** Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. (Chapter 182-550 WAC.)

(o) **Intermediate care facility/services for persons with intellectual disabilities -** Habilitative training, health-related care, supervision, and residential care. (Chapter 388-835 WAC.)

(p) **Maternity care and delivery services -** Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, family planning services and community health worker visits. (WAC 182-533-0330.)

(q) **Medical equipment, durable (DME) -** Wheelchairs, hospital beds, respiratory equipment; casts, splints, crutches, trusses, and braces. (Chapter 182-543 WAC.)

(r) **Medical equipment, nondurable (MSE) -** Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, and urological supplies. (Chapter 182-543 WAC.)

(s) **Medical nutrition services -** Enteral and parenteral nutrition, including supplies. (Chapters 182-553 and 182-554 WAC.)

(t) **Nursing facility services -** Nursing, therapies, dietary, and daily care services. (Chapter 388-97 WAC.)

(u) **Organ transplants -** Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. (WAC 182-550-1900 and 182-556-0400.)

(v) **Orthodontic services** - (Chapter 182-535A WAC).

(w) **Out-of-state services** - (WAC 182-502-0120).

(x) **Outpatient rehabilitation services (OT, PT, ST) -** Evaluations, assessments, and treatment. (WAC 182-545-200.)

(y) **Personal care services -** Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). (WAC 388-106-0010, 388-106-0200, 388-106-0300, 388-106-0600, 388-106-0700, 388-106-0745, and 388-106-0900.)

(z) **Prescription drugs -** Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. (WAC 182-530-2000.) Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(aa) **Private duty nursing -** Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. (WAC 182-551-3000.) For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(bb) **Prosthetic/orthotic devices -** Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. (WAC 182-543-5000.)

(cc) **Reproductive health services -** Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. (WAC 182-532-001 through 182-532-140.)

(dd) **Respiratory care (oxygen) -** All services, oxygen, equipment, and supplies related to respiratory care. (Chapter 182-552 WAC.)

(ee) **School-based medical services -** Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). (Chapter 182-537 WAC.)

(ff) **Vision care -** Eye exams, refractions, fittings, visual field testing, vision therapy, ocular prosthetics, and surgery. (WAC 182-531-1000.)

(gg) **Vision hardware -** Frames and lenses. (Chapter 182-544 WAC.)

[Statutory Authority: RCW 41.05.021, 2013 2nd sp.s. c 4, and Patient Protection and Affordable Care Act (P.L. 111-148). WSR 14-06-045, § 182-501-0065, filed 2/26/14, effective 3/29/14. Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-501-0065, filed 7/11/13, effective 8/11/13. WSR 11-14-075, recodified as § 182-501-0065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-501-0065, filed 11/30/06, effective 1/1/07.]

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

(2) This section does not apply to health care services provided as a result of the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter 182-534 WAC.

(3) The agency or its designee does not pay for any ancillary health care service(s) provided in association with a noncovered health care service.

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

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

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

(c) Chiropractic care for adults;

(d) Cosmetic, reconstructive, or plastic surgery, and any related health care services, not specifically allowed under WAC 182-531-0100(4);

(e) Discography;

(f) Ear or other body piercing;

(g) Face lifts or other facial cosmetic enhancements;

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

(i) Artificial insemination;

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

(iii) In vitro fertilization;

(iv) Penile implants;

(v) Reversal of sterilization; and

(vi) Sex therapy.

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

(j) Marital counseling;

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

(l) Nonmedical equipment;

(m) Penile implants;

(n) Prosthetic testicles;

(o) Psychiatric sleep therapy;

(p) Subcutaneous injection filling;

(q) Tattoo removal;

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

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

(t) Vehicle purchase - New or used vehicle.

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

(a) Ambulance transportation and nonemergent transportation as described in chapter 182-546 WAC;

(b) Dental services as described in chapter 182-535 WAC;

(c) Durable medical equipment as described in chapter 182-543 WAC;

(d) Hearing care services as described in chapter 182-547 WAC;

(e) Home health services as described in WAC 182-551-2130;

(f) Hospital services as described in WAC 182-550-1600;

(g) Health care professional services as described in WAC 182-531-0150;

(h) Prescription drugs as described in chapter 182-530 WAC;

(i) Vision care hardware for clients twenty years of age and younger as described in chapter 182-544 WAC; and

(j) Vision care exams as described in WAC 182-531-1000.

