PROPOSED RULE MAKING

CR-102 (June 2024)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: June 26, 2025
TIME: 1:40 PM

WSR 25-14-056

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR 24-15-084 ; 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) 182-531-0050, Physician-related services definitions; 182-531-0450, Critical care—Physician-related services; 182-531-0900, Neonatal intensive care unit (NICU) physician-related services; 182-531-1150, Physician care plan oversight services; 182-531-1250, Physician standby services; 182-531-1350, Prolonged physician-related service

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
August 5, 2025	10:00 AM	The Health Care Authority holds public hearings virtually without a physical meeting place	To attend the virtual public hearing, you must register in advance: https://us02web.zoom.us/webinar/register/WN_vJLHecCxQ1aJX1bCJPq5SA If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing

Date of intended adoption: Not sooner than August 6, 2025 (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
Beginning (date and time) June 28, 2025, 8:00 AM
By (date and time) August 5, 2025, by 11:59 PM

Assistance for persons with disabilities:
Contact HCA Rules Coordinator
Phone 360-725-1349
Fax 360-586-9727
TTY Telecommunication Relay Service (TRS): 711
Email arc@hca.wa.gov
Other
By (date) July 18, 2025

Purpose of the proposal and its anticipated effects, including any changes in existing rules: HCA is reviewing these rules to evaluate their alignment with current billing practices.

Reasons supporting proposal: See Purpose

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:

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
Type of proponent: ☐ Private. ☐ Public. ☒ Governmental.

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting	Jason Crabbe	PO Box 42716, Olympia WA 98504-2716	360-725-9563
Implementation	Andrea Allen	PO Box 45502, Olympia, WA 98504-5502	360-725-9805
Enforcement	Andrea Allen	PO Box 45502, Olympia, WA 98504-5502	360-725-9805

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 and Small Business Economic Impact Statement
Note: The Governor's Office for Regulatory Innovation and Assistance (ORIA) provides support in completing this part.

(1) Identification of exemptions:
This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). For additional information on exemptions, consult the exemption guide published by ORIA. 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)(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 19.85.025(4). (Does not affect small businesses).

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

Explanation of how the above exemption(s) applies to the proposed rule:

(2) Scope of exemptions: *Check one.*

☐ The rule proposal: Is fully exempt. *(Skip section 3.)* Exemptions identified above apply to all portions of the rule proposal.

☐ The rule proposal: Is partially exempt. *(Complete section 3.)* The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using this template from ORIA):

☐ The rule proposal: Is not exempt. *(Complete section 3.)* No exemptions were identified above.

(3) Small business economic impact statement: *Complete this section if any portion is not exempt.*

If any portion of 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 minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs. These rules add definitions and update language to align the rules with current billing practices. The agency does not anticipate these rules will add any new costs to providers, therefore, these rules do not impose more-than-minor costs on small businesses.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact 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: June 26, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 25-07-078, filed 3/17/25, effective 4/17/25)

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.

"Actual acquisition cost" - See WAC 182-530-1050.

"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 multidisciplinary team at a medicaid agency-approved rehabilitation facility. The program provides 24-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 medicaid 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 182-505 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 medicaid 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.

"Critical illness or injury" - An impairment to one or more vital organ systems with an increased risk of rapid or imminent life-threatening health deterioration.

"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 medicaid 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:

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

(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:

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

(b) Is qualified to participate in 340B discount purchasing as an HTC. See WAC 182-530-7900;

(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 website;

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

(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 the following:

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

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

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

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

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

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

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

(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 alphanumerical 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:

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

(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 medicaid agency will reimburse a provider for specific services, supplies, and equipment.

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

"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.

"Medication for opioid use disorder (MOUD)" - 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.

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

"Modifier" - A two-digit alphabetic or numeric, or both, 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.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the medicaid 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.

"Qualified health care professional (QHCP)" – An individual who is authorized to provide health care services based on their scope of practice and who may independently report those services.

"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 medicaid 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.

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

WAC 182-531-0450 Critical care—Physician-related services. (1) The ((~~department reimburses the following~~)) medicaid agency pays physicians or qualified health care professionals (QHCPs) for critical care physician-related services to critically ill or injured clients as follows:

(a) ((~~The attending physician who assumes responsibility for the care of a client during a life-threatening episode;~~

~~(b)~~)) More than one physician or QHCP if the services provided involve ((~~multiple organ systems~~)) different specialties; or

((~~(c)~~)) (b) Only one physician or QHCP for services provided in the emergency room.

