PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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DATE: September 19, 2018
TIME: 9:38 AM

WSR 18-19-101

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 18-05-067, 18-11-093 **; 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); or**

☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) The following sections from Chapter 182-543, Medical Equipment: 182-543-0500 General; 182-543-1000 Definitions; 182-543-1100 Client eligibility; 182-543-2000 Eligible providers and provider requirements; 182-543-2100 Requests to include new medical equipment and technology; 182-543-2200 Proof of delivery; 182-543-2250 Rental or purchase; 182-543-3100 Covered–Patient lifts/traction, equipment/fracture, and frames/transfer boards; 182-543-4200 Covered–Wheelchairs–Power-drive; 182-543-4300 Covered-Wheelchairs–Modifications, accessories, and repairs; 182-543-4400 Covered–Complex rehabilitation technology; 182-543-5000 Covered – Prosthetics/orthotics; 182-543-5500 Covered–Medical supplies and related services; 182-543-5700 Covered–Medical equipment for clients in skilled nursing facilities; 182-543-7000 Authorization; 182-543-7100 Prior authorization; 182-543-7200 Prior authorization for limits on amount, frequency or duration; 182-543-7300 Expedited prior authorization (EPA); 182-543-8000 Billing general; 182-543-8100 Billing for managed care clients; 182-543-8200 Billing for clients eligible medicare and medicaid; 182-543-9000 General reimbursement; 182-543-6000 DME and related supplies, medical supplies and related services–Noncovered; 182-543-9100 Reimbursement method–Other DME; 182-543-9200 Reimbursement method–Wheelchairs; 182-543-9250 Reimbursement method–Complex rehabilitation technology; 182-543-9300 Reimbursement method–Prosthetics and orthotics; 182-543-9400 Reimbursement method – Medical supplies and related services.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
October 23, 2018	10:00 AM	Health Care Authority Cherry Street Plaza **Pear Conference Room (107)** 626 8th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than October 24, 2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: (360) 586-9727
Other:
By (date) October 23, 2018

Assistance for persons with disabilities:

Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: (800) 848-5429 or 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) October 19, 2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is amending these rules to align with federal rules under 42 C.F.R. Part 440.70. The proposed rules require that medical supplies, equipment and appliances be prescribed by physicians and that other non-physician practitioners must document that a face-to-face encounter (related to the primary reason medical equipment is needed) occurred within a reasonable timeframe.

The proposed rules use the term "medical equipment" to replace "durable medical equipment" (DME) and the other items formerly listed with DME. The rules provide that if the agency denies a requested service, the client may request an administrative hearing. The agency has removed unnecessary definitions from this chapter. The rules clarify that medical equipment may be used in any setting where normal life activities take place. The rules clarify that prosthetics and orthotics requested beyond stated limits may be prior authorized when medically necessary. The agency considers requests for prior authorization for items meeting the definition of medical equipment, and grants prior authorization when the service is medically necessary. The proposed rules repeal WAC 182-543-6000, which list noncovered DME.

The proposed rules align with section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, which added section 1903(i)(27) to the Social Security Act. The proposed rules prohibit reimbursement for certain medical equipment expenditures that are, in the aggregate, in excess of what Medicare would have paid for the items. To remove redundancy, WAC 182-543-9000 also includes reimbursement provisions previously contained in WAC 182-543-9100 through -9400; these rules will be repealed.

Reasons supporting proposal: See Purpose above

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: 42 C.F.R. Section 440.70 and Section 1903(i)(27) of the Social Security Act

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

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia WA 98504-2716	360-725-1408
Implementation:	Erin Mayo	PO Box 45506, Olympia, WA 98504-5506	360-725-1729
Enforcement:	Erin Mayo	PO Box 45506, Olympia, WA 98504-5506	360-725-1729

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:

Fax:
TTY:
Email:
Other:

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:
TTY:
Email:
Other:

☒ 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.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☒ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description: 42 C.F.R. Section 440.70 provides that physicians prescribe medical supplies, equipment and appliances and that practitioners document a face-to-face encounter within a reasonable time. This section also provides that clients have a right to a hearing, that medical equipment may be used any place where normal life activities take place, and prohibits lists of noncovered items. Section 1903(i)(27) of the Social Security Act prohibits reimbursement for certain medical equipment that are, in the aggregate, more than Medicare would pay for the items.

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☐ No Briefly summarize the agency's analysis showing how costs were calculated. i

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:

Phone:
Fax:
TTY:
Email:
Other:

Date: September 19, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

Chapter 182-543 WAC
((~~DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, COMPLEX REHABILITATION TECHNOLOGY, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES~~)) MEDICAL EQUIPMENT, SUPPLIES, AND APPLIANCES

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-0500 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))General. (1) The federal government considers ((~~durable~~)) medical equipment ((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, and medical~~)), supplies ((~~to be optional~~)), and appliances, which the medicaid agency refers to throughout this chapter as medical equipment, services under the medicaid program((~~, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The medicaid agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations~~)).

(2) The agency ((~~covers the DME and related supplies, CRT, prosthetics, orthotics, and related services~~)) pays for medical equipment, including modifications, accessories, and repairs((~~, and medical supplies listed in this chapter~~)), according to agency rules and subject to the limitations and requirements in this chapter((~~.~~

~~(3) The agency pays for DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies when they are:~~

~~(a) Covered;~~

~~(b) Within the scope of the client's medical program (see WAC 182-501-0060 and 182-501-0065);~~

~~(c)~~)) when the medical equipment is:

(a) Medically necessary, as defined in WAC 182-500-0070;

((~~(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), naturopathic physicians, or physician assistant certified (PAC) within the scope of his or her licensure, except for dual eligible medicare/medicaid clients when medicare is the primary payer and the agency is being billed for a co-pay and/or deductible only;~~

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

((~~(f)~~)) (c) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices((~~; and~~

((~~(g) Provided and used within accepted medical or physical medicine community standards of practice~~)).

((~~(4)~~)) (3) For the initiation of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires medical equipment and must occur no later than six months prior to the start of services.

(4) The face-to-face encounter must be conducted by the ordering physician, a nonphysician practitioner as described in WAC

182-500-0075, or the attending acute, or post-acute physician, for beneficiaries admitted to home health immediately after an acute or post-acute stay.

(5) If a nonphysician practitioner as described in WAC 182-500-0075 (or the attending physician when a client is discharged from an acute hospital stay) performs the face-to-face encounter, the nonphysician practitioner (or attending physician) must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the client's medical record.