(6) A client has a right to request an administrative hearing, if one is available under state and federal law. When the agency or its designee denies all or part of a request for a noncovered health care service(s), the agency or its designee sends the client and the provider written notice, within ten business days of the date the decision is made, that includes:

(a) A statement of the action the agency or its designee intends to take;

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

(c) Sufficient detail to enable the recipient to:

(i) Learn why the agency's or its designee's action was taken; and

(ii) Prepare a response to the agency's or its designee's decision to classify the requested health care service as noncovered.

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

(e) The following information:

(i) Administrative hearing rights;

(ii) Instructions on how to request the hearing;

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

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

(v) Information regarding agency-covered health care services, if any, as an alternative to the requested noncovered health care service; and

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

(7) A client can request an exception to rule (ETR) as described in WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-16-084, § 182-501-0070, filed 7/31/15, effective 8/31/15. Statutory Authority: RCW 41.05.021. WSR 13-15-044, § 182-501-0070, 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, § 182-501-0070, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-501-0070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.-530, and 74.09.700. WSR 09-23-112, § 388-501-0070, filed 11/18/09, effective 12/19/09; WSR 07-04-036, § 388-501-0070, filed 1/29/07, effective 3/1/07.]

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

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

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

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

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

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

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

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

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

Health Care Authority
COB Casualty Unit
P.O. Box 45561
Olympia, WA 98504-5561
Fax: 360-753-3077

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

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

(d) If the client and the agency cannot agree upon the appropriate reimbursement amount, any party may bring a motion in superior court for a hearing to determine the amount of reimbursement to the agency from settlement or judgment proceeds.

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

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0100, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: 42 U.S.C. §§ 1396a, 1396k, 1396p, chapter 43.20B RCW, RCW 74.08.090, 74.09.180, 74.09.185. WSR 08-17-046, § 388-501-0100, filed 8/14/08, effective 12/1/08. Statutory Authority: RCW 74.08.090 and 74.09.185. WSR 07-23-080 and 08-01-041, § 388-501-0100, filed 11/19/07 and 12/12/07, effective 12/1/08. Statutory Authority: RCW 74.04.050 and 74.08.090. WSR 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

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

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

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

(a) A statement about the client's right to:

(i) Make decisions concerning the client's medical care;

(ii) Accept or refuse surgical or medical treatment;

(iii) Execute an advance directive;

(iv) Revoke an advance directive at any time;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility or organization for refusing to withhold or withdraw life-sustaining treatment.

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

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

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

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

WAC 182-501-0135 Patient review and coordination (PRC). (1) **Patient review and coordination (PRC)** is a health and safety program that coordinates care and ensures clients enrolled in PRC use services appropriately and in accordance with agency rules and policies.

(a) PRC applies to medical assistance fee-for-service and managed care clients.

(b) PRC is authorized under federal medicaid law by 42 U.S.C. 1396n (a)(2) and 42 C.F.R. 431.54.

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

"Appropriate use" - Use of health care services that are safe and effective for a client's health care needs.

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

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

(a) A client with a medical history of:

(i) Seeking and obtaining health care services at a frequency or amount that is not medically necessary; or

(ii) Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

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

(i) Indications of forging or altering prescriptions;

(ii) Referrals from medical personnel, social services personnel, or MCO personnel about inappropriate behaviors or practices that place the client at risk;

(iii) Noncompliance with medical or drug and alcohol treatment;

(iv) Paying cash for medical services that result in a controlled substance prescription or paying cash for controlled substances;

(v) Arrests for diverting controlled substance prescriptions;

(vi) Positive urine drug screen for illicit street drugs or nonprescribed controlled substances;

(vii) Negative urine drug screen for prescribed controlled substances; or

(viii) Unauthorized use of a client's services card for an unauthorized purpose.

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

"Client" - A person enrolled in an agency health care program and receiving service from fee-for-service provider(s) or an MCO-contracted with the agency.

