RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 12, 2023
TIME: 1:38 PM

WSR 23-21-061

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose:

WAC 182-502-0030

- Removed the term "agreement" from the WAC title and replace it with "enrollment."
- Removed the term "core provider agreement" (CPA) and replace it with "enrollment" to provide clarity that all providers (not just those with a CPA) are subject to the rules.
- Updated the WAC reference in subsection (1)(a)(ii) from WAC 246-934-100 to Chapter 246-16 WAC to align with the correct Department of Health (DOH) definition of sexual misconduct.
- Added a new subsection (4) to address effective date of termination.
- Added a new subsection (5) to address administrative hearings/appeals.
- Added language clarification and housekeeping fixes in 182-502-0030.

WAC 182-500-0075, WAC 182-500-0085

- Removed the definition of nonbilling provider and referenced updated provider definition in WAC 182-500-0085.
- Amended the definition of provider to include servicing providers, nonbilling providers, providers with a CPA, and providers with other contracts with the Medicaid agency.

WAC 182-502-0005, 182-530-1000, 182-531-0250

- Updated the term "performing provider" to "servicing provider" to align with consistent agency language.

WAC 182-526-0195

- Added a new subsection (7)(e) added to reflect that an appeal by a provider of their termination under this rule requires a mandatory prehearing conference with a reference to WAC 182-502-0030

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-502-0030, 182-500-0075, 182-500-0085, 182-502-0005, 182-526-0195, 182-530-1000, 182-531-0250,
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: None

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 23-18-088 on September 6, 2023 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

	New	Amended	Repealed
Federal statute:			
Federal rules or standards:			
Recently enacted state statutes:			

The number of sections adopted at the request of a nongovernmental entity:

New	Amended	Repealed

The number of sections adopted on the agency's own initiative:

New	Amended	Repealed
	7	

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	Amended	Repealed
	7	

The number of sections adopted using:

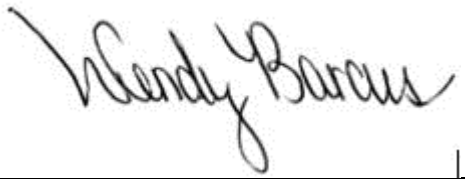
	New	Amended	Repealed
Negotiated rule making:			
Pilot rule making:			
Other alternative rule making:		7	

Date Adopted: October 12, 2023

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-500-0075 Medical assistance definitions—N. "National correct coding initiative (NCCI)" is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from ((~~specialty~~)) professional societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at: http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National provider indicator (NPI)" is a ((~~federal system for uniquely identifying all providers of health care services, supplies, and equipment~~)) unique identification number for covered health care providers.

"NCCI edit" is a software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency or the agency's designee's fee schedules, billing instructions, and other publications. The agency or the agency's designee has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards or agency or agency's designee policy.

"Nonapplying spouse" see "spouse" in WAC 182-500-0100.

"Nonbilling provider" ((~~is a health care professional enrolled with the agency only as an ordering, referring, prescribing provider for the Washington medicaid program and who is not otherwise enrolled as a medicaid provider with the agency~~)) see definition for provider in WAC 182-500-0085.

"Noncovered service" see "covered service" in WAC 182-500-0020.

"Nonphysician practitioner" means the following professionals who work in collaboration with an ordering physician: Nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant.

"Nursing facility" see "institution" in WAC 182-500-0050.

"Nursing facility long-term care services" are services in a nursing facility when a person does not meet the criteria for rehabilitation. Most long-term care assists people with support services. (Also called custodial care.)

"Nursing facility rehabilitative services" are the planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

AMENDATORY SECTION (Amending WSR 15-21-063, filed 10/19/15, effective 11/19/15)

WAC 182-500-0085 Medical assistance definitions—P. "Patient transportation" means client transportation to or from covered health care services under federal and state health care programs.

"Physician" means a doctor of medicine, osteopathy, naturopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Prescribing provider" means a health care professional authorized by law or rule to prescribe drugs to Washington apple health ((~~(WAH)~~)) clients.

