RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

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:

The agency is amending these rules to correct agency names and WAC citations for programs formerly administered by the Department of Social and Health services that are now administered by the Health Care Authority.

Citation of existing rules affected by this order:

Repealed:

Amended: 182-531-0300, 182-531-0400, 182-531-0650, 182-531-1100, 182-531-1450, 182-531-1700, 182-531-1750, 182-531-1800, 182-531-1850

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 16-23-155 on November 22, 2016.

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: N/A

Name: phone ( ) _____

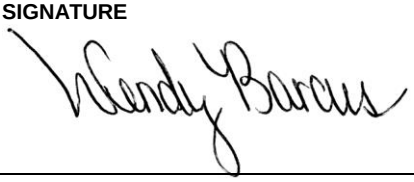
Address: fax ( ) _____

e-mail _____

Date adopted: January 25, 2017

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE



TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: January 25, 2017
TIME: 10:21 AM

WSR 17-04-039

(COMPLETE REVERSE SIDE)

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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	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New _____ Amended _____ Repealed _____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 in the agency's own initiative:

New _____ Amended _____ Repealed _____

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

New _____ Amended 9 Repealed _____

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New		Amended	9	Repealed	

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

WAC 182-531-0300 Anesthesia providers and covered physician-related services. The ((~~department~~)) medicaid agency bases coverage of anesthesia services on medicare policies and the following rules:

(1) The ((~~department~~)) agency reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) Certified registered nurse anesthetists (CRNAs);

(c) Oral surgeons with a special agreement with the ((~~department~~)) agency to provide anesthesia services; and

(d) Other providers who have a special agreement with the ((~~department~~)) agency to provide anesthesia services.

(2) The ((~~department~~)) agency covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The ((~~department~~)) agency covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC ((~~388-531-1550~~)) 182-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC ((~~388-531-1450~~)) 182-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The ((~~department~~)) agency does not allow the ((~~anaesthesiologist~~)) anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The ((~~department~~)) agency requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the ((~~department~~)) agency reimburses the base anesthesia units (BAU) for the major procedure only.

(b) The ((~~department~~)) agency does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, the ((~~department~~)) agency reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, the ((~~department~~)) agency limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) The ((~~department~~)) agency pays CRNAs or anesthesiologists for pain management services.

(b) The ((~~department~~)) agency allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The ((~~department~~)) agency does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC ((~~388-531-1550~~)) 182-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter ((~~388-533~~)) 182-533 WAC for more information about maternity-related services.

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

WAC 182-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC ((~~388-501-0100~~)) 182-501-0100, for noncovered services as defined in WAC ((~~388-501-0050~~)) 182-501-0050 or for services excluded from the client's benefits package as defined under WAC ((~~388-501-0060~~)) 182-501-0060. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter ((~~388-542~~)) 182-542 WAC. Also, see WAC ((~~388-502-0160,~~)) 182-502-0160 Billing the client.

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

WAC 182-531-0650 Hospital physician-related services not requiring authorization when provided in ((~~department-approved~~)) agency-approved centers of excellence or hospitals authorized to provide the specific services. The ((~~department~~)) medicaid agency covers the following services without prior authorization when provided in ((~~department-approved~~)) agency-approved centers of excellence. The ((~~department~~)) agency issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC ((~~388-550-1900~~)) 182-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC ((~~388-550-2400~~)) 182-550-2400. See also WAC ((~~388-531-0700~~)) 182-531-0700;

(3) Sleep studies including, but not limited to, polysomnograms for clients one year of age and older. The ((~~department~~)) agency allows sleep studies only in outpatient hospital settings as described under WAC ((~~388-550-6350~~)) 182-550-6350. See also WAC ((~~388-531-1500~~)) 182-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC ((~~388-550-6300~~)) 182-550-6300.

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

WAC 182-531-1100 Out-of-state physician services. (1) The ((~~department~~)) medicaid agency covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC ((~~388-501-0180~~)) 182-501-0180.