"Conflicting" - Drugs or health care services that are incompatible or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated" - A medical treatment, procedure, or medication that is inadvisable or not recommended or warranted.

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

"Emergency department information exchange (EDIE)" - An internet-delivered service that enables health care providers to better identify and treat high users of the emergency department and special needs patients. When patients enter the emergency room, EDIE can proactively alert health care providers through different venues such as fax, phone, e-mail, or integration with a facility's current electronic medical records.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency services" - See 42 C.F.R. 447.53.

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

"Managed care client" - A medical assistance client enrolled in, and receiving health care services from, an agency-contracted managed care organization (MCO).

"Managed care organization" or **"MCO" -** See WAC 182-538-050.

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

(a) A physician under chapter 18.71 RCW;

(b) A physician assistant under chapter 18.71A RCW;

(c) An osteopathic physician under chapter 18.57 RCW;

(d) An osteopathic physician assistant under chapter 18.57A RCW; and

(e) An advanced registered nurse practitioner under chapter 18.79 RCW.

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

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

(a) A usage review report indicates the client has not used health care services appropriately; or

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

(4) **When a fee-for-service client is selected for PRC review,** the prior authorization process as defined in WAC 182-500-0085 may be required:

(a) Prior to or during a PRC review; or

(b) When the client is currently in the PRC program.

(5) **Review for placement in the PRC program.** When the agency or MCO selects a client for PRC review, the agency or MCO staff, with clinical oversight, reviews either the client's medical history or billing history, or both, to determine if the client has used health care services at a frequency or amount that is not medically necessary (42 C.F.R. 431.54(e)).

(6) **Usage guidelines for PRC placement.** Agency or MCO staff use the following usage guidelines to initiate review for PRC placement. A client may be placed in the PRC program when either the client's medical history or billing history, or both, documents any of the following:

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

(i) Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice;

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received ten or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers not located in the same clinic or practice;

(v) Received similar services in the same day not located in the same clinic or practice; or

(vi) Had ten or more office visits;

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

(i) Made two or more emergency department visits;

(ii) Exhibits "at-risk" usage patterns;

(iii) Made repeated and documented efforts to seek health care services that are not medically necessary; or

(iv) Was counseled at least once by a health care provider, or an agency or MCO staff member with clinical oversight, about the appropriate use of health care services;

(c) The client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the ninety-day review period; or

(d) The client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous twelve months:

(i) Using health care services in a manner that is duplicative, excessive, or contraindicated;

(ii) Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice;

(iii) Being on substance abuse programs such as the Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

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

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

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

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

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

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

(iii) Place the client into the PRC program for an initial placement period of no less than twenty-four months. For clients younger than eighteen years of age, the MCO must get agency approval prior to placing the client into the PRC program.

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

(a) The agency or MCO places the client for no less than twenty-four months with one or more of the following types of health care providers:

(i) Primary care provider (PCP);

(ii) Pharmacy for all prescriptions;

(iii) Prescriber of controlled substances;

(iv) Hospital for nonemergency services unless referred by the assigned PCP or a specialist. A client may receive covered emergency services from any hospital; or

(v) Another qualified provider type, as determined by agency or MCO program staff on a case-by-case basis.

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

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

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

(iii) The client is in a voluntary enrollment program or a voluntary enrollment county.

(c) A managed care client placed in the PRC program must remain in the PRC program for no less than twenty-four months regardless of whether the client changes MCOs or becomes a fee-for-service client.

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

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

(b) Directs the client to respond to the agency or MCO within ten business days of the date of the written notice;

(c) Directs the client to take the following actions:

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

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

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

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

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

(10) **Selection and role of assigned provider.** A client will have a limited choice of providers.

(a) The following providers are not available:

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

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

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

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

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

(ii) PCP supervises and coordinates health care services for the client, including continuity of care and referrals to specialists when necessary.

(A) The PCP:

(I) Provides the plan of care for clients that have documented use of the emergency department for a reason that is not deemed to be an emergency medical condition;

(II) Files the plan of care with each emergency department that the client is using or with the emergency department information exchange;

(III) Makes referrals to substance abuse treatment for clients who are using the emergency department for substance abuse issues; and

(IV) Makes referrals to mental health treatment for clients who are using the emergency department for mental health treatment issues.