"Prior authorization" ((~~is~~)) means the requirement that a provider must request, on behalf of a client and when required by rule or agency billing instructions, the agency or the agency's designee's approval to provide a health care service before the client receives the health care service, prescribed drug, device, or drug-related supply. The agency or the agency's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

"Prosthetic device" means a preventive, replacement, corrective, or supportive device prescribed by a ((~~physician or other~~)) licensed ((~~practitioner,~~)) provider within ((~~the~~)) their scope of ((~~his or her~~)) practice under state law.

"Provider" means an institution, agency, or person that is licensed, certified, accredited, credentialed, or registered according to ((~~Washington~~)) state law, is an eligible provider type according to WAC 182-502-0002, authorized to provide services to Washington apple health clients, and has((~~:~~

~~(a) A signed core provider agreement or contract with the agency or the agency's designee, and is authorized to provide health care, goods, and services to WAH clients; or~~

~~(b) Authorization from a managed care organization (MCO) that contracts with the agency or the agency's designee to provide health care, goods, and services to eligible WAH clients enrolled in the MCO plan.~~)) a signed core provider agreement, a nonbilling provider agreement, or other contract with the agency or is a servicing provider.

(a) **"Servicing provider"** means a health care professional screened and enrolled with the agency under a group, facility, or organization that has a signed core provider agreement (CPA).

(b) **"Nonbilling provider"** means a health care professional enrolled with the agency only as an ordering, referring, prescribing provider for the Washington medicaid program and who is not otherwise enrolled as a medicaid provider with the agency.

"Provider guide" means an agency publication that describes a specific benefit covered under ((~~WAH~~)) Washington apple health, which includes client eligibility verification instructions, provider responsibilities, authorization requirements, coverage, billing, and how to complete and submit claims.

"Public institution" see "institution" in WAC 182-500-0050.

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

WAC 182-502-0005 Core provider agreement (CPA). (1) The agency only pays claims submitted for services provided by or on behalf of:

(a) 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~~));

(b) A servicing provider ((~~on~~)) enrolled under an approved CPA with the agency((~~,~~));

(c) A provider who has an approved agreement with the agency as a nonbilling provider in accordance with WAC 182-502-0006.

(2) ((~~Performing~~)) Servicing providers ((~~of~~)) performing services ((~~to~~)) for 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~~)) 365 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.

AMENDATORY SECTION (Amending WSR 15-14-039, filed 6/24/15, effective 7/25/15)

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

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

(i) Moral turpitude;

(ii) Sexual misconduct ((~~as defined in WAC 246-934-100~~)) according to chapter 246-16 WAC or in profession specific rules of the department of health (DOH);

(iii) A statement of allegations or statement of charges by DOH or equivalent from other state licensing boards;

(iv) Restrictions or limitations placed by ((~~DOH~~)) any state licensing, credentialing, or certification agency on the provider's current credentials or 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 or failure to disclose the reasons to the agency;

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

(vii) Patient drug mismanagement, failure to identify substance ((~~abuse or addiction~~)) use disorder, or failure to refer the patient for substance ((~~abuse~~)) use disorder treatment once ((~~abuse or addiction is~~)) identified;

(viii) Use of health care providers or health care staff who are unlicensed to practice or who provide health care services that 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 182-502-0016;

(x) Failure of the health care ((~~practitioner~~)) provider with ((~~an alcohol or chemical dependency~~)) a substance use disorder(s) to furnish documentation or other assurances as determined by the agency to adequately safeguard the health and safety of Washington apple health 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~~)) disorder 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 that the agency 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 182-502-0010 and 182-502-0020;

(ii) Dishonesty or other unprofessional conduct;

(iii) ((~~Investigatory (e.g., audit), civil,~~)) Civil or criminal findings of fraudulent or abusive billing practices through an investigation or other review (e.g., audit or record review);

(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 ongoing 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~~)) to the agency during or after enrollment including on the application for a core provider agreement (CPA), ((~~failure to supply requested information, or failure to update CPA as required~~)) a nonbilling provider agreement, or servicing providers enrolled under a core provider agreement;

(x) Failure to comply with an agency request for information;

(xi) Failure to cooperate with an agency investigation, audit, or review;

(xii) Providing health care services that 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 that the agency determines is contrary to the interest of the agency or its clients.

