



RULE-MAKING ORDER PERMANENT RULE ONLY

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

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FILED

DATE: October 25, 2019

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WSR 19-22-017

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 revising this section to remove requirements and restrictions on how a provider addresses tobacco/nicotine cessation, and to centralize coverage information to make it easier for providers to navigate this topic. This includes moving and cross-referencing content from the maternity care and newborn delivery section (WAC 182-533-0400) and adding information on pharmacotherapy for tobacco/nicotine cessation.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-531-0100, 182-531-1720, 182-533-0400
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 19-19-076 on September 17, 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:
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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Federal statute:	New	___	Amended	___	Repealed	___
Federal rules or standards:	New	___	Amended	___	Repealed	___
Recently enacted state statutes:	New	___	Amended	___	Repealed	___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New	___	Amended	___	Repealed	___
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The number of sections adopted on the agency's own initiative:

New	___	Amended	___	Repealed	___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

New	___	Amended	<u>3</u>	Repealed	___
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The number of sections adopted using:

Negotiated rule making:	New	___	Amended	___	Repealed	___
Pilot rule making:	New	___	Amended	___	Repealed	___
Other alternative rule making:	New	___	Amended	<u>3</u>	Repealed	___

Date Adopted: October 25, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1)

The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's Washington apple health program. Refer to WAC 182-501-0060 and 182-501-0065; and

(b) Medically necessary as defined in WAC 182-500-0070.

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC 182-501-0165.

(3) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

(4) The agency covers the following physician-related services and health care professional services, subject to the conditions in subsections (1), (2), and (3) of this section:

(a) Alcohol and substance misuse counseling (refer to WAC 182-531-1710);

(b) Allergen immunotherapy services;

(c) Anesthesia services;

(d) Dialysis and end stage renal disease services (refer to chapter 182-540 WAC);

(e) Emergency physician services;

(f) ENT (ear, nose, and throat) related services;

(g) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 182-534-0100);

(h) Habilitative services (refer to WAC 182-545-400);

(i) Reproductive health services (refer to chapter 182-532 WAC);

(j) Hospital inpatient services (refer to chapter 182-550 WAC);

(k) Maternity care, delivery, and newborn care services (refer to chapter 182-533 WAC);

(l) Office visits;

(m) Vision-related services (refer to chapter 182-544 WAC for vision hardware for clients twenty years of age and younger);

(n) Osteopathic treatment services;

(o) Pathology and laboratory services;

(p) Physiatry and other rehabilitation services (refer to chapter 182-550 WAC);

(q) Foot care and podiatry services (refer to WAC 182-531-1300);

(r) Primary care services;

(s) Psychiatric services;

(t) Psychotherapy services (refer to WAC 182-531-1400);

(u) Pulmonary and respiratory services;

(v) Radiology services;

(w) Surgical services;

(x) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects (e.g., congenital or as a result of illness or physical trauma), or for mastectomy reconstruction for post cancer treatment;

(y) Telemedicine (refer to WAC 182-531-1730);

(z) Tobacco/nicotine cessation counseling (refer to WAC 182-531-1720);

(aa) Vaccines for adults, adolescents, and children in the United States administered according to the current advisory committee on immunization practices (ACIP) recommended immunization schedule published by the Centers for Disease Control and Prevention (CDC). Vaccines outside the regular schedule may be covered if determined to be medically necessary;

(bb) Other outpatient physician services.

(5) The agency covers physical examinations for Washington apple health clients only when the physical examination is for one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 182-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(6) By providing covered services to a client eligible for Washington apple health, a provider who meets the requirements in WAC 182-502-0005(3) accepts the agency's rules and fees which includes federal and state law and regulations, billing instructions, and provider notices.

WAC 182-531-1720 Tobacco/nicotine cessation counseling. (1) The medicaid agency covers tobacco/nicotine cessation counseling when ((delivered by qualified providers through the agency contracted quit-line or during face-to-face office visits for tobacco cessation for pregnant clients.))

