



PROPOSED RULE MAKING

CR-102 (December 2017) (Implements RCW 34.05.320)

Do NOT use for expedited rule making

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FILED

DATE: March 05, 2019

TIME: 3:26 PM

WSR 19-06-079

Agency: Health Care Authority

Original Notice

Supplemental Notice to WSR _____

Continuance of WSR _____

Preproposal Statement of Inquiry was filed as WSR 18-14-112 ; 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)

WAC 182-531-0050 Physician-related services definitions

WAC 182-531-2040 (New section) Enhanced reimbursement – Medication Assisted Treatment

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
April 9, 2019	10:00 AM	Health Care Authority Cherry Street Plaza Sue Crystal Conf Rm 106A 626 8 th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than April 10, 2019 (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) April 9, 2019

Assistance for persons with disabilities:

Contact Amber Lougheed

Phone: (360) 725-1349

Fax: (360) 586-9727

TTY: Telecommunication Relay Services (TRS): 711

Email: amber.lougheed@hca.wa.gov

Other:

By (date) April 5, 2019

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The Washington State legislature provided funding to increase the Medication Assisted Therapy (MAT) rate for opioid use disorder to match the Medicare rate in order to encourage more providers to treat patients with opioid use disorder. This represents an exception to current payment methodology and needs to be described in the administrative code.

Reasons supporting proposal: See Purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160, ESSB 6032 - 2017-2019 Omnibus Operating Budget – 2018 Supplemental

Statute being implemented: RCW 41.05.021, 41.05.160, ESSB 6032 - 2017-2019 Omnibus Operating Budget – 2018 Supplemental

Is rule necessary because of a:

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

If yes, CITATION:

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:	Amy Emerson	PO Box 42716, Olympia WA 98504-2716	360-725-1348
Implementation:	Wendy Steffens	PO Box 45500, Olympia, WA 98504	360-725-5145-
Enforcement:	Wendy Steffens	PO Box 45500, Olympia, WA 98504	360-725-5145

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:

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)(e)
(Dictated by statute)

RCW 34.05.310 (4)(c)
(Incorporation by reference)

RCW 34.05.310 (4)(f)
(Set or adjust fees)

RCW 34.05.310 (4)(d)
(Correct or clarify language)

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. The updates to WAC 182-531-0050 and WAC 182-531-2040 do not impose additional compliance costs or requirements on providers.

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: March 5, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, apply to this chapter.

"Acquisition cost" - The cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" - Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" - A comprehensive inpatient and rehabilitative program coordinated by a multi-disciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 182-550-2501).

"Add-on procedure(s)" - Secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" - The medical condition responsible for a hospital admission, as defined by the ICD diagnostic code.

"Advanced registered nurse practitioner (ARNP)" - A registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Allowed charges" - The maximum amount reimbursed for any procedure that is allowed by the agency.

"Anesthesia technical advisory group (ATAG)" - An advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" - Any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" - A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intraoperative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" - Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" - Supplies that are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

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

"Call" - A face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" - A reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Center of excellence (COE)" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)," see WAC 182-500-0020.

"Certified registered nurse anesthetist (CRNA)" - An advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the national certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 182-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" - Regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" - Dollar amounts the agency uses to calculate the maximum allowable fee for physician-related services.

"Covered service" - A service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" - Physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Emergency medical condition(s)," see WAC 182-500-0030.

"Emergency services" - Medical services required by and provided to a patient experiencing an emergency medical condition.

"Evaluation and management (E&M) codes" - Procedure codes that categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" - The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the agency which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness. A service is not "experimental" if the service:

((+1)) (a) Is generally accepted by the medical profession as effective and appropriate; and

((+2)) (b) Has been approved by the federal Food and Drug Administration or other requisite government body, if such approval is required.

"Federally approved hemophilia treatment center" - A hemophilia treatment center (HTC) that:

((+1)) (a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

((+2)) (b) Is qualified to participate in 340B discount purchasing as an HTC;

((3)) (c) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC web site;

((4)) (d) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and

((5)) (e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

"Fee-for-service," see WAC 182-500-0035.

"Flat fee" - The maximum allowable fee established by the agency for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" - As defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 182-531-1700.

