PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

☐ **Preproposal Statement of Inquiry was filed as WSR; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR; or**
☒ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR**
☐ **Continuance of WSR** _____

Title of rule and other identifying information: (Describe Subject)

182-501-0055 How the department determines coverage of services for its health care programs using health technology assessments.
182-501-0100 Subrogation.
182-501-0163 Health care coverage-Process for submitting a valid request for authorization.
182-501-0165 Medical and dental coverage-Fee-for-service (FFS) prior authorization-Determination process for payment
182-501-0169 Health care coverage-Limitation extension.
182-501-0180 Health care services provided outside the state of Washington-General provisions.
182-501-0182 Health care provided in another state of U.S. territory-Nonemergency.
182-501-0184 Health care services provided outside of the United States and U.S. territories or in a foreign country.
182-501-0200 Third-party resources
182-501-0213 Case management services

Hearing location(s):
Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: 360-725-1000

Date: **July 7, 2015** Time: **10:00 a.m.**

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360) 586-9727

by **5:00 p.m. on July 7, 2015**

Date of intended adoption: Not sooner than **July 8, 2015**
(Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Kelly Richters by June 29, 2015

TTY (800) 848-5429 or (360) 725-1307 or e-mail: kelly.richters@hca.wa.gov

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

These are housekeeping rule changes to correct agency names, program names, rule numbers, and to make other clarifications that do not change the effect of the rules.

Reasons supporting proposal: These changes will provide the reader with correct information and improve clarity.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE
May 21, 2015

NAME (type or print)
Jason R. P. Crabbe

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 21, 2015
TIME: 2:26 PM

WSR 15-12-014

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
N/A

Name of proponent: Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Melinda Froud	Olympia, WA 98504-2716	(360) 725-1408
Implementation....	Melinda Froud	Olympia, WA 98504-2716	(360) 725-1408
Enforcement.....	Melinda Froud	Olympia, WA 98504-2716	(360) 725-1408

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

☒ No. Explain why no statement was prepared.

The proposed filing is exempt from the SBEIS requirement under chapter 19.85 RCW.

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

☒ No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

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

WAC 182-501-0055 Health care coverage—How the ((~~department~~)) agency determines coverage of services for its health care programs using health technology assessments. (1) The ((~~department~~)) medicaid agency uses health technology assessments ((~~in determining~~)) to determine whether a new technology, new indication, or existing technology approved by the Food and Drug Administration (FDA) is a covered service under ((~~department~~)) agency health care programs. The ((~~department~~)) 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 ((~~department~~)) agency; or

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

(2) The ((~~department~~)) agency reviews available evidence relevant to a medical or dental service or health care-related equipment and uses a technology evaluation matrix((~~, in order~~)) 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 ((~~department~~)) agency may determine the technology, device, or technology-related supply is:

(a) Covered (see WAC ((~~388-501-0060~~)) 182-501-0060 for the scope of coverage ((~~for department medical assistance~~)) under Washington apple health (WAH) programs((~~.~~)));

(b) Covered with authorization (see WAC ((~~388-501-0165~~)) 182-501-0165 for the process on how authorization is determined((~~.~~)));

(c) Covered with limitations (see WAC ((~~388-501-0169~~)) 182-501-0169 for how limitations can be extended((~~.~~)); or

(d) Noncovered (see WAC ((~~388-501-0070~~)) 182-501-0070 for ((~~the~~)) noncovered services ((~~determined to be noncovered.~~))).

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

(5) The ((~~department~~)) agency evaluates the evidence and criteria ((~~presented by~~)) from HTACC to determine whether a service is covered ((~~in accordance with WAC 388-501-0050~~)) under WAC 182-501-0050 (9) and (10) and this section.

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

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 ((~~department~~)) 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 ((~~department as provided in~~)) agency under RCW 43.20B.060 and 74.09.180.

(4) The ((~~department~~)) 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 ((~~department~~)) 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 ((~~department~~)) 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 ((~~as provided~~)) under RCW 43.20B.040 through 43.20B.070, ((~~RCW~~)) 74.09.180, and 74.09.185.

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

(a) The client or the client's legal representative must notify the ((~~department~~)) agency in writing ((~~at the time of~~)) 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. ((~~Written~~)) Send notices ((~~to the department~~)) under this section ((~~should be sent~~)) to:

Health ((~~and Recovery Services Administration~~)) 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 ((~~provide the department with~~)) 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 ((~~department~~)) agency to determine the appropriate reimbursement amount for payments the ((~~department~~)) agency made for the client's benefit.

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

(7) The ((~~secretary of the department~~)) agency director or the ((~~secretary's~~)) 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 ((~~department~~)) 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 ((~~department that is~~)) agency based on its assignment, lien, or subrogation rights.