(6) The agency requires prior authorization for covered ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services~~)) medical equipment when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The agency evaluates requests requiring prior authorization on a case-by-case basis to determine medical necessity as defined in WAC 182-500-0070, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-543-7000, 182-543-7100, 182-543-7200, and 182-543-7300 for specific details regarding authorization.

((~~(5)~~)) (7) The agency bases its determination about which ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services~~)) medical equipment requires prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 182-543-7100 for PA and WAC 182-543-7300 for EPA). The agency considers all of the following when establishing utilization criteria:

(a) Cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

((~~(6)~~)) (8) The agency evaluates a request for ((~~any item listed as noncovered in this chapter~~)) equipment that does not meet the definition of medical equipment or that is determined not medically necessary under the provisions of WAC 182-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-543-0100 for EPSDT rules).

((~~(7)~~)) (9) The agency may terminate a provider's participation with the agency according to WAC 182-502-0030 and 182-502-0040.

((~~(8)~~)) (10) The agency evaluates a request for a service that ((~~is in a covered category,~~)) meets the definition of medical equipment but has been determined to be experimental or investigational, under the provisions of WAC 182-501-0165.

(11) If the agency denies a requested service, the agency notifies the client in writing that the client may request an administrative hearing under chapter 182-526 WAC. (For MCO enrollees, see WAC 182-538-110.)

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-1000 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, and orthotics, medical supplies and related services~~))Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

"By-report (BR)" - See WAC 182-500-0015.

"Complex needs patient" - An individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology (CRT)" - Wheelchairs and seating systems classified as durable medical equipment within the medicare program that:

((~~(1)~~)) (a) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

((~~(2)~~)) (b) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

((~~(3)~~)) (c) Require certain services necessary to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting.

"Date of delivery" - The date the client actually took physical possession of an item or equipment.

"Digitized speech" (also referred to as devices with whole message speech output) - Words or phrases that have been recorded by an individual other than the speech generating device (SGD) user for playback upon command of the SGD user.

"Disposable supplies" - Supplies which may be used once, or more than once, but are time limited.

((~~**"Durable medical equipment (DME)" -** Equipment that:~~

~~(1) Can withstand repeated use;~~

~~(2) Is primarily and customarily used to serve a medical purpose;~~

~~(3) Generally is not useful to a person in the absence of illness or injury; and~~

~~(4) Is appropriate for use in the client's place of residence.~~))

"EPSDT" - See WAC 182-500-0030.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Fee-for-service (FFS)" - See WAC 182-500-0035.

"Health care common procedure coding system (HCPCS)" - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"Home" - For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client receives care.

"House wheelchair" - A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Individually configured" - A device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the

device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

((**"Limitation extension"** - A client-specific authorization by the agency for additional covered services beyond the set amount allowed under agency rules. See WAC 182-501-0169.))

"Manual wheelchair" - See "Wheelchair - Manual."

"Medical equipment" - Includes medical equipment and appliances, and medical supplies.

"Medical equipment and appliances" - Health care-related items that:

(a) Are primarily and customarily used to serve a medical purpose;

(b) Generally are not useful to a person in the absence of illness or injury;

(c) Can withstand repeated use;

(d) Can be reusable or removable; and

(e) Are suitable for use in any setting where normal life activities take place.

"Medical supplies" - ((~~Supplies~~)) Health care-related items that are:

((~~(1) Primarily and customarily used to service a medical purpose; and~~

~~(2)~~)) (a) Consumable or disposable or cannot withstand repeated use by more than one person;

(b) Required to address an individual medical disability, illness, or injury;

(c) Suitable for use in any setting which is not a medical institution and in which normal life activities take place; and

(d) Generally not useful to a person in the absence of illness or injury.

"Medically necessary" - See WAC 182-500-0070.

"National provider indicator (NPI)" - See WAC 182-500-0075.

((**"Other durable medical equipment (other DME)"** - All durable medical equipment, excluding wheelchairs and wheelchair-related items.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Personal or comfort item" - An item or service which primarily serves the comfort or convenience of the client or caregiver.)) **"Orthotic device"** or **"orthotic"** - A corrective or supportive device that:

(a) Prevents or corrects physical deformity or malfunction; or

(b) Supports a weak or deformed portion of the body.

"Power-drive wheelchair" - See "Wheelchair - Power."

"Pricing cluster" - A group of manufacturers' list prices for brands/models of ((~~DME, medical supplies and nondurable~~)) medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by medicare.

"Prior authorization" - See WAC 182-500-0085.

"Prosthetic device" or **"prosthetic"** - See WAC 182-500-0085.

"Qualified complex rehabilitation technology supplier" - A company or entity that:

((~~(1)~~)) (a) Is accredited by a recognized accrediting organization as a supplier of CRT;

((~~(2)~~)) (b) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

((~~(3)~~)) (c) For each site that it operates, employs at least one CRT professional, certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of clients, and provide training in the use of the selected covered CRT items;

((~~(4)~~)) (d) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured CRT for the complex needs patient;

((~~(5)~~)) (e) Provides service and repairs by qualified technicians for all CRT products it sells; and

((~~(6)~~)) (f) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair of the delivered CRT.

"Resource-based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"Reusable supplies" - Supplies which are to be used more than once.

"Scooter" - A federally approved, motor-powered vehicle that:

((~~(1)~~)) (a) Has a seat on a long platform;

((~~(2)~~)) (b) Moves on either three or four wheels;

((~~(3)~~)) (c) Is controlled by a steering handle; and

((~~(4)~~)) (d) Can be independently driven by a client.

"Specialty bed" - A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Synthesized speech" - Is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules, unlike prerecorded messages of digitized speech. A SGD that has synthesized speech is not limited to prerecorded messages but rather can independently create messages as communication needs dictate.

"Three- or four-wheeled scooter" - A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

((~~(1)~~)) (a) Rear drive;

((~~(2)~~)) (b) A twenty-four volt system;

((~~(3)~~)) (c) Electronic or dynamic braking;

((~~(4)~~)) (d) A high to low speed setting; and

((~~(5)~~)) (e) Tires designed for indoor/outdoor use.

"Trendelenburg position" - A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" - See WAC 182-500-0110.

