RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
FILED

DATE: April 03, 2018
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WSR 18-08-075

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending WAC 182-501-0135, Patient review and coordination (PRC), as follows:

- Adding patient review and coordination (PRC) program clients that may change managed care organizations (MCOs) and assigned primary care providers in a time period of less than twelve months;
- Revising the section about billing PRC program clients that receive nonemergency health care services obtained from providers to specify "nonpharmacy" providers; and
- Clarifying information about administrative hearing and appeals for clients receiving services through fee-for-service (FFS) and MCOs.

The agency is amending WAC 182-502-0160, Billing a client: specifically subsection (6)(c), to correct a WAC reference, and subsection (6)(d), to align the language with changes to WAC 182-501-0135.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-501-0135, 182-502-0160
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-03-085 on January 16, 2018 (date).

Describe any changes other than editing from proposed to adopted version:

Proposed/Adopted	WAC Subsection	Reason
Original WAC # 182-501-0135, Patient review and coordination (PRC)		
Proposed	(g) A client who requests an administrative hearing or appeal and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.	The agency added "in all other cases," clarifying that this subsection covers any client who requests an administrative hearing or appeal while already placed in the PRC program. (Subsection (e) refers to a timely request for an appeal of an initial PRC placement, and subsection (f) refers to untimely request for an appeal of an initial PRC placement.)
Adopted	(g) A client who requests an administrative hearing or appeal in all other cases and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.	

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

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

	New	____	Amended	2	Repealed	____

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

	New	____	Amended	____	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: April 3, 2018

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:

AMENDATORY SECTION (Amending WSR 13-05-006, filed 2/6/13, effective 3/9/13)

WAC 182-501-0135 Patient review and coordination (PRC). (1) **Patient review and coordination (PRC)** is a health and safety program that coordinates care and ensures clients enrolled in PRC use services appropriately and in accordance with agency rules and policies.

(a) PRC applies to medical assistance fee-for-service and managed care clients.

(b) PRC is authorized under federal medicaid law by 42 U.S.C. 1396n (a)(2) and 42 C.F.R. 431.54.

(2) **Definitions.** Definitions found in chapter 182-500 WAC and WAC 182-526-0010 apply to this section. The following definitions apply to this section only:

"Appropriate use" - Use of health care services that are safe and effective for a client's health care needs.

"Assigned provider" - An agency-enrolled health care provider or one participating with an agency-contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for a fee-for-service or managed care client in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a prescriber of controlled substances, and a hospital for nonemergency services.

"At-risk" - A term used to describe one or more of the following:

(a) A client with a medical history of:

(i) Seeking and obtaining health care services at a frequency or amount that is not medically necessary; or

(ii) Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

(b) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

(i) Indications of forging or altering prescriptions;

(ii) Referrals from medical personnel, social services personnel, or MCO personnel about inappropriate behaviors or practices that place the client at risk;

(iii) Noncompliance with medical or drug and alcohol treatment;

(iv) Paying cash for medical services that result in a controlled substance prescription or paying cash for controlled substances;

(v) Arrests for diverting controlled substance prescriptions;

(vi) Positive urine drug screen for illicit street drugs or nonprescribed controlled substances;

(vii) Negative urine drug screen for prescribed controlled substances; or

(viii) Unauthorized use of a client's services card for an unauthorized purpose.

"Care management" - Services provided to clients with multiple health, behavioral, and social needs to improve care coordination, client education, and client self-management skills.

((~~**"Client"** - A person enrolled in an agency health care program and receiving service from fee-for-service provider(s) or an MCO contracted with the agency.~~))

"Conflicting" - Drugs or health care services that are incompatible or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated" - A medical treatment, procedure, or medication that is inadvisable or not recommended or warranted.

"Duplicative" - Applies to the use of the same or similar drugs and health care services without due medical justification. Example: A client receives health care services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

"Emergency department information exchange (EDIE)" - An internet-delivered service that enables health care providers to better identify and treat high users of the emergency department and special needs patients. When patients enter the emergency room, EDIE can proactively alert health care providers through different venues such as fax, phone, email, or integration with a facility's current electronic medical records.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency services" - See 42 C.F.R. 447.53.

"Just cause" - A legitimate reason to justify the action taken, including but not limited to, protecting the health and safety of the client.

"Managed care client" - A medical assistance client enrolled in, and receiving health care services from, an agency-contracted managed care organization (MCO).

((~~**"Managed care organization"** or **"MCO"** - See WAC 182-538-050.~~))

"Prescriber of controlled substances" - Any of the following health care professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, Uniform Controlled Substance Act) for a legitimate medical purpose:

(a) A physician under chapter 18.71 RCW;

(b) A physician assistant under chapter 18.71A RCW;

(c) An osteopathic physician under chapter 18.57 RCW;

(d) An osteopathic physician assistant under chapter 18.57A RCW; and

(e) An advanced registered nurse practitioner under chapter 18.79 RCW.

