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: October 14, 2019
TIME: 3:15 PM

WSR 19-21-087

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 these rules to align with section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, which added section 1903(i)(27) to the Social Security Act.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-552-0001, 182-552-1400, 182-552-1600
Suspended:

Statutory authority for adoption: RCW 41.05.021, RCW 41.05.160, 42 CFR 431.16 Section 1903(i)(27) of the Social Security Act

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-14-061 on June 28, 2019 (date).

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

WAC 182-552-1400 (2)		
Proposed	(2) The medicaid agency may adopt policies, procedure codes, ((~~and/or~~)) and rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.	The agency added: "to: (i) Assure that payments are sufficient to enlist providers and maintain access to care and services; or (ii) Comply with legislative budget directives."
Adopted	(2) The medicaid agency may adopt policies, procedure codes, ((~~and/or~~)) and rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary to: (i) Assure that payments are sufficient to enlist providers and maintain access to care and services; or (ii) Comply with legislative budget directives.	
WAC 182-552-1600 (3)		
Proposed	(3) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at either the DMEPOS rate divided by 0.15 or multiplied by ten. The agency sets the maximum allowable fee for daily rental at one three-hundredth of	The agency removed "divided by 0.15" from the purchase rate methodology.

	the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule.	
Adopted	(3) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at the DMEPOS rate multiplied by ten. The agency sets the maximum allowable fee for daily rental at one three-hundredth of the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule.	
WAC 182-552-1600 (5)		
Proposed	(5) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness, and payment value on a case-by-case basis. The agency's payment rate is eighty percent of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or one hundred percent of the wholesale acquisition cost (AC).	The agency added the following to the payment rate methodology: "…or one hundred percent (oxygen only) or one hundred twenty-five percent (all other respiratory items) of the wholesale acquisition cost (AC)."
Adopted	(5) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness, and payment value on a case-by-case basis. The agency's payment rate is eighty percent of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or one hundred percent (oxygen only) or one hundred twenty-five percent (all other respiratory items) of the wholesale acquisition cost (AC).	

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	2	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 1 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	3	Repealed	____

Date Adopted: October 14, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-0001 Respiratory care—General. (1) The respiratory care, equipment, and supplies described in this chapter ((~~is considered part of the agency's durable medical equipment (DME) benefit. This chapter~~)) applies to:

(a) Medicaid clients who require respiratory care in their homes, community residential settings, and skilled nursing facilities;

(b) Providers who supply respiratory care to medicaid clients; and

(c) Licensed health care professionals whose scope of practice allows for the provision of respiratory care.

(2) The ((~~medicaid~~)) agency covers the respiratory care listed in this chapter according to the limitations and requirements in this chapter.

(3) The ((~~medicaid~~)) agency pays for respiratory care for medicaid clients when it is:

(a) Covered;

(b) Within the scope of the eligible client's medical care program;

(c) Medically necessary, as defined under chapter 182-500 WAC;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC) within the scope of his or her licensure;

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

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

(g) Provided and used within accepted medical or respiratory care community standards of practice.

(4) The agency does not require prior authorization for requests for covered respiratory care for medicaid clients that meets the clinical criteria set forth in this chapter.

(5) The agency requires prior authorization for covered respiratory care for medicaid clients when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The ((~~medicaid~~)) agency evaluates requests requiring prior authorization on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-552-1300, 182-552-1325, 182-552-1350, and 182-552-1375 for specific details regarding authorization.

(6) The agency evaluates on a case-by-case basis for medical necessity and appropriateness items, procedures, and services that do not have an established procedure code available and which are billed using miscellaneous procedure codes.