(2) If a ((~~provider~~)) provider's enrollment is terminated for cause, the agency pays only for authorized services provided up to the date of termination ((~~only~~)) of enrollment if other program requirements are met including, but not limited to, the requirements in WAC 182-502-0016.

(3) ((~~If~~)) When the agency terminates enrollment of a servicing provider who is also a full or partial owner of ((~~a~~)) an enrolled group practice, the agency ((~~also~~)) terminates the enrolled group practice and all enrolled servicing providers who are not linked to ((~~the~~)) another enrolled group practice contracted with the agency. The remaining practitioners in the group practice may reapply for participation with the agency subject to WAC 182-502-0010((~~(2)~~)).

(4) ((~~A provider who is terminated for cause may dispute an agency decision under the process in WAC 182-502-0050.~~)) Effective date. The effective date of the termination of a provider's enrollment is the date stated in the notice. The filing of an appeal as provided in subsection (5) of this section does not stay the effective date of termination.

(5) Administrative hearing.

(a) The provider may appeal the agency decision to terminate the provider's enrollment for cause by submitting a written request to the address contained in the decision notice within 28 calendar days of the date on the notice and in a manner that provides proof of receipt by the agency. The agency does not allow good cause exception related to this subsection.

(b) If the agency receives a timely appeal, the presiding officer will schedule a prehearing conference in accordance with WAC 182-526-0195.

(c) The administrative hearing process is governed by the Administrative Procedure Act, chapter 34.05 RCW, and chapter 182-526 WAC.

(d) Burden of proof.

(i) The provider has the burden of proof.

(ii) The standard of proof in a provider termination hearing is "clear and convincing evidence" meaning the evidence is highly and substantially more likely to be true than untrue. This is a higher standard of proof than proof by a preponderance of the evidence, but it does not require proof beyond a reasonable doubt.

AMENDATORY SECTION (Amending WSR 21-18-077, filed 8/27/21, effective 9/27/21)

WAC 182-526-0195 Prehearing conferences. (1) ((~~Unlike a prehearing meeting,~~)) A prehearing conference is a formal proceeding conducted on the record by an administrative law judge (ALJ) to address issues and prepare for a hearing.

(a) The ALJ must make an audio record of the prehearing conference.

(b) An ALJ may conduct the prehearing conference in person, by telephone, or in any other manner acceptable to the parties.

(2) All parties must attend the prehearing conference. If the party who requested the hearing does not attend the prehearing conference, the ALJ may enter an order of default and an order dismissing the hearing.

(3) The ALJ may require a prehearing conference. Any party may request a prehearing conference.

(4) The ALJ must grant the appellant's, and may grant the managed care organization's or the agency representative's, first request for a prehearing conference if it is filed with the office of administrative hearings (OAH) at least seven business days before the scheduled hearing date.

(5) When the ALJ grants a party's request for a prehearing conference, the ALJ must continue the previously scheduled hearing when necessary to comply with notice requirements in this section.

(6) The ALJ may grant additional requests for prehearing conferences.

(7) The office of administrative hearings (OAH) must schedule prehearing conferences for all cases which concern:

(a) Provider and vendor overpayment hearings.

(b) Estate recovery and predeath liens.

(c) Notice of violation disputes under chapter 182-51 WAC.

(d) Notice of violation disputes under chapter 182-70 WAC.

(e) Provider termination disputes under WAC 182-502-0030.

