RULE-MAKING ORDER
PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 12, 2019
TIME: 3:36 PM

WSR 19-09-052

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 Washington State legislature provided funding to increase the Medication Assisted Treatment (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

Citation of rules affected by this order:

New: 182-531-2040
Repealed:
Amended: 182-531-0050
Suspended:

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

Other authority: N/A

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-06-079 on March 5, 2019 (date).

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

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:

	New		Amended		Repealed	
Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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New ____ Amended ____ Repealed ____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New ____ Amended ____ Repealed ____

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

New 1 Amended 1 Repealed ____

The number of sections adopted using:

	New		Amended		Repealed	
Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	1	Amended	1	Repealed	____

Date Adopted: April 12, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:

AMENDATORY SECTION (Amending WSR 17-21-040, filed 10/12/17, effective 11/12/17)

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 multidisciplinary 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

((~~(c)~~)) (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:

((~~(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.