(B) The assigned PCP must be one of the following:

(I) A physician;

(II) An advanced registered nurse practitioner (ARNP); or

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

(iii) Prescriber of controlled substances prescribes all controlled substances for the client;

(iv) Pharmacy fills all prescriptions for the client; and

(v) Hospital provides all hospital nonemergency services.

(c) A client placed in the PRC program must remain with the assigned provider for twelve months after the assignments are made, unless:

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

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

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

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

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

(d) When an assigned prescribing provider no longer contracts with the agency or the MCO:

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

(ii) All prescriptions from the provider are subject to applicable prescription drugs (outpatient) rules in chapter 182-530 WAC or appropriate MCO rules; and

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

(11) **PRC placement.**

(a) The initial PRC placement is no less than twenty-four consecutive months.

(b) The second PRC placement is no less than an additional thirty-six consecutive months.

(c) Each subsequent PRC placement is no less than seventy-two consecutive months.

(12) **Agency or MCO review of a PRC placement period.** The agency or MCO reviews a client's use of health care services prior to the end of each PRC placement period described in subsection (11) of this section using the guidelines in subsection (6) of this section.

(a) The agency or MCO assigns the next PRC placement if the usage guidelines for PRC placement in subsection (6) of this section apply to the client.

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

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

(ii) Of the length of the subsequent PRC placement;

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

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

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

(vi) Of the rules that support the decision.

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

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

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

(iii) Maintains appropriate use of health care services within the usage guidelines described in subsection (6) of this section for six consecutive months after the date the treatment ends.

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

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

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

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

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

(b) A managed care client who believes the MCO has taken an invalid action pursuant to this section or chapter 182-538 WAC must exhaust the MCO's internal appeal process set forth in WAC 182-538-110 prior to requesting a hearing. Managed care clients cannot change MCOs until the appeal or hearing is resolved and there is a final ruling.

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

(d) The agency conducts a hearing according to chapter 182-526 WAC. Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 182-526-0010.

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

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

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

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

(i) The client who requests a hearing challenging placement into the PRC program has the burden of proving the agency's or MCO's action was invalid. For standard of proof, see chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021 and 2011 1st sp.s. c 50. WSR 13-05-006, § 182-501-0135, filed 2/6/13, effective 3/9/13. WSR 11-14-075, recodified as § 182-501-0135, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-501-0135, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 431.51, 431.54(e) and 456.1; 42 U.S.C. 1396n. WSR 08-05-010, § 388-501-0135, filed 2/7/08, effective 3/9/08. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.04.055, and 42 C.F.R. 431.54. WSR 06-14-062, § 388-501-0135, filed 6/30/06, effective 7/31/06. Statutory Authority: RCW 74.08.090, 74.04.055, and 42 C.F.R. Subpart B 431.51, 431.54 (e) and (3), and 456.1. WSR 04-01-099, § 388-501-0135, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

WAC 182-501-0160 Exception to rule—Request for a noncovered health care service. A client or the client's provider may request that the medicaid agency or its designee pay for a noncovered health care service. This is called an exception to rule (ETR). The request for ETR must be made before the service is rendered.

(1) The agency's medical director or designee evaluates and considers requests on a case-by-case basis. The agency's medical director has final authority to approve or deny a request for ETR.

(2) The agency or its designee cannot approve an ETR if the requested service is excluded under state statute.

(3) Any item or service for which an ETR is requested must:

(a) Fall within accepted standards and precepts of good medical practice;

(b) Represent cost-effective use of public funds; and

(c) Be submitted to the agency or its designee in writing within ninety days of the date of the written notification denying authorization for the noncovered service.

(4) For the agency or its designee to consider the ETR request:

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

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

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

(ii) Inappropriate for that specific client.

(5) Within fifteen business days of receiving the request, the agency or its designee must send written notification to the provider and the client:

(a) Approving the ETR request;

(b) Denying the ETR request; or

(c) Requesting additional information.

(i) The additional information must be received by the agency or its designee within thirty days of the date the information was requested.