"Warranty-period" - A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

"Wheelchair - Manual" - A federally approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

((~~(1)~~)) (a) Standard:

((~~(a)~~)) (i) Usually is not capable of being modified;

((~~(b)~~)) (ii) Accommodates a person weighing up to two hundred fifty pounds; and

((~~(c)~~)) (iii) Has a warranty period of at least one year.

((~~(2)~~)) (b) Lightweight:

((~~(a)~~)) (i) Composed of lightweight materials;

((~~(b)~~)) (ii) Capable of being modified;

((~~(c)~~)) (iii) Accommodates a person weighing up to two hundred fifty pounds; and

((~~(d)~~)) (iv) Usually has a warranty period of at least three years.

((~~(3)~~)) (c) High-strength lightweight:

((~~(a)~~)) (i) Is usually made of a composite material;

((~~(b)~~)) (ii) Is capable of being modified;

((~~(c)~~)) (iii) Accommodates a person weighing up to two hundred fifty pounds;

((~~(d)~~)) (iv) Has an extended warranty period of over three years; and

((~~(e)~~)) (v) Accommodates the very active person.

((~~(4)~~)) (d) Hemi:

((~~(a)~~)) (i) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

((~~(b)~~)) (ii) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

((~~(5)~~)) (e) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

((~~(6)~~)) (f) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

((~~(7)~~)) (g) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

((~~(8)~~)) (h) Heavy duty:

((~~(a)~~)) (i) Specifically manufactured to support a person weighing up to three hundred pounds; or

((~~(b)~~)) (ii) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

((~~(9)~~)) (i) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

((~~(10)~~)) (j) Custom heavy duty:

((~~(a)~~)) (i) Specifically manufactured to support a person weighing over three hundred pounds; or

((~~(b)~~)) (ii) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

((~~(11)~~)) (k) Custom manufactured specially built:

((~~(a)~~)) (i) Ordered for a specific client from custom measurements; and

((~~(b)~~)) (ii) Is assembled primarily at the manufacturer's factory.

"Wheelchair - Power" - A federally approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

((~~(1)~~)) (a) Custom power adaptable to:

((~~(a)~~)) (i) Alternative driving controls; and

((~~(b)~~)) (ii) Power recline and tilt-in-space systems.

((~~(2)~~)) (b) Noncustom power: Does not need special positioning or controls and has a standard frame.

((~~(3)~~)) (c) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-1100 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Client eligibility. (1) Refer to the table in WAC 182-501-0060 to see which Washington apple health ((~~(WAH)~~)) programs include ((~~DME~~)) home health services, including medical equipment and related services, ((~~complex rehabilitation technology (CRT), prosthetics and orthotics, medical supplies and related services~~)) in their benefit package.

(2) For clients eligible under an alien emergency medical (AEM) program, see WAC 182-507-0115.

(3) Clients who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for ((~~DME~~)) medical equipment and related services((~~, CRT, prosthetics and orthotics, medical supplies and related services~~)).

(4) Clients who are enrolled in a medicaid agency-contracted managed care organization (MCO) must arrange for ((~~DME and related services, prosthetics and orthotics, medical supplies~~)) medical equipment and related services directly through ((~~his or her~~)) the client's agency-contracted MCO. The agency does not pay for medical equipment ((~~and/or~~)) or services provided to a client who is enrolled in ((~~a~~)) an agency-contracted MCO, but chose not to use one of the MCO's participating providers.

(5) For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(6) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies, and related~~)) equipment when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

AMENDATORY SECTION (Amending WSR 17-15-073, filed 7/14/17, effective 8/14/17)

WAC 182-543-2000 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for ((~~durable~~)) medical equipment ((~~(DME) and related supplies, complex rehabilitation tech-~~

~~nology (CRT), prosthetics, orthotics, medical supplies,~~)) and repairs((~~, and related services~~)) on a fee-for-service basis as follows:

(a) ((~~DME~~)) Providers who are enrolled with medicare for ((~~DME~~)) medical equipment and related repair services;

(b) Qualified complex rehabilitation technology (CRT) suppliers who are enrolled with medicare ((~~for DME and related repair services~~));

(c) Medical equipment dealers ((~~who are enrolled with medicare,~~)) and pharmacies who are enrolled with medicare, ((~~and home health agencies under their~~)) and have a national provider identifier (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy;

(f) Physicians who provide medical equipment ((~~and supplies~~)) in the office((~~. The agency may pay separately for medical supplies, subject to the provisions in the agency's resource-based relative value scale fee schedule~~)); and

(g) Out-of-state prosthetics and orthotics providers who meet their state regulations.

(2) Providers and suppliers of ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies and related items~~)) equipment must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Have the proper business license and be certified, licensed and bonded if required, to perform the services billed to the agency;

(c) Have a valid prescription for the ((~~DME~~)) medical equipment.

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at((~~: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx~~)) https://www.hca.wa.gov/billers-providers/forms-and-publications;

(B) Be written by a physician((~~, advanced registered nurse practitioner (ARNP), naturopathic physician, or physician's assistant certified (PAC)~~)) as defined in WAC 182-500-0085 and meet the face-to-face encounter requirements described in WAC 182-551-2040;

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the ((~~supply,~~)) medical equipment((~~, or device~~)). Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual-eligible clients when medicare is the primary payer and the agency is being billed for only the copay, only the deductible, or both, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Provide only new equipment to clients, which include full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Provide documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

(g) Bill the agency using only the allowed procedure codes listed in the agency's published ((~~DME and related supplies, prosthetics and orthotics, medical supplies and related items~~)) medical equipment billing ((~~instructions~~)) guide.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2100 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Requests to include new ((equipment/supplies/technology)) medical equipment and technology. (1) An interested party may request the medicaid agency to include new ((~~equipment/supplies~~)) medical equipment in the agency's ((~~durable~~)) medical equipment ((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related services~~)) billing ((~~instructions~~)) guide.

(2) The request ((~~should~~)) must include credible evidence, including but not limited to:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (((~~included~~)) including FDA approval, if required);

(d) Proof of certification from the Centers for Medicare and Medicaid Services (CMS), if applicable; and

(e) Any additional information the requester feels would aid the agency in its determination.

