RULE-MAKING ORDER
PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

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STATE OF WASHINGTON
FILED

DATE: September 18, 2019
TIME: 10:49 AM

WSR 19-19-090

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: This rulemaking is necessary to implement E2SHB 1358 which directs the agency to adopt standards for the reimbursement of health care services provided to eligible clients by fire departments pursuant to a community assistance referral and education services program under RCW 35.21.930. The standards must allow payment for covered health care services provided to individuals whose medical needs do not require ambulance transport to an emergency department

Citation of rules affected by this order:

New: 182-531-1740
Repealed:
Amended: 182-546-0200, 182-546-0250, 182-546-0400
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160, E2SHB 1358

Other authority: N/A

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-15-150 on July 24, 2019 (date).

Describe any changes other than editing from proposed to adopted version: N/A

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:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	

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	New		Amended		Repealed	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	New		Amended		Repealed	

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

	New	1	Amended	3	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	1	Amended	3	Repealed	

Date Adopted: September 18, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

NEW SECTION

WAC 182-531-1740 Treat and refer services. (1) The purpose of treat and refer services is to reduce the number of avoidable emergency room transports, i.e., transports that are nonemergency or nonurgent.

(2) Treat and refer services are covered health care services for a client who has accessed 911 or a similar public dispatch number, and whose condition does not require ambulance transport to an emergency department based on the clinical information available at the time of service.

(3) Treat and refer services can be provided by any city and town fire department, fire protection district organized under Title 52 RCW, regional fire protection service authority organized under chapter 52.26 RCW, provider of emergency medical services that levy a tax under RCW 84.52.069, and federally recognized Indian tribe.

(4) To receive payment for covered health care services provided to clients under this section, an entity that meets the criteria in subsection (3) of this section must be an enrolled medicaid provider with an active core provider agreement for the service period specified in the claim, and have an established community assistance referral and education services program under RCW 35.21.930.

(a) Prior to billing and receiving payment, participating providers must submit a participation agreement and attestation form to the agency certifying their compliance with RCW 35.21.930.

(b) Providers must immediately notify the agency if they no longer meet the requirements of RCW 35.21.930. Providers who no longer meet the requirements of the program and continue to bill and receive payment under the program must return any overpayment under RCW 41.05A.170.

(5) Treat and refer services must be documented in a standard medical incident report that includes a clinical or mental health assessment.

(6) The health care professionals providing treat and refer services must:

(a) Be state-certified emergency medical technicians, state-certified advanced emergency medical technicians, or state-certified paramedics under chapters 18.71 and 18.73 RCW;

(b) Be under the supervision and direction of an approved medical director according to RCW 35.21.930(1); and

(c) Not perform medical procedures they are not trained and certified to perform, according to RCW 35.21.930(1).

(7) Entities that meet the criteria in subsections (3) and (4) of this section must retain the standard medical incident report in subsection (5) of this section according to WAC 182-502-0020.

(8) Payments under this section are subject to review and audit under chapter 182-502A WAC.

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

WAC 182-546-0200 Scope of coverage for ambulance transportation. (1) The ambulance program is a medical transportation service. The ((~~medical assistance administration (MAA)~~)) medicaid agency pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see WAC ((~~388-501-0060~~)) 182-501-0060);

(b) Medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0005 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The nearest appropriate ((~~MAA-contracted~~)) agency-contracted medical provider of ((~~MAA-covered~~)) agency-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) ((~~MAA~~)) The agency limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ambulance service is not covered by ((~~MAA~~)) the agency. See WAC ((~~388-546-0250~~)) 182-546-0250 (1) and (2) for noncovered ambulance services.

(3) If medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, ((~~MAA~~)) the agency requires the provider when billing ((~~MAA~~)) the agency for that trip to:

(a) Report the third party determination on the claim; and

(b) Submit documentation showing that the trip meets the medical necessity criteria of ((~~MAA~~)) the agency. See WAC ((~~388-546-1000 and 388-546-1500~~)) 182-546-1000 and 182-546-1500 for requirements for nonemergency ambulance coverage.

(4) ((~~MAA~~)) The agency covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when ((~~MAA~~)) the agency determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the air ambulance transportation must be prior authorized by ((~~MAA~~)) the agency. See WAC ((~~388-546-1500~~)) 182-546-1500 for nonemergency air ambulance coverage.

(5) See also WAC 182-531-1740 Treat and refer services.

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

WAC 182-546-0250 Ambulance services the ((~~department~~)) agency does not cover. (1) The ((~~department~~)) medicaid agency does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC ((~~388-546-1000~~)) 182-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC ((~~388-546-4000~~)) 182-546-4000(2));

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC ((~~388-546-0500~~)) 182-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the ((~~department~~)) agency does not cover the ambulance service, except as provided in WAC ((~~388-546-0500(2)~~)) 182-546-0500(2) and 182-531-1740 Treat and refer services.

(3) The ((~~department~~)) agency evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC ((~~388-501-0160~~)) 182-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the ((~~department~~)) agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The ((~~department~~)) agency approves such requests when medically necessary, according to the provisions of WAC ((~~388-501-0165 and 388-501-0169~~)) 182-501-0165 and 182-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC ((~~388-502-0160~~)) 182-502-0160 are met.

AMENDATORY SECTION (Amending WSR 18-12-091, filed 6/5/18, effective 7/6/18)

WAC 182-546-0400 General limitations on payment for ambulance services. (1) In accordance with WAC 182-502-0100(8), the agency pays providers the lesser of the provider's usual and customary charges or the maximum allowable rate established by the agency. The agency's fee

schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) The agency:

(a) Pays providers under fee-for-service for ground ambulance services provided to a client who is enrolled in an agency-contracted managed care organization (MCO).

(b) Pays providers under fee-for-service for air ambulance services provided to a client who is enrolled in an agency-contracted MCO.

(3) The agency does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. The agency pays for loaded mileage only as follows:

(a) The agency pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) The agency pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

(4) The agency does not pay for ambulance services if:

(a) The client is not transported, unless the services are provided under WAC 182-531-1740 Treat and refer services;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 182-546-0500(2)).

(5) For clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs, the agency's payment is as follows:

(a) If medicare covers the service, the agency pays the lesser of:

(i) The full coinsurance and deductible amounts due, based upon medicaid's allowed amount; or

(ii) The agency's maximum allowable for that service minus the amount paid by medicare.

(b) If medicare does not cover or denies ambulance services that the agency covers according to this chapter, the agency pays its maximum allowable fee; except the agency does not pay for clients on the qualified medicare beneficiaries (QMB) only program.