"HCPCS Level II" - Health care common procedure coding system, a coding system established by Centers for Medicare and Medicaid Services (CMS) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" - The name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" - A group of health care providers involved in the care of a client.

"Hospice" - A medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD," see "International Classification of Diseases."

"Informed consent" - That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

((1)) (a) Disclosed and discussed the client's diagnosis; (~~and~~
(2))

(b) Offered the client an opportunity to ask questions about the procedure and to request information in writing; (~~and~~
(3))

(c) Given the client a copy of the consent form; (~~and~~
(4))

(d) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

((5)) (e) Given the client oral information about all of the following:

((a)) (i) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; (~~and~~

(b))

(ii) Alternatives to the procedure including potential risks, benefits, and consequences; and

((e)) (iii) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" - An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases (ICD)" - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumeric designations (coding).

"Investigational" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness for a particular condition. A service is not "investigational" if the service:

((1)) (a) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

((2)) (b) Is supported by an overall balance of objective scientific evidence, that examines the potential risks and potential benefits and demonstrates the proposed service to be of greater overall benefit to the client in the particular circumstance than another generally available service.

"Life support" - Mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension," see WAC 182-501-0169.

"Long-acting reversible contraceptive (LARC)" - Subdermal implants and intrauterine devices (IUDs).

"Maximum allowable fee" - The maximum dollar amount that the agency will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 182-500-0070.

"Medication assisted treatment (MAT)" - The use of Food and Drug Administration-approved medications that have published evidence of effectiveness, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

"Medicare clinical diagnostic laboratory fee schedule" - The fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Medicare physician fee schedule database (MPFSDB)" - The official CMS publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" - The official CMS publication of the medicare fees for physician services.

"Mentally incompetent" - A client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient," see WAC 182-500-0080.

"Peer-reviewed medical literature" - A research study, report, or findings regarding a medical treatment that is published in one or more reputable professional journals after being critically reviewed by appropriately credentialed experts for scientific validity, safety, and effectiveness.

"Physician care plan" - A written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" - Physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "current procedural terminology (CPT)."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" - The diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Point-of-sale (POS) actual acquisition cost (AAC)" - The agency determined rate paid to pharmacies through the POS system, which is intended to reflect pharmacy providers' actual acquisition cost.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the agency's fee schedules that is not routinely covered.

"Preventive" - Medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization," see WAC 182-500-0085.

"Professional component" - The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" - The probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" - Face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 182-500-0085.

"Radioallergosorbent test" or "RAST" - A blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RBRVS RVU" - A measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - Physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"Reimbursement" - Payment to a provider or other agency-approved entity who bills according to the provisions in WAC 182-502-0100.

"Reimbursement steering committee (RSC)" - An interagency work group that establishes and maintains RBRVS physician fee schedules and

other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Relative value guide (RVG)" - A system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" - A unit that is based on the resources required to perform an individual service or intervention.

"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.

"RSC RVU" - A unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"RVU," see relative value unit.

"Stat laboratory charges" - Charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" - A tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by CMS to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" - An advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Technical component" - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

NEW SECTION

WAC 182-531-2040 Enhanced reimbursement—Medication assisted treatment for opioid use disorder. (1) The medicaid agency pays an enhanced reimbursement using the medicare rate when medication assisted treatment (MAT) is part of the visit for selected evaluation and management (E/M) codes and the provider meets the criteria in this section.

(2) The purpose of this enhanced reimbursement is to encourage providers to obtain and use a Drug Addiction Treatment Act of 2000 waiver (DATA 2000 waiver) to increase client access to evidence-based treatment using medications for opioid use disorder.

(3) To receive the enhanced reimbursement for MAT, a provider must:

(a) Bill using the agency's expedited prior authorization process;

(b) Currently use a DATA 2000 waiver to prescribe MAT to clients with opioid use disorder;

(c) Bill for treating a client with a qualifying diagnosis for opioid use disorder; and

(d) Provide opioid-related counseling during the visit.

(4) The agency payment for MAT under this section is limited to one enhanced reimbursement, per client, per day.

(5) The agency does not pay an enhanced reimbursement for services a client receives for opioid use disorder through an opioid treatment program facility licensed by the department of health.