((~~(3) Requests should be sent to the DME Program Management Unit, P.O. Box 45505, Olympia WA 98504-5506.~~))

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2200 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Proof of delivery. (1) When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the medicaid agency requests that information. All of the following apply:

(a) The agency requires a delivery slip as proof of delivery. The proof of delivery slip must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For ((~~durable~~)) medical equipment ((~~(DME) and complex rehabilitation technology (CRT)~~)) that may require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or the client's authorized representative; or

(ii) For nondurable medical supplies for which the agency has established a monthly maximum, on or after the date the item was received by the client or the client's authorized representative.

(2) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must furnish proof of delivery that the client received the equipment and/or supply, when the agency requests that information.

(a) If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery. The tracking slip must include:

(i) The client's name or a reference to the client's ((~~package(s)~~)) package or packages;

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) If the provider/supplier does the delivering, the delivery slip is the proof of delivery. The delivery slip must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand ((~~name(s)~~)) name or names of the items being shipped; and

(iv) For ((~~DME and CRT~~)) medical equipment that may require future repairs, the serial number.

(c) When billing the agency, use:

(i) ((~~Use~~)) The shipping date as the date of service on the claim if the provider uses a delivery/shipping service; or

(ii) ((~~Use~~)) The actual date of delivery as the date of service on the claim if the provider/supplier does the delivery.

(3) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(4) Providers must obtain prior authorization when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

(5) The agency does not pay for ((~~DME and related supplies, CRT, prosthetics and orthotics, medical supplies~~)) medical equipment and related items furnished to the agency's clients when:

(a) The medical professional who provides medical justification to the agency for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of ((~~DME and related supplies, CRT, prosthetics and orthotics, medical supplies,~~)) medical equipment and related items.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2250 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services~~))Rental or purchase. (1) The medicaid agency bases its decision to rent or purchase ((~~durable~~)) medical equipment ((~~(DME)~~)) on the length of time the client needs the equipment.

(2) A provider must not bill the agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(3) The agency purchases new ((~~DME~~)) medical equipment ((~~and complex rehabilitation technology (CRT)~~)) only.

(a) A new ((~~DME~~)) medical equipment item that is placed with a client initially as a rental item is considered a new item by the agency at the time of purchase.

(b) A used ((~~DME~~)) medical equipment item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the agency.

(4) The agency requires a dispensing provider to ensure the ((~~DME~~)) medical equipment rented to a client is:

(a) In good working order; and

(b) Comparable to equipment the provider rents to individuals with similar medical equipment needs who are either private pay or who have other third-party coverage.

(5) The agency's minimum rental period for covered ((~~DME~~)) medical equipment is one day.

(6) The agency authorizes rental equipment for a specific period of time. The provider must request authorization from the agency for any extension of the rental period.

(7) The agency's reimbursement amount for rented ((~~DME~~)) medical equipment includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(8) The agency considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.

(9) ((~~DME and related supplies, CRT, prosthetics, and orthotics~~)) Medical equipment purchased by the agency for a client ((~~are~~)) is the client's property.

(10) The agency rents, but does not purchase, certain ((~~DME~~)) medical equipment for clients. This includes, but is not limited to, the following:

(a) Bilirubin lights for newborns ((~~at home~~)) with jaundice in any setting where normal life activities take place; and

(b) Electric hospital-grade breast pumps.

(11) The agency stops paying for any rented medical equipment effective the date of a client's death. The agency prorates monthly rentals as appropriate.

(12) For a client who is eligible for both medicare and medicaid, the agency only pays ((~~only~~)) the client's coinsurance and deductibles. The agency discontinues paying client's coinsurance and deducti-

bles for rental medical equipment covered by medicare when either of the following applies:

(a) The reimbursement amount reaches medicare's reimbursement cap for the medical equipment; or

(b) Medicare considers the medical equipment purchased.

(13) The agency does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards. The medicaid agency covers the purchase of the following, with the stated limitations, without prior authorization:

(1) Patient lift, hydraulic, with seat or sling - One per client in a five-year period.

(2) Traction equipment - One per client in a five-year period.

(3) Trapeze bars - One per client in a five-year period. The agency requires prior authorization for rental.

(4) Fracture frames - One per client in a five-year period. The agency requires prior authorization for rental.

(5) Transfer board or devices - One per client in a five-year period.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4200 Covered—Wheelchairs—Power-drive. (1) The medicaid agency ((~~covers~~)) pays for power-drive wheelchairs when the prescribing physician certifies that ((~~the following clinical criteria are met~~)):

(a) The client can independently and safely operate a power-drive wheelchair;

(b) The client's medical condition negates ((~~his or her~~)) the client's ability to self-propel any of the wheelchairs listed in the manual wheelchair category in any setting where normal life activities take place; and

(c) A power-drive wheelchair will:

(i) Provide the client the only means of independent mobility in any setting where normal life activities take place; or

(ii) Enable a child to achieve age-appropriate independence and developmental milestones.

(2) ((~~The following additional information is required~~)) Additionally, for a three or four-wheeled power-drive scooter/power-operated vehicle (POV)((~~:~~

~~(a)~~)), the prescribing physician ((~~certifies that the client's condition is stable; and~~

~~(b) The client~~)) must certify the client's condition is unlikely to require a standard power-drive wheelchair within the next two years.

(3) When the agency approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria in subsection (5) of this section.

(4) The agency pays to maintain only the client's primary wheelchair, unless the conditions of subsection (6) of this section apply.

(5) The agency pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients only when one of the following circumstances applies:

(a) The architecture of locations where the client's ((~~home is~~)) normal life activities take place are completely unsuitable for a power-drive wheelchair, due to conditions such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius;

(b) The architecture of the bathroom in locations where the client's ((~~home bathroom~~)) normal life activities take place is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The agency requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home or along a pathway that does not provide for safe use of a power wheelchair; and

(ii) Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

(6) When the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the circumstances in subsection (5) of this section, the agency pays to maintain both wheelchairs.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs. (1) The medicaid agency covers, with prior authorization, wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. To receive payment, providers must submit the following to the agency:

(a) A completed General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) A completed Prescription Form (HCA 13-794);

(c) A completed Medical Necessity for Wheelchair Purchase (for home clients only) form (HCA 13-727). The date on this form (HCA

13-727) must not be dated prior to the date on the Prescription Form (HCA 13-794);

(d) The make, model, and serial number of the wheelchair to be modified;

(e) The modification requested; and

(f) Any specific information regarding the client's medical condition that necessitates the modification.

(2) The agency pays for transit option restraints only when used for client-owned vehicles.