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-1400 Respiratory care—Reimbursement—General. (1) The medicaid agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for covered respiratory care provided on a fee-for-service (FFS) basis as follows:

(a) To medicaid agency-enrolled ((~~durable~~)) medical equipment ((~~(DME)~~)) and supplies providers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the agency's current respiratory care medicaid ((~~provider~~)) billing guide; and

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

(2) ((~~The medicaid agency updates the maximum allowable fees for respiratory care at least once per year, unless otherwise directed by the legislature or unless deemed necessary by the agency.~~

~~(3) The medicaid agency sets, evaluates, and updates the maximum allowable fees for respiratory care using available published information including, but not limited to:~~

~~(a) Commercial databases;~~

~~(b) Manufacturer's catalogs;~~

~~(c) Medicare fee schedules; and~~

~~(d) Wholesale prices.~~

~~(4)~~)) The medicaid agency may adopt policies, procedure codes, ((~~and/or~~)) and rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary to:

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

(ii) Comply with legislative budget directives.

((~~(5)~~)) (3) The medicaid agency's maximum payment for respiratory care is the lesser of either of the following:

(a) Provider's usual and customary charges; or

(b) Established rates, except as provided in WAC 182-502-0110(3).

((~~(6)~~)) (4) The medicaid agency is the payer of last resort for clients with medicare or third-party insurance.

((~~(7)~~)) (5) The medicaid agency does not pay for respiratory care provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

((~~(8)~~)) (6) The medicaid agency's ((~~reimbursement~~)) payment rate for covered oxygen and respiratory equipment and supplies includes all of the following:

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

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

(c) Telephone calls;

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

(e) Maintenance for rented equipment including, but not limited to, testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting ((~~and/or~~)) or setup, or both; and

(g) Instruction to the client or client's caregiver in the appropriate use of the respiratory care.

((~~(9)~~)) (7) Respiratory care equipment, supplies, and related repairs and labor charges that are supplied to eligible clients under the following ((~~reimbursement~~)) payment methodologies are included in those methodologies and are not reimbursed under fee-for-service (FFS):

(a) Hospice provider's per diem reimbursement;

(b) Hospital's diagnosis-related group (DRG) reimbursement;

(c) Managed care organization's capitation rate;

(d) Skilled nursing facilities per diem rate; and

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

((~~(10)~~)) (8) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the respiratory care equipment, and warranty period, available to the medicaid agency upon request.

((~~(11)~~)) (9) The dispensing provider who furnishes respiratory care equipment or supplies to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any equipment or supply that the medicaid agency considers purchased requires repair during the applicable warranty period;

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

(c) The respiratory care equipment or supply continues to be medically necessary.

((~~(12)~~)) (10) If rental respiratory equipment or supplies must be replaced during the warranty period, the medicaid agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the respiratory equipment or supply provided to the client if:

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

(b) The respiratory care equipment or supply continues to be medically necessary.

((~~(13)~~)) (11) The medicaid agency does not ((~~reimburse~~)) pay for respiratory care equipment and supplies, or related repairs and labor charges under FFS when the client is any of the following:

(a) An inpatient hospital client;

(b) Terminally ill and receiving hospice care; or

(c) Enrolled in a risk-based MCO that includes coverage for such items ((~~and/or~~)) or services, or both.

((~~(14)~~)) (12) The medicaid agency rescinds any purchase order for a prescribed item if the equipment or supply was not supplied to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by an MCO.

((~~(15)~~)) (13) See also WAC ((~~182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400~~)) 182-543-9000 for ((~~other~~)) general reimbursement ((~~methodologies~~)).

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-1600 Respiratory care equipment and supplies—Reimbursement—Methodology for purchase, rental, and repair. (1) The medicaid agency sets, evaluates, and updates the maximum allowable fees for ((~~purchased~~)) respiratory care equipment and supplies at least once yearly ((~~using one or more of the following:~~

~~(a) The current medicare rate, as established by the federal Centers for Medicare and Medicaid Services (CMS), for a new purchase if a medicare rate is available;~~

~~(b) A pricing cluster; or~~

~~(c) On a by-report basis.~~

~~(2)~~)), unless otherwise directed by the legislature or determined necessary by the agency.