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

WAC 182-501-0163 Health care coverage—Process for submitting a valid request for authorization. (1) The ((~~department~~)) medicaid agency requires providers to obtain authorization for certain health care services ((~~in accordance with~~)) under this section, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, other applicable ((~~department~~)) agency rules, current published ((~~department~~)) agency billing instructions, and((~~/or~~)) 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 ((~~388-500-0005~~)) 182-500-0085) must submit a written, electronic, or telephonic request to the ((~~department~~)) agency. To be a valid request for ((~~prior authorization~~)) PA, the provider must ((~~submit~~)) send the request and ((~~conform to~~)) follow the ((~~department's~~)) agency's current published program billing instructions, numbered memoranda, and any additional requirements in Washington Administrative Code (WAC) and((~~/or~~)) 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 ((~~department's~~)) agency's current published program billing instructions, numbered memoranda, and any additional requirements in WAC and((~~/or~~)) RCW. The provider must use the ((~~department-assigned~~)) agency-assigned EPA number when submitting a claim for payment to the ((~~department~~)) agency.

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

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

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

(3) The ((~~department~~)) 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 ((~~department's~~)) agency's authorization of health care ((~~service(s)~~)) services does not guarantee payment. See WAC ((~~388-501-0050~~)) 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 ((~~department~~)) agency evaluates a request for ((~~an~~)) authorization of a health care service that exceeds identified limitations((~~,~~)) on a case-by-case basis and ((~~in accordance with WAC 388-501-0169~~)) under WAC 182-501-0169.

(7) The ((~~department~~)) agency may recoup any payment made to a provider if the ((~~department~~)) agency later determines the health care service was not properly authorized or did not meet EPA criteria. ((~~Refer to~~)) See chapters ((~~388-502 and 388-502A~~)) 182-502 and 182-502A WAC.

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

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 ((~~EPSDT~~)) early and periodic screening, diagnosis, and treatment services; and

(b) Require prior authorization by the ((~~department~~)) medicaid agency.

(2) The following definitions and those found in ((~~WAC 388-500-0005~~)) 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 (((~~e.g.,~~)) 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 ((~~individuals~~)) people are minimized and are not unreasonable;

(3) The risks to ((~~individuals~~)) 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 ((~~individual~~)) person who is responsible for diagnosing, prescribing, and providing medical, dental, or mental health services to ((~~department~~)) agency clients.

(3) The ((~~department~~)) agency authorizes, on a case-by-case basis, requests described in subsection (1) of this section when the ((~~department~~)) agency determines the service or equipment is medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-070. The process the ((~~department~~)) 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 ((~~department~~)) 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 ((~~department~~)) agency considers and evaluates all available clinical information and credible evidence relevant to the client's condition. ((~~At the time of request,~~)) The provider responsible for the client's diagnosis ((~~and/~~)), 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 ((~~client-specific~~)) 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 ((~~and/~~)), or videos ((~~when~~)), or both, if requested ((~~by the department~~)); 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 ((~~department~~)) 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 ((~~department~~)) 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 ((~~department~~)) 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 ((~~department-recognized~~)) agency-recognized:

(I) Clinical guidelines; ((~~or~~))

(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 ((~~and/~~)), or efficacy ((~~such as~~)), 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 ((~~department~~)) 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; ((~~and~~))

(B) Is less costly to the ((~~department~~)) 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 ((~~department~~)) agency and the requesting provider.

(7) Within fifteen days of receiving the request from the client's provider, the ((~~department~~)) 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 ((~~department~~)) 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 ((~~department's~~)) agency's request.

(ii) The ((~~department~~)) 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 ((~~department~~)) agency will deny the requested service.

(8) When the ((~~department~~)) agency denies all or part of a request for a covered service((~~(s)~~)) or equipment, the ((~~department~~)) 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 ((~~department~~)) 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 ((~~department's~~)) 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 ((~~department's~~)) 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 ((~~department~~)) 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 ((~~department will~~)) agency pays for the independent assessment if the ((~~department~~)) agency agrees that it is necessary, or an administrative law judge orders the assessment.

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

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

(1) No limitation extension of covered health care services ((~~will be~~)) 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 ((~~department~~)) agency evaluates requests for limitation extensions as follows:

(a) For a fee-for-service client, the process described in WAC ((~~388-501-0165~~)) 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 ((~~department~~)) 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.

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

WAC 182-501-0180 Health care services provided outside the state of Washington—General provisions. WAC ((~~388-501-0180 through 388-501-0184~~)) 182-501-0180 through 182-501-0184 apply only to services payable on a fee-for-service basis for Washington ((~~state medical assistance~~)) apple health (WAH) clients.

(1) Subject to the exceptions and limitations in this section, WAC ((~~388-501-0182 and 388-501-0184~~)) 182-501-0182, and 182-501-0184, the ((~~department~~)) medicaid agency covers emergency and nonemergency out-of-state health care services provided to eligible ((~~Washington state medical assistance clients~~)) WAH recipients when the services are:

(a) Within the scope of the client's health care program as specified under chapter ((~~388-501~~)) 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 ((~~388-500-0005~~)) 182-500-0070.

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

(4) The ((~~department~~)) agency determines coverage for transportation services provided out of state, including ambulance services, according to chapter ((~~388-546~~)) 182-546 WAC.