(ii) The agency or its designee must approve or deny the ETR request within five business days of receiving the additional information.

(iii) If the requested information is insufficient or not provided within thirty days, the agency or its designee denies the ETR request.

(6) A client does not have a right to a fair hearing on ETR decisions.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-044, § 182-501-0160, filed 8/27/15, effective 9/27/15. Statutory Authority: RCW 41.05.021. WSR 13-18-035, § 182-501-0160, filed 8/28/13, effective 9/28/13. Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act. WSR 12-18-062, § 182-501-0160, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-501-0160, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.-530, and 74.09.700. WSR 06-24-036, § 388-501-0160, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. WSR 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

WAC 182-501-0163 Health care coverage—Process for submitting a valid request for authorization. (1) The medicaid agency requires providers to obtain authorization for certain health care services under this section, chapters 182-501 and 182-502 WAC, other applicable agency rules, current published agency billing instructions, and numbered memoranda. For the purposes of this section, health care services include treatment, equipment, related supplies, and drugs.

(a) For health care services that require prior authorization (PA), a provider (as defined in WAC 182-500-0085) must submit a written, electronic, or telephonic request to the agency. To be a valid request for PA, the provider must send

the request and follow the agency's current published program billing instructions, numbered memoranda, and any additional requirements in Washington Administrative Code (WAC) and Revised Code of Washington (RCW).

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

(c) The agency requires PA for covered health care services when the applicable EPA criteria are not met.

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

(2) Agency authorization requirements for covered health care services are not a denial of service.

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

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

(5) The agency's authorization of health care services does not guarantee payment. See WAC 182-501-0050 for other general requirements that must be satisfied before payment can be made for a health care service requested and authorized under this section.

(6) The agency evaluates a request for authorization of a health care service that exceeds identified limitations on a case-by-case basis and under WAC 182-501-0169.

(7) The agency may recoup any payment made to a provider if the agency later determines the health care service was not properly authorized or did not meet EPA criteria. See chapters 182-502 and 182-502A WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0163, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0163, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 09-23-112, § 388-501-0163, filed 11/18/09, effective 12/19/09.]

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

(a) Are identified as covered services or early and periodic screening, diagnosis, and treatment services; and

(b) Require prior authorization by the medicaid agency.

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

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

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

- Clinical guidelines
- Government sources
- Independent medical evaluation (IME)
- Independent review organization (IRO)
- Independent technology assessment organizations
- Medical and hospital associations
- Policies of other health plans
- Regulating agencies (for example, the Federal Drug Administration or Department of Health)
- Treating provider
- Treatment pathways

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

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

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

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

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

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

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

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

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

"Provider" - The person who is responsible for diagnosing, prescribing, and providing medical, dental, or mental health services to agency clients.

(3) The agency authorizes, on a case-by-case basis, requests described in subsection (1) of this section when the agency determines the service or equipment is medically necessary as defined in WAC 182-500-070. The process the agency uses to assess medical necessity is based on:

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

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

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

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

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Evaluate pertinent client information;

(e) Compare to alternative technologies; and

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

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

(a) A physiological description of the client's disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) Pertinent X-ray and/or imaging reports;

(d) Individual patient records pertinent to the case or request;

(e) Photographs, or videos, or both, if requested; and

(f) Objective medical/dental/mental health information such as medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.

(6) The agency uses the following processes to determine whether a requested service described in subsection (1) is medically necessary:

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

(i) Type I: Meta-analysis done with multiple, well-designed controlled studies;

(ii) Type II: One or more well-designed experimental studies;

(iii) Type III: Well-designed, quasi-experimental studies such as nonrandomized controlled, single group pre-post, cohort, time series, or matched case-controlled studies;

(iv) Type IV: Well-designed, nonexperimental studies, such as comparative and correlation descriptive, and case studies (uncontrolled); and

(v) Type V: Credible evidence submitted by the provider.