(2) Out-of-state border areas as described under WAC ((~~388-501-0175~~)) 182-501-0175 are not subject to out-of-state limitations. The ((~~department~~)) agency considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

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

WAC 182-531-1450 Radiology physician-related services. (1) The ((~~department~~)) medicaid agency reimburses radiology services subject to the limitations in this section and under WAC ((~~388-531-0300~~)) 182-531-0300.

(2) The ((~~department~~)) agency does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Cli-

ents receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) The ((~~department~~)) agency reimburses separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by the ((~~department~~)) agency, and reimbursement is at acquisition cost.

(4) The ((~~department~~)) agency reimburses general anesthesia for radiology procedures. See WAC ((~~388-531-0300~~)) 182-531-0300.

(5) The ((~~department~~)) agency reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC ((~~388-531-1700~~)) 182-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The ((~~department~~)) agency reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate professional component modifier.

(7) The ((~~department~~)) agency reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of ((~~contract [contrast]~~)) contrast media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

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

WAC 182-531-1700 Surgical physician-related services. (1) The ((~~department's~~)) agency's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) The ((~~department's~~)) agency's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) The ((~~department's~~)) agency's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, the ((~~department~~)) agency does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) The ((~~department's~~)) agency's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of the ((~~department's~~)) agency's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of the ((~~department's~~)) agency's allowed fee for each procedure.

(6) The ((~~department~~)) agency allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) The ((~~department's~~)) agency's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, the ((~~department~~)) agency pays the full amount of the procedure with the highest maximum allowable fee.

(d) The ((~~department~~)) agency pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) The ((~~department~~)) agency does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) The ((~~department~~)) agency restricts reimbursement for surgery assists to selected procedures as follows:

(a) The ((~~department~~)) agency applies multiple surgery reimbursement rules for surgery assists ((~~apply~~)). See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) The ((~~department~~)) agency bases payment splits between preoperative, intraoperative, and postoperative services on medicare determinations for given surgical procedures or range of procedures. The ((~~department~~)) agency pays any procedure that does not have an established medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC ((~~388-531-0450~~)) 182-531-0450.

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

WAC 182-531-1750 Transplant coverage for physician-related services. The ((~~department~~)) medicaid agency covers transplants when performed in ((~~a department-approved~~)) an agency-approved center of excellence. See WAC ((~~388-550-1900~~)) 182-550-1900 for information regarding transplant coverage.

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

WAC 182-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC ((~~388-550-2000~~)) 182-550-2000 for information about medical criteria to receive transplants.

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

WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(1) The ((~~department~~)) medicaid agency bases the payment methodology for most physician-related services on medicare's RBRVS. The ((~~department~~)) agency obtains information used to update the ((~~department's~~)) agency's RBRVS from the MPFSPS.

(2) The ((~~department~~)) agency updates and revises the following RBRVS areas each January prior to the ((~~department's~~)) agency's annual update.

(3) The ((~~department~~)) agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels. Then,

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The ((~~department~~)) agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, the ((~~department~~)) agency establishes maximum allowable fees, also known as "flat" fees.

(i) The ((~~department~~)) agency does not use the conversion factor for these codes.

(ii) The ((~~department~~)) agency updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC ((~~388-530-1050~~)) 182-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, the ((~~department~~)) agency pays the provider a flat fee only for administering the immunization.

(B) A cast material maximum allowable fee is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, the ((~~department~~)) agency reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) The ((~~department~~)) agency reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The technical advisory group reviews RBRVS changes.

(6) The ((~~department~~)) agency also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as the ((~~department's~~)) agency's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the ((~~department~~)) agency applies the increase after calculating budget-neutral fees. The ((~~department~~)) agency pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The ((~~department~~)) agency does not allow separate reimbursement for bundled services. However, the ((~~department~~)) agency allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for the ((~~department~~)) agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.