(5) With the exception of designated bordering cities (see WAC ((~~388-501-0175~~)) 182-501-0175), if the client travels out of state expressly to obtain health care, the service((~~(s)~~)) must be prior authorized by the ((~~department~~)) agency. See WAC ((~~388-501-0182~~)) 182-501-0182 for requirements related to out-of-state nonemergency treatment and WAC ((~~388-501-0165~~)) 182-501-0165 for the ((~~department's~~)) agency's medical necessity determination process.

(6) The ((~~department~~)) agency does not cover health care services provided outside the United States and U.S. territories, ((~~with the exception of~~)) except in British Columbia, Canada. See WAC ((~~388-501-0184~~)) 182-501-0184 for limitations on coverage of, and payment for, health care provided to ((~~medical assistance~~)) WAH clients in British Columbia, Canada.

(7) See WAC ((~~388-502-0120~~)) 182-502-0120 for provider requirements for payment of health care provided outside the state of Washington.

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

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 ((~~that~~)) the ((~~department~~)) medicaid agency has prior authorized for a client; and

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

(2) ((~~In accordance with~~)) Under the prior authorization process described in WAC ((~~388-501-0165~~)) 182-501-0165, except as specified in subsection (3) of this section, the ((~~department~~)) agency pays for covered nonemergency health care services provided to an eligible Washington ((~~state medical assistance client~~)) 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 ((~~department~~)) agency determines that:

(a) Services are medically necessary and the client's health will be endangered if the client ((~~is required to~~)) 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 ((~~388-501-0175~~)) 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 ((~~department~~)) agency pays for covered nonemergency health care services ((~~furnished to~~)) for an eligible ((~~Washington state medical assistance client~~)) WAH recipient in another state or U.S. territory, unless the out-of-state provider ((~~is unwilling to~~)) will not accept the ((~~department's~~)) agency's payment as payment in full ((~~according to~~)) under 42 C.F.R. 447.15. The ((~~department~~)) agency does not pay when the provider refuses to accept the ((~~department's~~)) agency's payment as payment in full.

(4) The ((~~department~~)) 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 ((~~388-501-0175~~)) 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 ((~~388-501-0165~~)) 182-501-0165 for the ((~~department's~~)) agency's medical necessity determination process).

(5) See WAC ((~~388-501-0180~~)) 182-501-0180 for additional information regarding health care services provided outside the state of Washington.

(6) The ((~~department's health and recovery services administration's (HRSA) assistant secretary~~)) agency's director or designee reviews all exception to rule (ETR) requests.

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

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 ((~~and/or~~)), substance abuse, and mental health services.

(1) The provisions of WAC ((~~388-501-0182~~)) 182-501-0182 apply to this section.

(2) The ((~~department~~)) 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 ((~~the conditions specified in~~)) this section. The ((~~department~~)) agency pays for medical services furnished in British Columbia, Canada, to ((~~the following~~)) Washington ((~~state medical assistance~~)) apple health (WAH) clients only when those clients:

(a) ((~~Those who~~)) Reside in Point Roberts, Washington;

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

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

(3) For ((~~those medical assistance~~)) WAH clients identified in subsection (2) of this section, the ((~~department~~)) 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 ((~~388-501~~)) 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 ((~~388-500-0005~~)) 182-500-0070.

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

(a) It is general practice for ((~~Washington state medical assistance~~)) WAH clients ((~~residing in these particular localities~~)) 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 ((~~same~~)) 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 ((~~department~~)) 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) ((~~When the department pays~~)) The agency's payment for covered medical services furnished to a ((~~Washington state medical assistance~~)) WAH client in British Columbia, Canada, ((~~its payment~~)) is payment in full according to 42 C.F.R. 447.15.

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

(a) ((~~Such~~)) 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 ((~~department~~)) 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.

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

WAC 182-501-0200 Third-party resources. (1) The ((~~department~~)) 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 ((~~department~~)) agency pays for medical services and seeks reimbursement from ((~~the~~)) 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 ((~~EPSDT~~)) early and periodic screening, diagnosis and treatment program.

(3) The ((~~department~~)) 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 ((~~department~~)) 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 ((~~department~~)) agency or the client for a covered service when a third party pays a provider the same amount as or more than the ((~~department~~)) agency rate.

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

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

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

(6) The ((~~department is not responsible to~~)) agency does not pay for medical services ((~~when the~~)) if third-party benefits are available to pay for the client's medical services ((~~at the time~~)) when the provider bills the ((~~department~~)) agency, except ((~~as described~~)) 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 ((~~such~~)) 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 ((~~388-505-0540~~)) 182-503-0540 for assignment of rights.

(8) The ((~~department~~)) 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 ((~~department~~)) agency is responsible for providing medical services ((~~as described~~)) under WAC ((~~388-501-0100~~)) 182-501-0100.

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

WAC 182-501-0213 Case management services. (1) The ((~~department shall~~)) medicaid agency provides case management services to ((~~medical assistance~~)) 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.