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

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

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

(A) Multiple Type II or III evidence or combinations of Type II, III or IV evidence with generally consistent findings of effectiveness and safety (A **"B"** rating cannot be based on Type IV evidence alone); or

(B) Singular Type II, III, or IV evidence in combination with agency-recognized:

(I) Clinical guidelines;

(II) Treatment pathways; or

(III) Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

(iii) **"C" level evidence:** Shows only weak and inconclusive evidence regarding safety, or efficacy, or both. For example:

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

(B) Only Type V evidence is available.

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

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

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

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

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

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

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

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

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

(iii) Denies **"D"** rated requests unless:

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

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

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

(a) Approves the request;

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

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

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

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

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

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

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

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

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

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

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

(ii) Prepare an appropriate response.

(e) Is in sufficient detail to determine what additional or different information might be provided to challenge the agency's determination;

(f) Includes the client's administrative hearing rights;

(g) Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and

(h) Includes examples(s) of "lesser cost alternatives" that permit the affected party to prepare an appropriate response.

(9) If an administrative hearing is requested, the agency or the client may request an independent review organization (IRO) or independent medical examination (IME) to provide an opinion regarding whether the requested service or equipment is medically necessary. The agency pays for the independent assessment if the agency agrees that it is necessary, or an administrative law judge orders the assessment.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0165, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0165, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-23-031, § 388-501-0165, filed 11/8/05, effective 12/9/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.-035. WSR 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

WAC 182-501-0169 Health care coverage—Limitation extension. This section addresses requests for limitation extensions regarding scope, amount, duration, and frequency of a covered health care service. For the purposes of this section, health care services includes treatment, equipment, related supplies, and drugs. The medicaid agency does not authorize or pay for any covered health care services exceeding identified limitations unless authorization is obtained before the client receives the service.

(1) No limitation extension of covered health care services is authorized when prohibited by specific program rules.

(2) When a limitation extension is not prohibited by specific program rules, the client's provider may request a limitation extension.

(3) The agency evaluates requests for limitation extensions as follows:

(a) For a fee-for-service client, the process described in WAC 182-501-0165.

(b) For a managed care enrollee, the client's managed care organization (MCO) evaluates requests for limitation extensions according to the MCO's prior authorization process.

(c) Both the agency and MCO consider the following in evaluating a request for a limitation extension:

(i) The level of improvement the client has shown to date related to the requested health care service and the reasonably calculated probability of continued improvement if the requested health care service is extended; and

(ii) The reasonably calculated probability the client's condition will worsen if the requested health care service is not extended.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0169, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0169, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 09-23-112, § 388-501-0169, filed 11/18/09, effective 12/19/09; WSR 06-24-036, § 388-501-0169, filed 11/30/06, effective 1/1/07.]

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

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

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

WAC 182-501-0180 Health care services provided outside the state of Washington—General provisions. WAC 182-501-0180 through 182-501-0184 apply only to services payable on a fee-for-service basis for Washington apple health (WAH) clients.

(1) Subject to the exceptions and limitations in this section, WAC 182-501-0182, and 182-501-0184, the medicaid agency covers emergency and nonemergency out-of-state health care services provided to eligible WAH recipients when the services are:

(a) Within the scope of the client's health care program as specified under chapter 182-501 WAC;

(b) Allowed to be provided outside the state of Washington by specific program WAC; and

(c) Medically necessary as defined in WAC 182-500-0070.

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

(3) When the agency pays for covered health care services furnished to an eligible WAH client outside the state of Washington, its payment is payment in full according to 42 C.F.R. 447.15.

(4) The agency determines coverage for transportation services provided out of state, including ambulance services, according to chapter 182-546 WAC.

(5) With the exception of designated bordering cities (see WAC 182-501-0175), if the client travels out of state expressly to obtain health care, the service must be prior authorized by the agency. See WAC 182-501-0182 for requirements related to out-of-state nonemergency treatment and WAC 182-501-0165 for the agency's medical necessity determination process.

(6) The agency does not cover health care services provided outside the United States and U.S. territories, except in British Columbia, Canada. See WAC 182-501-0184 for limitations on coverage of, and payment for, health care provided to WAH clients in British Columbia, Canada.