(3) The agency covers, with prior authorization, wheelchair repairs. To receive payment, providers must submit the following to the agency:

(a) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000);

(b) A completed Medical Necessity for Wheelchair Purchase form (for home clients only) (HCA 13-727);

(c) The make, model, and serial number of the wheelchair to be repaired; and

(d) The repair requested.

(4) Prior authorization is required for the repair and modification of client-owned equipment.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4400 Covered—Complex rehabilitation technology. (1) The medicaid agency covers, with prior authorization, individually configured, complex rehabilitation technology (CRT) products.

(2) CRT must be supplied by a CRT supplier with the appropriate taxonomy number to bill for the items.

(3) Each site that a company operates must employ at least one CRT professional who has been certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(4) The client must be evaluated by a licensed health care provider who performs specialty evaluations within their scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.

(a) At the evaluation, a CRT professional must also be present from the company ordering the equipment; or

(b) The CRT provider must be present at the evaluation to:

(i) Assist in selection of the appropriate CRT item(s); and

(ii) Provide training in the use of the selected items.

(5) The CRT provider must:

(a) Provide service and repairs by qualified technicians for all CRT products it sells; and

(b) Provide written information to the client at the time of delivery as to how the client may receive services and repairs.

AMENDATORY SECTION (Amending WSR 17-15-073, filed 7/14/17, effective 8/14/17)

WAC 182-543-5000 Covered—Prosthetics/orthotics. (1) The medicaid agency covers, without prior authorization (PA), the following prosthetics and orthotics. Items that meet the definition of medical equipment may be covered under the requirements for medical equipment. Prosthetics and orthotics that do not meet those definitions are covered, with stated limitations:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - One every five years.

(b) Preparatory, above knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot plaster socket, molded to model - One per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - One per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - One per twelve-month period, per limb.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - One per twelve-month period, per limb.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(g) Prosthetics and orthotics beyond these limits may be prior authorized when medically necessary, as defined in WAC 182-500-0070.

(2) The agency pays only licensed prosthetic and orthotic providers to supply prosthetics and orthotics. This licensure requirement does not apply to the following:

(a) Providers who are not required to have specialized skills to provide select orthotics, but meet ((~~DME~~)) medical equipment and pharmacy provider licensure requirements;

(b) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy; and

(c) Out-of-state providers, who must meet the licensure requirements of that state.

(3) The agency pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), that meet the definition of prosthetic or orthotic in WAC 182-543-1000 and are prescribed under WAC 182-543-1100 ((~~and 182-543-1200~~)).

(4) The agency pays for repair or modification of a client's current prosthesis. To receive payment, all of the following must be met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has submitted supporting documentation; and

(c) The repair must have a warranty for a minimum of ninety days.

(5) Clients are responsible for routine maintenance of their prosthetic or orthotic. If a client does not have the physical or mental ability to perform this task, the client's caregiver is responsible for routine maintenance of the prosthetic or orthotic. The agency requires PA for extensive maintenance to a prosthetic or orthotic.

((~~(6) For prosthetics dispensed for cosmetic reasons only, see WAC 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered.~~))

AMENDATORY SECTION (Amending WSR 12-07-022, filed 3/12/12, effective 4/12/12)

WAC 182-543-5500 Covered—Medical supplies and related services. The medicaid agency ((~~covers, without prior authorization unless otherwise specified,~~)) pays for the following medical supplies and related services without prior authorization unless otherwise specified:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - One pint per month;

(b) Alcohol wipes (box of two hundred) - One box per month;

(c) Betadine or pHisoHex solution - One pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - One box per month;

(2) Bandages, dressings, and tapes;

(3) Batteries - Replacement batteries:

(a) The agency pays for the purchase of replacement batteries for wheelchairs with prior authorization.

(b) The agency does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. ((~~See WAC 182-543-3400 for speech generating devices and chapter 182-548 WAC for ventilators.~~))

(4) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary ((~~home~~)) or specialized blood glucose monitor - One in a three-month period;

(b) Spring-powered device for lancet - One in a six-month period;

(c) Diabetic test strips as follows:

(i) For clients((~~, twenty years of~~)) age twenty and younger, as follows:

(A) Insulin dependent, three hundred test strips and three hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, per month.

(ii) For clients((~~,~~)) age twenty-one ((~~years of age~~)) and older:

(A) Insulin dependent, one hundred test strips and one hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, every three months.

(iii) For pregnant ((~~women~~)) people with gestational diabetes, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to sixty days postpartum.

(d) See WAC 182-543-5500(12) for blood glucose monitors.

(5) Braces, belts, and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - Two per twelve-month period;

(b) Ankle, elbow, or wrist brace - Two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - One per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - One per twelve-month period.

(6) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - One per twelve-month period;

(b) Synthetic or lamb's wool sheepskin pad - One per twelve-month period;

(c) Heel or elbow protectors - Four per twelve-month period.

(7) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - Four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - Ten per month.

(c) Adhesive remover or solvent - Three ounces per month.

(d) Adhesive remover wipes, fifty per box - One box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - Sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - Ten per month.

(g) Continent plug for continent stoma - Thirty per month.

(h) Continent device for continent stoma - One per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - Twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - Twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(m) Irrigation bag - Two every six months.

(n) Irrigation cone and catheter, including brush - Two every six months.

(o) Irrigation supply, sleeve - One per month.

(p) Ostomy belt (adjustable) for appliance - Two every six months.

(q) Ostomy convex insert - Ten per month.

(r) Ostomy ring - Ten per month.

(s) Stoma cap - Thirty per month.

(t) Ostomy faceplate - Ten per month. The agency does not pay for either of the following when billed in combination with an ostomy faceplate:

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(8) Syringes and needles;

(9) Urological supplies - Diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a top sheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the back sheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a back sheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing

fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The agency pays for urological products when they are used alone. The following are examples of products ((~~which~~)) the agency does not pay for when used in combination with each other:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) The agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use. Example: pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

(h) Purchased disposable diapers (any size) are limited to two hundred per month for clients <u>age</u> three ((~~years of age~~)) and older.

(i) Reusable cloth diapers (any size) are limited to:

(i) Purchased - Thirty-six per year; and

(ii) Rented - Two hundred per month.

(j) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a client age three ((~~to~~)) <u>through age</u> eighteen ((~~years of age~~)); and

(ii) One hundred fifty per month for a client <u>age</u> nineteen ((~~years of age~~)) and older.

(k) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - Four per year.