(2) The ((~~department reimburses~~)) agency pays preoperative and postoperative critical care in addition to ((~~a~~)) the **global surgical package** when all the following apply:

(a) The client is critically ill or injured and the physician or QHCP is engaged in work directly related to the ((~~individual~~)) client's care((~~, whether that time is spent at the immediate bedside or elsewhere on the floor~~));

(b) ((~~The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;~~

~~(c)~~)) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed and goes beyond the normal procedure; and

((~~(d)~~)) (c) The provider uses ((~~any necessary,~~)) an appropriate modifier when billing the ((~~department~~)) agency if appropriate.

(3) ((~~The department limits payment for critical care services to a maximum of three hours per day, per client.~~

~~(4)~~)) The ((~~department~~)) agency does not pay separately for ((~~certain~~)) the following services performed by the provider when delivering critical care during a critical care period ((~~when the services are provided on a per hour basis. These services include, but are not limited to, the following~~)):

(a) ((~~Analysis of information data stored in computers~~)) Collection and interpretation of physiologic data; (e.g., ((~~ECG~~)) electrocardiogram, blood pressure, hematologic data, etc.);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X-rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

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

WAC 182-531-0900 Neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU) physician-related services. (1) ((~~The department pays the physician directing the care of a neonate or infant in an NICU, for NICU services.~~

~~(2) NICU services include, but are not limited to, any of the following:~~

~~(a) Patient management;~~

~~(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;~~

~~(c) Parent counseling; and~~

~~(d) Personal direct supervision by the~~ **~~health care team~~** ~~of activities required for diagnosis, treatment, and supportive care of the patient.~~

~~(3) Payment for NICU care begins with the date of admission to the NICU.~~

~~(4) The department~~)) The medicaid agency reimburses a provider for ((~~only~~)) one ((~~NICU~~)) neonatal intensive care unit (NICU) or pediatric intensive care unit (PICU) service per client, per day.

((~~(5) A provider may bill~~)) (2) The agency pays for NICU and PICU physician-related services when the billing physician or other qualified health care professional (QHCP) follows standard current procedural terminology (CPT) coding guidelines.

(3) The agency pays for NICU services in addition to **prolonged services** and newborn resuscitation when the ((~~provider~~)) physician or QHCP is present at the delivery.

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

WAC 182-531-1150 ((~~Physician~~)) Care plan oversight services. (1) The ((~~department~~)) medicaid agency covers **((~~physician~~)) care plan** oversight services only when:

(a) ((~~A~~)) The billing physician ((~~provides the service~~)) or other qualified health care professional (QHCP) follows standard current procedural terminology (CPT) coding guidelines; ((~~and~~))

(b) The client is served by a home health agency, a nursing facility, or a **hospice((~~.~~**

~~(2) The department reimburses for physician care plan oversight services when both of the following apply:~~

~~(a)~~))**;**

(c) The facility/agency has established a plan of care; and

((~~(b)~~)) (d) The physician or QHCP spends ((~~thirty~~)) 30 or more minutes per calendar month providing oversight for the client's care.

((~~(3)~~)) (2) The ((~~department reimburses~~)) medicaid agency pays for only one ((~~physician~~)) care plan oversight service per client, per month((~~, for physician care plan oversight services.~~

~~(4) The department reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery~~)).

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

WAC 182-531-1250 Physician standby services. (1) The ((~~department reimburses~~)) medicaid agency pays **physician standby** services only when the standby physician or qualified health care professional (QHCP) does not provide care or services to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician or QHCP requests another physician or QHCP to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) The ((~~department~~)) agency does not ((~~reimburse~~)) pay for physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than ((~~thirty~~)) 30 minutes; or

(c) Time is spent proctoring another physician.

(3) ((~~One unit of physician standby service equals thirty minutes. The department reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. The department rounds down fractions of a thirty-minute time unit.~~

~~(4)~~)) The ((~~provider~~)) physician or QHCP must clearly document the need for physician standby services in the client's medical record.

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

WAC 182-531-1350 Prolonged physician-related services. (1) The ((~~department reimburses~~)) medicaid agency pays for prolonged services based on established medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician or qualified health care professional (QHCP) and the client; and

(b) Be provided with other services.

(2) The ((~~department allows reimbursement~~)) medicaid agency pays for a prolonged service procedure in addition to an evaluation and management (E&M) procedure or consultation((~~, up to three hours per client, per diagnosis, per day,~~)) subject to ((~~other~~)) applicable coding limitations ((~~in the CPT codes that may be used~~)) and appropriate modifiers. ((~~The applicable CPT codes are indicated in the fee schedule.~~))