(7) See WAC 182-502-0120 for provider requirements for payment of health care provided outside the state of Washington.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0180, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as

§ 182-501-0180, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.057 and 74.09.510. WSR 11-14-054, § 388-501-0180, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-501-0180, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.08.-090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-501-0180, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.-035. WSR 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

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

(a) Health care services the medicaid agency has prior authorized for a client; and

(b) Health care services obtained by the client, independent of the agency, while traveling or visiting.

(2) Under the prior authorization process described in WAC 182-501-0165, except as specified in subsection (3) of this section, the agency pays for covered nonemergency health care services provided to an eligible Washington apple health (WAH) recipient in another state or U.S. territory to the same extent that it pays for covered nonemergency services provided within the state of Washington when the agency determines that:

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

(b) Medically necessary services are not available in Washington state or designated bordering cities (see WAC 182-501-0175) and are more readily available in another state; or

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

(3) The agency pays for covered nonemergency health care services for an eligible WAH recipient in another state or U.S. territory, unless the out-of-state provider will not accept the agency's payment as payment in full under 42 C.F.R. 447.15. The agency does not pay when the provider refuses to accept the agency's payment as payment in full.

(4) The agency does not pay for medically necessary, nonsymptomatic treatment (i.e., preventive care) furnished outside the state of Washington unless it is furnished in a designated bordering city, which is considered the same as an in-state city for the purposes of health care coverage (see WAC 182-501-0175). Covered nonemergency services requiring prior authorization, when provided in the state of Washington, also require prior authorization, when provided in a designated bordering city (see WAC 182-501-0165 for the agency's medical necessity determination process).

(5) See WAC 182-501-0180 for additional information regarding health care services provided outside the state of Washington.

(6) The agency's director or designee reviews all exception to rule (ETR) requests.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0182, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0182, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-501-0182, filed 3/31/08, effective 5/1/08.]

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

(1) The provisions of WAC 182-501-0182 apply to this section.

(2) The medicaid agency does not pay for health care services furnished in a foreign country, except for medical services furnished in the province of British Columbia, Canada, under this section. The agency pays for medical services furnished in British Columbia, Canada, to Washington apple health (WAH) clients only when those clients:

(a) Reside in Point Roberts, Washington;

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

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

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

(a) Within the scope of the client's health care program as specified in chapter 182-501 WAC;

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

(c) Medically necessary as defined in WAC 182-500-0070.

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

(a) It is general practice for WAH clients to use medically necessary resources across the Canadian border; or

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

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

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

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

(6) The agency's payment for covered medical services furnished to a WAH client in British Columbia, Canada, is payment in full according to 42 C.F.R. 447.15.

(7) A British Columbia, Canada, provider who furnished health care services or covered items to a WAH client receives payment from the agency only when:

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

(b) The participating British Columbia, Canada, provider:

(i) Has signed a core provider agreement with the agency;

(ii) Satisfies all medicaid conditions of participation;

(iii) Meets functionally equivalent licensing requirements; and

(iv) Complies with the same utilization control standards as in-state providers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0184, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0184, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.04.057 and 74.09.510. WSR 11-14-054, § 388-501-0184, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. WSR 08-08-064, § 388-501-0184, filed 3/31/08, effective 5/1/08.]

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

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

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment program.

(3) The agency pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

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

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

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

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

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

(a) Third-party payment when the payment is less than the agency's maximum allowable rate; or

(b) The agency payment when the third-party payment is equal to or more than the agency's maximum allowable rate.

(6) The agency does not pay for medical services if third-party benefits are available to pay for the client's medical services when the provider bills the agency, except under subsections (2) and (3) of this section.

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

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

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 182-503-0540 for assignment of rights.

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

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

(10) For third-party liability on personal injury litigation claims, the agency is responsible for providing medical services under WAC 182-501-0100.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0200, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-501-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00; WSR 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

WAC 182-501-0213 Case management services. (1) The medicaid agency provides case management services to Washington apple health recipients:

(a) By contract with providers of case management services.

(b) Limited to target groups of clients as determined by the contract.

(c) Limited to services as determined by the contract.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-15-053, § 182-501-0213, filed 7/9/15, effective 8/9/15. WSR 11-14-075, recodified as § 182-501-0213, filed 6/30/11, effective 7/1/11. WSR 00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. WSR 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]