(ii) Rented - One hundred fifty per month.

(l) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - One hundred eighty per month.

(ii) Purchased, reusable (large) - Forty-two per year.

(iii) Rented, reusable (large) - Ninety per month.

(10) Urological supplies - Urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - Two per month. The agency does not pay for these when billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - Two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The agency does not pay for these when billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - Two per twelve-month period.

(e) Indwelling catheters (any type) - Three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - One hundred and twenty per month. The agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - Three per month. The agency does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter, individual indwelling catheters, and/or individual lubricant packets.

(g) Intermittent urinary catheter - One hundred twenty per month. The agency does not pay for these when billed in combination with an insertion tray with or without drainage bag and catheter((~~/~~)), or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston). The agency does not pay for these when billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - Thirty per month. The agency does not pay for these when billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - Thirty per month. The agency does not pay for these when billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric), replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - Sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - Two per month. The agency does not pay for these when billed in combination with a latex urinary leg bag, urinary suspensory without leg bag, extension drainage tubing, or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - Two per month.

(o) Urinary leg bag, vinyl, with or without tube - Two per month. The agency does not pay for these when billed in combination with drainage bag and without catheter.

(p) Urinary leg bag, latex - One per month. The agency does not pay for these when billed in combination with or without catheter.

(11) Miscellaneous supplies:

(a) Bilirubin light therapy supplies when provided with a bilirubin light which the agency prior authorized - Five days supply.

(b) Continuous passive motion (CPM) softgoods kit - One, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - One box of twenty.

(d) Eye patch (adhesive wound cover) - One box of twenty.

(e) Nontoxic gel (e.g., LiceOff TM) for use with lice combs - One bottle per twelve-month period.

(f) Nonsterile gloves - Two hundred, per client, per month.

(i) For clients residing in an assisted living facility, the agency pays, with prior authorization, for additional nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of four hundred per client, per month.

(ii) Prior authorization requests must include a completed:

(A) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000 Authorization); and

(B) Limitation Extension Request Incontinent Supplies and Gloves form (HCA 13-870).

(g) Sterile gloves - Thirty pair, per client, per month.

(12) Miscellaneous ((~~DME~~)) medical equipment:

(a) Bilirubin light or light pad - Five days rental per twelve-month period for at-home newborns with jaundice.

(b) Blood glucose monitor ((~~(specialized or home)~~)) - One in a three-year period. See WAC 182-543-5500(4) for blood monitoring/testing supplies. The agency does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC 182-553-500 home infusion therapy/parenteral nutrition program.

(c) Continuous passive motion (CPM) machine - Up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - Two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - Two per twelve-month period.

(f) Pneumatic compressor - One in a five-year period.

(g) Positioning car seat - One in a five-year period.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-5700 Covered—((~~DME and related supplies and complex rehabilitation technology~~))Medical equipment for clients in skilled nursing facilities. (1) The medicaid agency's skilled nursing facility per diem rate, established in chapters 74.46 RCW, 388-96, and 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this section.

(2) The agency pays for the following ((~~covered DME and related supplies and complex rehabilitation technology (CRT)~~)) medical equipment outside of the skilled nursing facility per diem rate, subject to the limitations in this section:

(a) Manual or power-drive wheelchairs (including CRT);
(b) Speech generating devices (SGD); and
(c) Specialty beds.

(3) The agency pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization, according to the requirements in WAC 182-543-4100, 182-543-4200, and 182-543-4300. Requests for prior authorization must:

(a) Be for the exclusive full-time use of a skilled nursing facility resident;

(b) Not be included in the skilled nursing facility's per diem rate;

(c) Include a completed General Information for Authorization form (HCA 13-835);

(d) Include a copy of the telephone order, signed by the physician, for the wheelchair assessment;

(e) Include a completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729).

(4) The agency pays for wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges, with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A copy of the telephone order, signed by the physician for the wheelchair accessories and modifications;

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The date on this form (HCA 13-729) must not be prior to the date on the telephone order. The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(c) The make, model, and serial number of the wheelchair to be modified;

(d) The modification requested; and

(e) Specific information regarding the client's medical condition that necessitates modification.

(5) The agency pays for wheelchair repairs((~~,~~)) with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) The make, model, and serial number of the wheelchair to be repaired; and

(c) The repair requested.

(6) Prior authorization is required for the repair and modification of client-owned equipment.

(7) The skilled nursing facility must provide a house wheelchair as part of the per diem rate, when the client resides in a skilled nursing facility.

(8) When the client is eligible for both medicare and medicaid and is residing in a skilled nursing facility in lieu of hospitalization, the agency does not reimburse for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies~~)) equipment, related services, or related repairs or labor charges under fee-for-service (FFS).

(9) The agency pays for the purchase and repair of a speech generating device (SGD), with prior authorization. The agency pays for replacement batteries for SGDs in accordance with WAC 182-543-5500(3).

(10) The agency pays for the purchase or rental of a specialty bed (a heavy duty bariatric bed is not a specialty bed), with prior authorization, when:

(a) The specialty bed is intended to help the client heal; and

(b) The client's nutrition and laboratory values are within normal limits.

(11) The agency considers decubitus care products to be included in the skilled nursing facility per diem rate and does not reimburse for these separately.

(12) See WAC ((~~182-543-9200~~)) 182-543-9000 for reimbursement for wheelchairs and ((~~WAC 182-543-9250 for reimbursement for~~)) CRT.

(13) The agency pays for the following medical supplies for a client in a skilled nursing facility outside the skilled nursing facility per diem rate:

(a) Medical supplies or services that replace all or part of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to, the following:

(i) Colostomy and other ostomy bags and necessary supplies (see WAC 388-97-1060(3)); and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies.

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony.

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks post-surgery.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7000 Authorization. (1) The medicaid agency requires providers to obtain authorization for ((~~covered durable~~)) medical ((~~equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related~~)) equipment as required in this chapter, in chapters 182-501 and 182-502 WAC, and in published billing ((~~instructions and/or~~)) guides and provider notices or when the clinical criteria required in this chapter are not met.

(a) The agency considers requests for prior authorization (PA) for any item meeting the definition of medical equipment, and PA is granted when the service is medically necessary as defined in WAC 182-500-0070.