"Primary care provider" or **"PCP"** - A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant (PA) who supervises, coordinates, and provides health care services to a client, initiates referrals for specialty and ancillary care, and maintains the client's continuity of care.

(3) **Clients selected for PRC review.** The agency or MCO selects a client for PRC review when either or both of the following occur:

(a) A usage review report indicates the client has not used health care services appropriately; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals to the agency or MCO.

(4) **When a fee-for-service client is selected for PRC review**, the prior authorization process as defined in WAC 182-500-0085 may be required:

(a) Prior to or during a PRC review; or

(b) When the client is currently in the PRC program.

(5) **Review for placement in the PRC program.** When the agency or MCO selects a client for PRC review, the agency or MCO staff, with clinical oversight, reviews either the client's medical history or billing history, or both, to determine if the client has used health

care services at a frequency or amount that is not medically necessary (42 C.F.R. 431.54(e)).

(6) **Usage guidelines for PRC placement.** Agency or MCO staff use the following usage guidelines to initiate review for PRC placement. A client may be placed in the PRC program when either the client's medical history or billing history, or both, documents any of the following:

(a) Any two or more of the following conditions occurred in a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice;

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received ten or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers not located in the same clinic or practice;

(v) Received similar services in the same day not located in the same clinic or practice; or

(vi) Had ten or more office visits;

(b) Any one of the following occurred within a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Made two or more emergency department visits;

(ii) Exhibits "at-risk" usage patterns;

(iii) Made repeated and documented efforts to seek health care services that are not medically necessary; or

(iv) Was counseled at least once by a health care provider, or an agency or MCO staff member with clinical oversight, about the appropriate use of health care services;

(c) The client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the ninety-day review period; or

(d) The client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous twelve months:

(i) Using health care services in a manner that is duplicative, excessive, or contraindicated; or

(ii) Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice((~~;~~

~~(iii) Being on substance abuse programs such as the Alcohol and Drug Abuse Treatment and Support Act (ADATSA)~~)).

(7) **PRC review results.** As a result of the PRC review, the agency or MCO may take any of the following steps:

(a) Determine that no action is needed and close the client's file;

(b) Send the client and, if applicable, the client's authorized representative a one-time only ((~~letter~~)) written notice of concern with information on specific findings and notice of potential placement in the PRC program; or

(c) Determine that the usage guidelines for PRC placement establish that the client has used health care services at an amount or frequency that is not medically necessary, in which case the agency or MCO will take one or more of the following actions:

(i) Refer the client for education on appropriate use of health care services;

(ii) Refer the client to other support services or agencies; or

(iii) Place the client into the PRC program for an initial placement period of no less than twenty-four months. For clients younger than eighteen years of age, the MCO must get agency approval prior to placing the client into the PRC program.

(8) **Initial placement in the PRC program.** When a client is initially placed in the PRC program:

(a) The agency or MCO places the client for no less than twenty-four months with one or more of the following types of health care providers:

(i) Primary care provider (PCP);

(ii) Pharmacy for all prescriptions;

(iii) Prescriber of controlled substances;

(iv) Hospital for nonemergency services unless referred by the assigned PCP or a specialist. A client may receive covered emergency services from any hospital; or

(v) Another qualified provider type, as determined by agency or MCO program staff on a case-by-case basis.

(b) The managed care client will remain in the same MCO for no less than twelve months unless:

(i) The client moves to a residence outside the MCO's service area and the MCO is not available in the new location; or

(ii) The client's assigned PCP no longer participates with the MCO and is available in another MCO, and the client wishes to remain with the current provider; ((~~or~~))

(iii) The client is in a voluntary enrollment program or a voluntary enrollment county;

(iv) The client is in the address confidentiality program (ACP), indicated by P.O. Box 257, Olympia, WA 98507; or

(v) The client is an American Indian/Alaska native.

(c) A managed care client placed in the PRC program must remain in the PRC program for no less than twenty-four months regardless of whether the client changes MCOs or becomes a fee-for-service client.

(9) **Notifying the client about placement in the PRC program.** When the client is initially placed in the PRC program, the agency or the MCO sends the client and, if applicable, the client's authorized representative, a written notice that:

(a) Informs the client of the reason for the PRC program placement;

(b) Directs the client to respond to the agency or MCO within ten ((~~business~~)) calendar days of the date of the written notice;

(c) Directs the client to take the following actions:

(i) Select providers, subject to agency or MCO approval;

(ii) Submit additional health care information, justifying the client's use of health care services; or

(iii) Request assistance, if needed, from the agency or MCO program staff.