(8) During a prehearing conference the parties and the ALJ may:

(a) Simplify or clarify the issues to be decided during the hearing;

(b) Agree to the date, time, and place of the hearing;

(c) Identify any accommodation or safety issues;

(d) Agree to postpone the hearing;

(e) Allow the parties to make changes in their own documents, including the notice or the hearing request;

(f) Agree to facts and documents to be entered during the hearing;

(g) Set a deadline to exchange names and phone numbers of witnesses and documents before the hearing;

(h) Schedule additional prehearing conferences;

(i) Resolve the dispute;

(j) Consider granting a stay if authorized by law or program rule; or

(k) Rule on any procedural issues and substantive motions raised by any party.

(9) After the prehearing conference, the ALJ must enter a written order describing:

(a) The actions taken at the prehearing conference;

(b) Any changes to the documents;

(c) A statement of the issue or issues identified for the hearing;

(d) Any agreements reached; and

(e) Any ruling of the ALJ.

(10) OAH must serve the prehearing order on the parties at least ((~~fourteen~~)) 14 calendar days before the scheduled hearing.

(11) A party may object to the prehearing order by notifying OAH in writing within ((~~ten~~)) 10 calendar days after the mailing date of the order. The ALJ must issue a ruling on the objection within five days from the date a party files an objection.

(12) If no objection is made to the prehearing order, the order determines how the hearing is conducted, including whether the hearing will be in person or held by telephone conference or other means, unless the ALJ changes the order for good cause.

(13) The ALJ may take further appropriate actions to address other concerns raised by the parties.

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

WAC 182-530-1000 Outpatient drug program—General. (1) The purpose of the outpatient drug program is to reimburse providers for outpatient drugs, vitamins, minerals, devices, and drug-related supplies according to medicaid agency rules and subject to the limitations and requirements in this chapter.

(2) The agency reimburses for outpatient drugs, vitamins, minerals, devices, and pharmaceutical supplies that are:

(a) Covered. Refer to WAC 182-530-2000 for covered drugs, vitamins, minerals, devices, and drug-related supplies and to WAC 182-530-2100 for noncovered drugs and drug-related supplies;

(b) Prescribed by a provider with prescriptive authority (see exceptions for family planning and emergency contraception for women ((~~eighteen~~)) 18 years of age and older in WAC 182-530-2000 (1)(b), and over-the-counter (OTC) drugs to promote smoking cessation in WAC 182-530-2000 (1)(g));

(c) Prescribed by:

(i) A provider with an approved core provider agreement;

(ii) A provider who is enrolled as a ((~~performing~~)) servicing provider on an approved core provider agreement; or

(iii) A provider who is enrolled as a nonbilling provider.

(d) Within the scope of an eligible client's medical assistance program;

(e) Medically necessary as defined in WAC 182-500-0070 and determined according to the process found in WAC 182-501-0165;

(f) Authorized, as required within this chapter;

(g) Billed according to WAC 182-502-0150 and 182-502-0160; and

(h) Billed according to the requirements of this chapter.

(3) Coverage determinations for the agency are made by the agency's pharmacists or medical consultants in accordance with applicable federal law. The agency's determination may include consultation with the drug use review (DUR) board.

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

WAC 182-531-0250 Who can provide and bill for physician-related and health care professional services. (1) The health care professionals and health care entities listed in WAC 182-502-0002 and enrolled with the medicaid agency can bill for physician-related and health care professional services that are within their scope of practice.

(2) The agency pays for services provided by, or in conjunction with, a resident physician when:

(a) The services are billed under the teaching hospital's national provider identifier (NPI) or the supervising physician's NPI;

(b) The ((~~performing~~)) servicing provider is identified on the claim under the teaching or resident physician's NPI; and

(c) The services are provided and billed according to this chapter and chapters 182-501 and 182-502 WAC.

(3) The agency does not pay for services performed by any of the health care professionals listed in WAC 182-502-0003.

(4) The agency pays eligible providers for physician-related services and health care professional services if those services are mandated by, and provided to clients who are eligible for, one of the following:

(a) The early and periodic screening, diagnosis, and treatment (EPSDT) program;

(b) A Washington apple health program for qualified medicare beneficiaries (QMB); or

(c) A waiver program.