(b) For prior authorization (PA), a provider must submit a written request to the agency as specified in the agency's published billing ((~~instructions~~)) guides (see WAC 182-543-7100). All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. The agency's electronic forms are available online at((~~:~~)) http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

((~~(b)~~)) (c) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the

agency's published billing ((~~instructions~~)) guides. The appropriate EPA number must be used when the provider bills the agency (see WAC 182-543-7200).

(2) When a service requires authorization, the provider must properly request authorization in accordance with the agency's rules, billing ((~~instructions~~)) guides, and provider notices.

(3) The agency's authorization of ((~~service(s)~~)) services does not necessarily guarantee payment.

(4) When authorization is not properly requested, the agency rejects and returns the request to the provider for further action. The agency does not consider the rejection of the request to be a denial of service.

(5) Authorization requirements in this chapter are not a denial of service to the client.

(6) The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100 (1)(c).

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7100 Prior authorization. (1) The medicaid agency requires providers to obtain prior authorization for certain ((~~items~~)) medical equipment and services before delivering ((~~that item~~)) the equipment or service to the client, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. The ((~~item~~)) equipment or service must also be delivered to the client before the provider bills the agency.

(2) All prior authorization requests must be accompanied by a completed General Information for Authorization form (HCA 13-835), in addition to any program specific agency forms as required within this chapter. Agency forms are available online at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(3) When the agency receives the initial request for prior authorization, the ((~~prescription(s) for those items~~)) prescription for the medical equipment or services must not be older than ((~~three~~)) six months from the date the agency receives the request.

(4) The agency requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to((~~, the following~~)):

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(5) For prior authorization requests, the agency requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. The agency does not accept general standards of care or industry standards for generalized equipment as justification.

(6) The agency considers requests for ((~~new durable~~)) medical equipment ((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related~~

~~equipment~~)) that ((~~do~~)) does not have assigned health care common procedure coding system (HCPCS) codes and are not listed in the agency's published issuances, including billing instructions or provider notices. These items require prior authorization. The provider must furnish all of the following information to the agency to establish medical necessity:

(a) A detailed description of the ((~~item(s) or service(s)~~)) equipment or service to be provided;

(b) The cost or charge for the ((~~item(s)~~)) equipment;

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the ((~~item(s)~~)) equipment being provided; and

(d) A detailed explanation of how the requested ((~~item(s)~~)) equipment differs from an already existing code description.

(7) The agency does not pay for the purchase, rental, or repair of medical equipment that duplicates equipment that the client already owns, rents, or that the agency has authorized for the client. If the provider believes the purchase, rental, or repair of medical equipment is not duplicative, the provider must request prior authorization and submit the following to the agency:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet the client's medical needs.

(c) Upon request, documentation showing how the client's condition met the criteria for PA or EPA.

(8) A provider may resubmit a request for prior authorization for ((~~an item~~)) equipment or services that the agency has denied. The agency requires the provider to include new documentation that is relevant to the request.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7200 ((~~Limitation extension (LE).~~)) Prior authorization for limits on amount, frequency, or duration. (1) The medicaid agency limits the amount, frequency, or duration of certain ((~~covered medical supplies and equipment (MSE), durable~~)) medical equipment ((~~(DME), and related supplies, prosthetics, orthotics, medical supplies,~~)) and related services, and reimburses up to the stated limit without requiring prior authorization.

(2) Certain ((~~covered~~)) items have limitations on quantity and frequency. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

(3) The agency requires a provider to request prior authorization ((~~for a limitation extension (LE)~~)) in order to exceed the stated limits for ((~~nondurable~~)) medical equipment and ((~~medical~~)) supplies that do not require prior authorization. All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. Agency forms are available online at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(4) The agency evaluates such requests ((~~for LE~~)) under the provisions of WAC 182-501-0169, and grants prior authorization when it is medically necessary, as defined in WAC 182-500-0070.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7300 Expedited prior authorization (EPA). (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected ((~~durable~~)) medical equipment ((~~(DME)~~)) procedure codes.

(2) The medicaid agency requires a provider to create an authorization number for EPA for selected ((~~DME~~)) medical equipment procedure codes. The process and criteria used to create the authorization number is explained in the agency published ((~~DME-related~~)) medical equipment-related billing ((~~instructions~~)) guide. The authorization number must be used when the provider bills the agency.

(3) Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for EPA.

(4) A written or telephone request for prior authorization is required when a situation does not meet the EPA criteria for selected ((~~DME~~)) medical equipment procedure codes.

(5) The agency may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8000 ((~~DME~~))Billing general. (1) A provider must not bill the medicaid agency for the rental or purchase of medical equipment supplied to the provider at no cost by ((~~suppliers/manufacturers~~)) suppliers or manufacturers.

(2) The agency does not pay a ((~~durable~~)) medical equipment ((~~(DME)~~)) provider for medical supplies used in conjunction with a physician office visit. The agency pays the office physician for these supplies when appropriate. Refer to the agency's physician-related ((~~services/health care~~)) professional services billing ((~~instructions~~)) guide.

(3) The agency does not pay for any prosthetics and orthotics required for surgery or placed during the hospital stay under this chapter. See chapter 182-550 WAC. In this situation, the prosthetics and orthotics are included in the hospital reimbursement rate.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8100 ((~~DME~~))Billing for managed care clients. If a fee-for-service (FFS) client enrolls in a medicaid agency-contracted managed care organization (MCO), the following apply:

(1) The agency stops paying for any rented medical equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.

(2) The plan determines the client's continuing need for the medical equipment and is responsible for paying the provider.

(3) A client may become an MCO enrollee before the agency completes the purchase of prescribed medical equipment. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase:

(a) The agency rescinds the agency's authorization with the vendor until the MCO's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.

(4) If a client is disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment:

(a) The agency rescinds the MCO's authorization with the vendor until the client's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The agency does not pay for medical equipment and services provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

(d) The agency's applicable reimbursement policies apply to the purchase or rental of the equipment.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8200 Billing for clients eligible for medicare and medicaid. If a client is eligible for both medicare and medicaid((~~, the following apply~~)):

(1) The medicaid agency requires a provider to accept medicare assignment before any medicaid reimbursement;

(2) In accordance with WAC 182-502-0110(3):

(a) If the service provided is covered by medicare and medicaid, the agency pays only the deductible ((~~and/or~~)) or coinsurance up to medicare's or medicaid's allowed amount, whichever is less.