~~(2) The agency pays for face-to-face office visits for tobacco cessation counseling for pregnant clients with the following limits:~~

~~(a) When provided by physicians, advanced registered nurse practitioners (ARNPs), physician assistants-certified (PA-Cs), naturopathic physicians, and dentists;~~

~~(b) Two cessation counseling attempts (or up to eight sessions) are allowed every twelve months. An attempt is defined as up to four cessation counseling sessions.~~

~~(3) To be paid for tobacco cessation counseling through SBIRT, providers must bill the agency using the agency's published billing instructions):~~

(a) Delivered by qualified providers through an agency-approved tobacco/nicotine cessation telephone counseling service;

(b) The client is pregnant or in the postpartum period as defined in 42 C.F.R. 435.170. The agency pays for face-to-face office visits for tobacco/nicotine cessation counseling for these clients with the following limits:

(i) Counseling must be provided by qualified physicians, advanced registered nurse practitioners (ARNPs), physician assistants-certified (PA-Cs), naturopathic physicians, pharmacists, certified nurse-midwives (CNM), licensed midwives (LM), psychologists, or dentists;

(ii) Two tobacco/nicotine cessation counseling attempts are allowed every twelve months. An attempt is defined as up to four tobacco/nicotine cessation counseling sessions; and

(iii) The agency does not cover more than one face-to-face tobacco/nicotine cessation counseling session per client, per day. The provider must keep written documentation in the client's record for each session.

(c) Provided through screening, brief intervention, and referral to treatment (SBIRT). To receive payment for tobacco/nicotine cessation counseling through SBIRT, providers must bill the agency using the agency's published billing instructions.

(2) A provider may prescribe pharmacotherapy for tobacco/nicotine cessation when the provider considers the treatment appropriate for the client. The agency covers certain pharmacotherapy for tobacco/nicotine cessation, including prescription drugs and over-the-counter (OTC) nicotine replacement therapy (NRT), as described in chapter 182-530 WAC.

WAC 182-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

(a) "**Birthing center**" means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) "**Bundled services**" means services integral to the major procedure that are included in the fee for the major procedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

(c) "**Facility fee**" means the portion of the medicaid agency's payment for the hospital or birthing center charges. This does not include the agency's payment for the professional fee.

(d) "**Global fee**" means the fee the agency pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) "**High-risk**" pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) "**Professional fee**" means the portion of the agency's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 182-531-1850 for reimbursement methodology.)

(2) The agency covers full scope medical maternity care and newborn delivery services for fee-for-service and managed care clients under WAC 182-501-0060. (~~(See subsection (21) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.)~~)

(3) The agency does not provide maternity care and delivery services to clients who are eligible for:

(a) Family planning only programs (a pregnant client under ~~(this)~~ these programs should be referred to the ~~(local community services office)~~ Washington healthplanfinder via www.wahealthplanfinder.org for eligibility review); or

(b) Any other program not listed in this section.

(4) The agency requires providers of maternity care and newborn delivery services to meet all the following requirements:

(a) Providers must be currently licensed:

(i) By the state of Washington's department of health (DOH), or department of licensing, or both; or

(ii) According to the laws and rules of any other state, if exempt under federal law ~~((?))~~.

(b) Providers must have a signed core provider agreement with the agency;

(c) Providers must be practicing within the scope of their licensure; and

(d) Providers must have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA)).

(5) The agency covers total obstetrical care services (paid under a global fee). Total obstetrical care includes all the following:

- (a) Routine antepartum care that begins in any trimester of a pregnancy;
- (b) Delivery (intrapartum care and birth) services; and
- (c) Postpartum care. This includes family planning counseling.
- (6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, the agency pays that provider a global obstetrical fee.
- (7) When an eligible client receives services from more than one provider, the agency pays each provider for the services furnished. The separate services that the agency pays appear in subsection (5) of this section.
- (8) The agency pays for antepartum care services in one of the following two ways:
 - (a) Under a global fee; or
 - (b) Under antepartum care fees.
- (9) The agency's fees for antepartum care include all the following:
 - (a) Completing an initial and any subsequent patient history;
 - (b) Completing all physical examinations;
 - (c) Recording and tracking the client's weight and blood pressure;
 - (d) Recording fetal heart tones;
 - (e) Performing a routine chemical urinalysis (including all urine dipstick tests); and
 - (f) Providing maternity counseling.
- (10) The agency covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section as follows:
 - (a) The agency pays for either of the following, but not both:
 - (i) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). The agency provides a list of diagnoses, or conditions, or both, that the agency identifies as justification for more frequent monitoring visits; or
 - (ii) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife.
 - (b) The agency pays for both of the following:
 - (i) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and
 - (ii) Treatment of medical problems that are not related to the pregnancy. The agency pays these fees to physicians or advanced registered nurse practitioners (ARNP).
- (11) The agency covers high-risk pregnancies. The agency considers a pregnant client to have a high-risk pregnancy when the client:
 - (a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or
 - (b) Has a diagnosis of multiple births.
- (12) The agency covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.
- (13) The agency pays a facility fee for delivery services in the following settings:
 - (a) Inpatient hospital; or
 - (b) Birthing centers.
- (14) The agency pays a professional fee for delivery services in the following settings:

- (a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;
 - (b) Planned home births and birthing centers.
- (15) The agency covers hospital delivery services for an eligible client as defined in subsection (2) of this section. The agency's bundled payment for the professional fee for hospital delivery services include:
- (a) The admissions history and physical examination; and
 - (b) The management of uncomplicated labor (intrapartum care); and
 - (c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or
 - (d) Cesarean delivery of the newborn.
- (16) The agency pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.
- (17) In addition to the agency's payment for professional services in subsection (15) of this section, the agency may pay separately for services provided by any of the following professional staff:
- (a) A stand-by physician in cases of high risk delivery, or newborn resuscitation, or both;
 - (b) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;
 - (c) A physician, ARNP, or licensed midwife for newborn examination as the delivery setting allows; and
 - (d) An obstetrician, or gynecologist specialist, or both, for external cephalic version and consultation.
- (18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, the agency allows additional fees for any of the following:
- (a) High-risk vaginal delivery;
 - (b) Multiple vaginal births. The agency's typical payment covers delivery of the first child. For each subsequent child, the agency pays at fifty percent of the provider's usual and customary charge, up to the agency's maximum allowable fee; or
 - (c) High-risk cesarean section delivery.
- (19) The agency does not pay separately for any of the following:
- (a) More than one child delivered by cesarean section during a surgery. The agency's cesarean section surgery fee covers one or multiple surgical births;
 - (b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as, or part of, postpartum care.
- (20) The agency pays for an early delivery, including induction or cesarean section, before thirty-nine weeks of gestation only if medically necessary. The agency considers an early delivery to be medically necessary:
- (a) If the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation; or
 - (b) If the provider documents a clinical situation that supports medical necessity.
- (21) The agency will only pay for antepartum and postpartum professional services for an early elective delivery as defined in WAC 182-500-0030.

(22) The hospital will receive no payment for an early elective delivery as defined in WAC 182-500-0030.

(23) In addition to the services listed in subsection (10) of this section, the agency covers counseling for tobacco ((dependency))/nicotine cessation for eligible ((pregnant women through two months postpregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) ~~The agency covers smoking cessation counseling for all FFS pregnant clients except those enrolled in TAKE CHARGE, Family Planning and Alien Emergency Medical (AEM). See (g) of this subsection for limitations on prescribing pharmacotherapy for eligible clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.~~

(b) ~~The agency pays a fee to providers who include face-to-face smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). The agency pays only the following providers for face-to-face smoking cessation counseling:~~

~~(i) Physicians;~~

~~(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;~~

~~(iii) ARNPs, including certified nurse midwives (CNM);~~

~~(iv) Licensed midwives (LM);~~

~~(v) Psychologists; and~~

~~(vi) Pharmacists.~~

(c) ~~The agency covers two face-to-face smoking cessation attempts (or up to eight cessation counseling sessions) every twelve months. A smoking cessation attempt is defined as up to four cessation counseling sessions.~~

(d) ~~The agency covers one face-to-face smoking cessation counseling session per client, per day. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information in (f) of this subsection.~~

(e) ~~The agency covers face-to-face counseling for eligible pregnant clients.~~

(f) ~~Smoking cessation counseling consists of providing face-to-face information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to the agency's physician-related services provider guide for specific counseling suggestions and billing requirements):~~

~~(i) Asking the client about her smoking status;~~

~~(ii) Advising the client to stop smoking;~~

~~(iii) Assessing the client's willingness to set a quit date;~~

~~(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see (g) of this subsection); and~~

~~(v) Arranging to track the progress of the client's attempt to stop smoking.~~

(g) ~~A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. The agency covers certain pharmacotherapy for smoking cessation, including prescription drugs and over-the-counter nicotine replacement therapy, as follows:~~

~~(i) The product must meet the rebate requirements described in WAC 182-530-7500;~~

~~(ii) The product must be prescribed by a physician, ARNP, or physician assistant;~~

~~(iii) The client for whom the product is prescribed must be age eighteen or older;~~

~~(iv) The pharmacy provider must obtain prior authorization from the agency when filling the prescription for pharmacotherapy; and~~

~~(v) The prescribing provider must include both of the following on the client's prescription:~~

~~(A) The client's estimated or actual delivery date; and~~

~~(B) Indication the client is participating in smoking cessation counseling.~~

~~(h) The agency's payment for smoking cessation counseling is subject to postpay review under WAC 182-502-0230 and chapter 182-502A WAC)) clients who are pregnant or in the postpartum period as defined in 42 C.F.R. 435.170. See WAC 182-531-1720.~~