(d) Informs the client of administrative hearing or appeal rights (see subsection (14) of this section).

(e) Informs the client that if a response is not received within ten calendar days of the date of the written notice, the client will be assigned a provider(s) by the agency or MCO.

(10) **Selection and role of assigned provider.** A client will have a limited choice of providers.

(a) The following providers are not available:

(i) A provider who is being reviewed by the agency or licensing authority regarding quality of care;

(ii) A provider who has been suspended or disqualified from participating as an agency-enrolled or MCO-contracted provider; or

(iii) A provider whose business license is suspended or revoked by the licensing authority.

(b) For a client placed in the PRC program, the assigned:

(i) Provider(s) must be located in the client's local geographic area, in the client's selected MCO, and be reasonably accessible to the client.

(ii) PCP supervises and coordinates health care services for the client, including continuity of care and referrals to specialists when necessary.

(A) The PCP:

(I) Provides the plan of care for clients that have documented use of the emergency department for a reason that is not deemed to be an emergency medical condition;

(II) Files the plan of care with each emergency department that the client is using or with the emergency department information exchange;

(III) Makes referrals to substance abuse treatment for clients who are using the emergency department for substance abuse issues; and

(IV) Makes referrals to mental health treatment for clients who are using the emergency department for mental health treatment issues.

(B) The assigned PCP must be one of the following:

(I) A physician;

(II) An advanced registered nurse practitioner (ARNP); or

(III) A licensed physician assistant (PA), practicing with a supervising physician.

(iii) Prescriber of controlled substances prescribes all controlled substances for the client;

(iv) Pharmacy fills all prescriptions for the client; and

(v) Hospital provides all hospital nonemergency services.

(c) A client placed in the PRC program must remain with the assigned providers for twelve months after the assignments are made, unless:

(i) The client moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's local geographic area and is no longer reasonably accessible to the client;

(iii) The provider refuses to continue to serve the client;

(iv) The client did not select the provider. The client may request to change an assigned provider once within thirty calendar days of the ((~~initial~~)) assignment; ((~~or~~))

(v) The client's assigned PCP no longer participates with the MCO. In this case, the client may select a new provider from the list of available providers in the MCO or follow the assigned provider to the new MCO; or

(vi) The client is in the address confidentiality program (ACP), indicated by P.O. Box 257, Olympia, WA 98507.

(d) When an assigned prescribing provider no longer contracts with the agency or the MCO:

(i) All prescriptions from the provider are invalid thirty calendar days following the date the contract ends;

(ii) All prescriptions from the provider are subject to applicable prescription drugs (outpatient) rules in chapter 182-530 WAC or appropriate MCO rules; and

(iii) The client must choose or be assigned another provider according to the requirements in this section.

(11) **PRC placement.**

(a) The initial PRC placement is no less than twenty-four consecutive months.

(b) The second PRC placement is no less than an additional thirty-six consecutive months.

(c) Each subsequent PRC placement is no less than seventy-two consecutive months.

(12) **Agency or MCO review of a PRC placement period.** The agency or MCO reviews a client's use of health care services prior to the end of each PRC placement period described in subsection (11) of this section using the guidelines in subsection (6) of this section.

(a) The agency or MCO assigns the next PRC placement if the usage guidelines for PRC placement in subsection (6) of this section apply to the client.

(b) When the agency or MCO assigns a subsequent PRC placement, the agency or MCO sends the client and, if applicable, the client's authorized representative, a written notice informing the client:

(i) Of the reason for the subsequent PRC program placement;

(ii) Of the length of the subsequent PRC placement;

(iii) That the current providers assigned to the client continue to be assigned to the client during the subsequent PRC placement;

(iv) That all PRC program rules continue to apply;

(v) Of administrative hearing or appeal rights (see subsection (14) of this section); and

(vi) Of the rules that support the decision.

(c) The agency may remove a client from PRC placement if the client:

(i) Successfully completes a treatment program that is provided by a chemical dependency service provider certified by the agency under chapter 388-805 WAC;

(ii) Submits documentation of completion of the approved treatment program to the agency; and

(iii) Maintains appropriate use of health care services within the usage guidelines described in subsection (6) of this section for six consecutive months after the date the treatment ends.

(d) The agency or MCO determines the appropriate placement for a client who has been placed back into the program.

(e) A client will remain placed in the PRC program regardless of change in eligibility program type or change in address.

(13) **Client financial responsibility.** A client placed in the PRC program may be billed by a provider and held financially responsible for nonemergency health care services ((~~when the client obtains nonemergency services and the~~)) obtained from a nonpharmacy provider ((~~who renders the services is not assigned or referred under the PRC program~~)) when the provider is not an assigned or appropriately referred provider as described in subsection (10) of this section. See WAC 182-502-0160.