(b) If the service provided is covered by medicare but is not covered by the agency, the agency pays only the deductible ((~~and/or~~)) or coinsurance up to medicare's allowed amount.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-9000 ((~~DME and related supplies, complex rehabilitation, prosthetics, orthotics, medical supplies and related services —~~))General reimbursement. (1) The medicaid agency pays qualified providers who meet all ((~~of the~~)) conditions in WAC 182-502-0100((~~, for durable~~)) for medical equipment ((~~(DME), supplies~~)), repairs, and related services provided on a fee-for-service (FFS) basis as follows:

(a) To agency-enrolled ((~~DME~~)) medical equipment providers, qualified complex rehabilitation technology (CRT) suppliers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the agency's current ((~~DME~~)) medical equipment billing ((~~instructions; and~~)) guide;

(b) In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignation; and

(c) Providers must code the specific brand and model of wheelchair or CRT products dispensed according to the centers for medicare and medicaid services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates, and updates the maximum allowable fees for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies~~)) equipment and related services at least once yearly ((~~using available published information, including but not limited to~~)), unless otherwise directed by the legislature or determined necessary by the agency.

(3) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule or Competitive Bid Area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) ((~~Commercial databases;~~
~~(b) Manufacturers' catalogs;~~
~~(c)~~)) Medicare fee schedules; ((~~and~~
~~(d) Wholesale prices.~~
~~(3)~~)) (b) Legislative direction;

(c) Input from stakeholders or relevant sources that the agency determines to be reliable and appropriate;

(d) Pricing clusters; or

(e) A by-report (BR) basis.

(4) The medicaid agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency's reimbursement rate is a percentage of the manufacturer's list or manufacturer's suggested retail price (MSRP), or a percentage of the wholesale acquisition cost (AC). The agency uses the following percentages:

(a) For basic standard wheelchairs, sixty-five percent of MSRP or one hundred forty percent of AC;

(b) For wheelchair parts and add-on CRT accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(c) For wheelchair seat and back cushions, CRT manual wheelchair base, and up-charge modifications and seating systems, eighty percent of MSRP or one hundred forty percent of AC;

(d) For CRT power-drive wheelchair base, eighty-five percent of MSRP or one hundred forty percent of AC;

(e) For prosthetics and orthotics and medical supplies and related services, eighty-five percent of MSRP or one hundred twenty-five percent of AC;

(f) For other medical equipment, eighty percent of MSRP or one hundred twenty-five percent of AC;

(g) For medical supplies, eighty-five percent of MSRP or one hundred twenty-five percent of AC.

(5) When establishing reimbursement rates for medical equipment based on pricing clusters for a specific HCPCS code, the maximum allowable fee is the median or average amount of all items in the cluster. The pricing cluster is comprised of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster due to:

(a) A client's medical needs;

(b) Product quality;

(c) Introduction, substitution or discontinuation of certain brands/models; and/or

(d) Cost.

(6) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at either the DMEPOS rate divided by 0.15 or multiplied by ten. The agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule;

(7) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary((~~.~~

~~(4) The agency updates the maximum allowable fees for DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related services at least once per year, unless otherwise directed by the legislature or deemed necessary by the agency.~~

~~(5)~~)) to:

(a) Assure that payments are sufficient to enlist providers and maintain access to care and services; or

(b) Comply with legislative budget directives.

(8) The agency's maximum payment for ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies~~)) medical equipment and related services is the lesser of either ((~~of the following~~)) the:

(a) Providers' usual and customary charges; or

(b) Established rates, except as provided in WAC 182-543-8200.

((~~(6)~~)) (9) The agency is the payor of last resort for clients with medicare or third-party insurance.

((~~(7) The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted managed care plan, but who did not use one of the plan's participating providers.~~

~~(8)~~)) (10) The agency's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds, fitting, shipping, handling or any other administrative expenses related to provision of the prosthetic or orthotic to the client.

(11) The agency's reimbursement rate for purchased or rented covered ((~~DME and related supplies, prosthetics, orthotics, medical supplies~~)) medical equipment and related services includes all of the following:

(a) Any adjustments or modifications to the medical equipment ((~~that are~~)) required within three months of the date of delivery or ((~~are~~)) covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up ((~~and/or~~)) or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, and/or postage;

(e) Routine maintenance ((~~of DME~~)) that includes testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting ((~~and/or~~)) and set-up; and

(g) Instruction to the client or client's caregiver in the appropriate use of the medical equipment((~~, device, and/or supplies~~)).

((~~(9) DME, supplies, repairs,~~)) (12) Medical equipment and related services supplied to eligible clients under the following reimbursement methodologies are included in those methodologies and are not reimbursed under fee-for-service:

(a) Hospice providers' per diem reimbursement;

(b) Hospitals' diagnosis-related group (DRG) reimbursement;

(c) Managed care plans' capitation rate;

(d) Skilled nursing facilities' per diem rate; and

(e) Professional services' resource-based relative value system reimbursement (RBRVS) rate.

((~~(10)~~)) (13) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the equipment, and warranty period, available to the agency upon request.

((~~(11)~~)) (14) The dispensing provider who furnishes the medical equipment((~~, supply or device~~)) to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any medical equipment ((~~that~~)) the agency considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The equipment((~~, supply or device~~)) continues to be medically necessary.

((~~(12)~~)) (15) If the rental medical equipment((~~, supply or device~~)) must be replaced during the warranty period, the agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the medical equipment((~~, supply or device~~)) delivered to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The equipment((~~, supply or device~~)) continues to be medically necessary.

((~~(13) See WAC 182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400 for other reimbursement methodologies.~~)) (16) The agency does not reimburse for medical equipment, related services, and rela-

ted repairs and labor charges under fee-for-service when the client is:

(a) An inpatient hospital client;

(b) Eligible for both medicare and medicaid, and is staying in a skilled nursing facility in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(17) The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(18) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the agency may pay the provider an amount it considers appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

(19) For clients residing in skilled nursing facilities, see WAC 182-543-5700.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-543-6000	DME and related supplies, medical supplies and related services—Noncovered.
WAC 182-543-9100	Reimbursement method—Other DME.
WAC 182-543-9200	Reimbursement method—Wheelchairs.
WAC 182-543-9250	Reimbursement method—Complex rehabilitation technology.
WAC 182-543-9300	Reimbursement method—Prosthetics and orthotics.
WAC 182-543-9400	Reimbursement method—Medical supplies and related services.