(2) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or competitive bid area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) Medicare fee schedules;

(b) Legislative direction;

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

(d) Pricing clusters; or

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

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

(4) When establishing ((~~reimbursement~~)) payment rates for ((~~purchased~~)) respiratory care equipment and supplies based on pricing clusters((~~.~~

~~(a) A pricing cluster is based on~~)) for a specific health care common procedure coding system (HCPCS) code((~~.~~

~~(b) The medicaid agency's~~)), the maximum allowable fee is the median or average amount of all items in the cluster. The pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the ((~~medicaid~~)) agency may limit the number of brands/models included in the pricing cluster((~~. The medicaid agency considers all of the following when establishing the pricing cluster:~~

~~(i)~~)) due to any one or more of the following:

(a) A client's medical needs;

((~~(ii)~~)) (b) Product quality;

((~~(iii)~~)) (c) Introduction, substitution, or discontinuation of certain brands/models; ((~~(iv) Cost; and/or~~

~~(v) Available alternatives.~~

~~(c) When establishing the fee for purchased respiratory care equipment and supplies in a pricing cluster, the maximum allowable fee is the median amount of available manufacturer's list or suggested retail prices for all brands/models as noted in (b) of this subsection.~~

~~(3) The medicaid agency evaluates items, procedures, and services billed using miscellaneous procedure codes, when an established code is not available, on a case-by-case basis for medical necessity, appropriateness, and reimbursement value. The medicaid agency calculates the purchase reimbursement rate for these items at eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or the cost from the manufacturer's invoice.~~

~~(4) The medicaid agency's maximum allowable fees for monthly rental are updated at least once yearly and are established using one of the following:~~

~~(a) For items with a monthly rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;~~

~~(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate; or~~

~~(c) For items not included in the current medicare fee schedule, as established by CMS, the medicaid agency considers the maximum allowable monthly reimbursement rate as by-report. The medicaid agency calculates the monthly reimbursement rate for these items at one-tenth of eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or one-tenth the cost from the manufacturer's invoice.~~

~~(5) The medicaid agency's maximum allowable fees for daily rental are updated at least once yearly and are established using one of the following:~~

~~(a) For items with a daily rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency equates its maximum allowable fee for daily rental to the current medicare daily rental rate;~~

~~(b) For items that have a new purchase rate but no daily rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency sets the maximum allowable fee for daily rental at one three-hundredth of the new purchase price of the current medicare rate; or~~

~~(c) For items not included in the current medicare fee schedule, as established by CMS, the medicaid agency considers the maximum allowable daily reimbursement rate as by-report. The medicaid agency calculates the daily reimbursement rate for these items at one three-hundredth of eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or one three-hundredth of the cost from the manufacturer's invoice~~)) or

(d) Cost.

(5) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness, and payment value on a case-by-case basis. The agency's payment rate is eighty percent of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or one hundred percent (oxygen only) or one hundred twenty-five percent (all other respiratory items) of the wholesale acquisition cost (AC).

(6) The ((~~medicaid~~)) agency((~~, with prior authorization, will~~)) pay for repairs of client-owned equipment only, with prior authorization (PA). In addition to agency-specific forms identified in the agency's respiratory care ((~~medicaid provider~~)) billing guide, providers must meet all of the following requirements ((~~must be met in or-~~

~~der~~)) to receive ((~~authorization~~)) PA and ((~~reimbursement~~)) payment for a repair of client-owned equipment:

(a) The provider must submit a manufacturer pricing sheet showing the manufacturer's list ((~~or suggested retail price (~~)) price, MSRP((~~)~~)), or manufacturer invoice showing the cost of the repair, identifying and itemizing the parts. The invoice must indicate the wholesale ((~~acquisition cost~~)) AC, the manufacturer's list price, or ((~~suggested retail price (~~))MSRP((~~)~~)) for all parts used in the repair for which ((~~reimbursement~~)) payment is being sought. ((~~Reimbursement for parts used in a repair will be:~~

~~(i) Eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year; or~~

~~(ii) The cost from the manufacturer's invoice.~~))

(b) ((~~Reimbursement for actual labor charges will be made according to the medicaid agency's current fee schedule.~~)) The provider must follow HCPCS coding guidelines and submit ((~~an authorization~~)) a PA request accordingly with actual labor units identified and supported by documentation.

(7) The agency pays for actual labor charges according to the agency's current fee schedule. The agency does not pay for base labor charges or other administrative-like fees ((~~will not be reimbursed~~)).