(14) **Right to administrative hearing or appeal.**

(a) A fee-for-service client who ((~~believes the agency has taken an invalid action pursuant to this section may request a hearing~~)) disagrees with an agency decision regarding placement or continued placement in the PRC program has the right to an administrative hearing regarding this placement. A client must request an administrative hearing from the agency within ninety days of the written notice of placement or continued placement to exercise this right.

(b) A managed care client who ((~~believes the MCO has taken an invalid action pursuant to this section or chapter 182-538 WAC must ex-~~

~~haust the MCO's internal appeal process set forth in WAC 182-538-110 prior to requesting a hearing. Managed care clients cannot change MCOs until the appeal or hearing is resolved and there is a final ruling~~)) disagrees with an MCO decision regarding placement or continued placement in the PRC program has a right to appeal this decision in the same manner as an adverse benefit determination under WAC 182-538-110.

(i) An appeal must be filed with the MCO within sixty calendar days of the written notice of the MCO's decision.

(ii) A client must exhaust the right to appeal through the MCO prior to requesting an administrative hearing.

(iii) A client who disagrees with the resolution of the appeal by the MCO may request an administrative hearing.

(iv) A client may exercise the right to an administrative hearing by filing a request within one hundred twenty calendar days from the written notice of resolution of the appeal by the MCO.

(c) A client ((~~must request the hearing or appeal within ninety calendar days after the client receives the written notice of placement in the PRC program~~)) enrolled in an MCO cannot change MCOs until the MCO appeal and any administrative hearing process has been completed and a final order entered.

(d) The agency conducts ((~~a~~)) an administrative hearing according to chapter 182-526 WAC. ((~~Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 182-526-0010.~~))

(e) A client who requests ((~~a~~)) an administrative hearing or appeal within ten calendar days from the date of the written notice of an initial PRC placement ((~~period under subsection (11)(a) of this section~~)) will not be placed in the PRC program until ((~~the date an initial order is issued that supports the client's placement in the PRC program or otherwise~~)) ordered by an administrative law judge (ALJ) or review judge.

(f) A client who requests ((~~a~~)) an administrative hearing or appeal more than ten calendar days from the date of the written notice ((~~under subsection (9) of this section~~)) of initial PRC placement will remain placed in the PRC program ((~~unless~~)) until a final administrative order is entered that orders the client's removal from the program.

(g) A client who requests ((~~a~~)) an administrative hearing or appeal ((~~within ninety calendar days from the date of receiving the written notice under subsection (9) of this section~~)) in all other cases and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(h) An ALJ may rule ((~~that~~)) the client be placed in the PRC program prior to the date the record is closed and prior to the date the initial order is issued based on a showing of just cause.

((~~(i) The client who requests a hearing challenging placement into the PRC program has the burden of proving the agency's or MCO's action was invalid. For standard of proof, see chapter 182-526 WAC.~~))

AMENDATORY SECTION (Amending WSR 13-15-044, filed 7/11/13, effective 8/11/13)

WAC 182-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 182-500-0085) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a medicaid agency-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050 (4)(a) and 182-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable medicaid agency or agency-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the agency or agency-contracted MCO for medical assistance services furnished to clients. See 42 C.F.R. § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the agency-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the agency or the client's MCO.

(c) A covered service when the agency or its designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC 182-501-0050(9), or a noncovered service, defined in WAC 182-501-0050(10) and 182-501-0070. The client and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at http://

hrsa.dshs.wa.gov/mpforms.shtml. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as ((~~pre-operative~~)) preoperative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for agency or the agency's designee review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in ((~~WAC 388-513-1380~~)) chapters 182-513 and 182-515 WAC, emergency medical expense requirement, deductible, or copayment required by the agency or its designee). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is ((~~under~~)) placed in the agency's or an agency-contracted MCO's patient review and coordination (PRC) program ((~~(WAC 182-501-0135)~~)) and ((~~receives~~)) obtains nonemergency services from a nonpharmacy provider((~~s or health care facilities other than those to whom the client is assigned or referred under the PRC program~~)) that is not an assigned or appropriately referred provider as described in WAC 182-501-0135;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 182-530-7700 (2)(a)(iii) are met;

(f) The service is within a service category excluded from the client's benefits package. See WAC 182-501-0060;

(g) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the agency or its designee after being informed by the provider that he or she is not contracted with the agency or its designee and that the services offered will not be paid by the client's health care program; and

(i) An agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

(7) Under chapter 182-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on health care expenses to become eligible for coverage under the medically needy program. An individual must incur health care expenses greater than or equal to the amount that he or she must spend down. The provider is prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the agency for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the agency or its designee or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the agency or its designee makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 182-500-0025; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 C.F.R. § 435.914(a) and defined in WAC 182-500-0095.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the agency or its designee for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).