



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 WAC 182-545-200 to add optometrists to the list of providers who can order certain outpatient rehabilitative services for a Washington Apple Health client.

Citation of existing rules affected by this order:

Repealed:
 Amended: 182-545-200
 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 15-24-015 on November 19, 2015.
 Describe any changes other than editing from proposed to adopted version:

Removed subsection (4)(d)(iii).

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

Name: _____ phone () _____
 Address: _____ fax () _____
 e-mail _____

Date adopted: January 14, 2016

NAME
 Wendy Barcus

SIGNATURE

TITLE
 HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED
DATE: January 14, 2016
TIME: 10:07 AM
WSR 16-03-042

**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Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____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New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	_____	Amended	_____	Repealed	_____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

New	_____	Amended	<u>1</u>	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>1</u>	Repealed	_____

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the agency, as defined in WAC 182-500-0010, to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible persons:

- (a) A physiatrist;
- (b) A licensed occupational therapist;
- (c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
- (d) A licensed physical therapist;
- (e) A physical therapist assistant supervised by a licensed physical therapist;
- (f) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; ~~((and))~~
- (g) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate; and
- (h) A licensed optometrist to provide vision occupational therapy only.

(2) Persons covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter.

(3) Persons who are enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through his or her agency-contracted MCO.

(4) The agency pays for outpatient rehabilitation when the services are:

- (a) Covered;
- (b) Medically necessary;
- (c) Within the scope of the eligible person's medical care program;
- (d) Ordered by:
 - (i) A physician, ((physician's)) physician assistant (PA), or an advanced registered nurse practitioner (ARNP); or
 - (ii) An optometrist, if the ordered services are for occupational therapy only.

(e) Within currently accepted standards of evidence-based medical practice;

(f) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices;

- (g) Begun within thirty calendar days of the date ordered;
- (h) Provided by one of the health professionals listed in subsection (1) of this section;
- (i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices; and
- (j) Provided as part of an outpatient treatment program:
 - (i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC;

(iii) In a neurodevelopmental center, as described in WAC 182-545-900; or

(iv) For children with disabilities, age two or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(5) For eligible persons, twenty years of age and younger, the agency covers unlimited outpatient rehabilitation.

(6) For persons twenty-one years of age and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for persons twenty-one years of age and older must:

(a) Restore, improve, or maintain the person's level of function that has been lost due to medically documented injury or illness; and

(b) Include an on-going management plan for the person and/or the person's caregiver to support timely discharge and continued progress.

(8) For eligible adults, twenty-one years of age and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per person, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge;

and

(C) Twenty-four units of occupational therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition;

and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Swallowing deficits due to injury or surgery to face, head, or neck;

(XI) Spinal cord injury which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per person, per year:

(i) Without authorization:
(A) One physical therapy evaluation;
(B) One physical therapy reevaluation at time of discharge; and
(C) Twenty-four units of physical therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of physical therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual functional deficits;

(III) Burns - Second and/or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior approved by the agency.

(c) Speech therapy, per person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Brain injury, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(II) Burns of internal organs such as nasal oral mucosa or upper airway;

(III) Burns of the face, head, and neck - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;

(VI) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre));

(VII) Speech deficit due to injury or surgery to face, head, or neck;

(VIII) Speech deficit which requires a speech generating device;

(IX) Swallowing deficit due to injury or surgery to face, head, or neck; or

(X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior approved by the agency.

(d) Durable medical equipment (DME) needs assessments, two per person, per year.

(e) Orthotics management and training of upper and/or lower extremities, two program units, per person, per day.

(f) Orthotic/prosthetic use, two program units, per person, per year.

(g) Muscle testing, one procedure, per person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.

(h) Wheelchair needs assessment, one per person, per year.

(9) For the purposes of this chapter:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(10) For expedited prior authorization (EPA):

(a) A provider must establish that:

(i) The person's condition meets the clinically appropriate EPA criteria outlined in this section; and

(ii) The services are expected to result in a reasonable improvement in the person's condition and achieve the person's therapeutic individual goal within sixty calendar days of initial treatment;

(b) The appropriate EPA number must be used when the provider bills the agency;

(c) Upon request, a provider must provide documentation to the agency showing how the person's condition met the criteria for EPA; and

(d) A provider may request expedited prior authorization once per year, per person, per each therapy type.

(11) The agency evaluates a request for outpatient rehabilitation that is in excess of the limitations or restrictions, according to WAC 182-501-0169. Prior authorization may be requested for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits;

(c) A new qualifying condition arises after the initial six visits are used.

(12) Duplicate services for outpatient rehabilitation are not allowed for the same person when both providers are performing the same or similar procedure(s).

(13) The agency does not pay separately for outpatient rehabilitation that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(14) The agency does not reimburse a health care professional for outpatient rehabilitation performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.