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WSR 20-17-010

RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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agency is revising these sections to update ambulance program policies, clarify existing policies and coverage, remove outdated information, update erroneous rule citations, reorganize sections for clarity, and perform other housekeeping fixes. Specifically, the agency added new definitions; updated client eligibility; added certificate requirements for air ambulance providers; clarified documentation requirements for medical necessity, clarified coverage for inpatient hospital stays; clarified payment for transport provided in another state, clarified nonemergency air payment, and added a new behavioral health section to align with integrated care.

Citation of rules affected by this order:

New: 182-546-0050, 182-546-0125, 182-546-4100, 182-546-4200, 182-546-4300

Repealed: 182-546-0001, 182-546-0505, 182-546-4000, 182-546-4600

Amended: 182-546-0100, 182-546-0150, 182-546-0200, 182-546-0250, 182-546-0300, 182-546-0400, 182-546-0425, 182-546-0450, 182-546-0500, 182-546-0510, 182-546-0515, 182-546-0520, 182-546-0525, 182-546-0545, 182-546-0600, 182-546-0700, 182-546-0800, 182-546-0900, 182-546-1000, 182-546-1500, 182-546-2500, 182-546-3000

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160, SHB 1721, Chapter 157, Laws of 2015, ESSHB 1358, Chapter 273, Laws of 2017, E3SHB 1713, Chapter 29, Laws of 2016

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 20-11-004 on May 8, 2020 (date).

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

Proposed/Adopted	WAC Subsection	Reason
WAC 182-546-0450		
Proposed	Administration of medication, not to include saline flush, by intravenous push/bolus or by continuous infusion	Medication administration to be determined by the ambulance provider.
Adopted	Administration of medication by intravenous push/bolus or by continuous infusion	

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		Repealed	

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

	New	5	Amended	22	Repealed	4

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	5	Amended	22	Repealed	4

Date Adopted: August 6, 2020	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

NEW SECTION

WAC 182-546-0050 Ambulance transportation—General. See WAC 182-546-0100 through 182-546-4300 for ambulance transportation and WAC 182-546-5000 through 182-546-6200 for brokered/nonemergency transportation.

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

WAC 182-546-0100 ((~~The MAA~~)) Ambulance transportation—Program. (1) The provisions of this chapter take precedence with respect to ambulance ((~~coverage~~)) services in cases of ambiguity in, or conflict with, other agency rules governing eligibility for ((~~medical~~)) health care services.

(2) The ((~~medical assistance administration (MAA) covers medically necessary~~)) medicaid agency covers emergency and nonemergency ambulance transportation to and from ((~~the provider of MAA covered services that is closest and most appropriate to meet the client's medical need. See WAC 388-546-0150 through 388-546-4000 for ambulance transportation and WAC 388-546-5000 through 388-546-5600 for brokered/nonemergency transportation~~)) a covered health care service, subject to the limitations and requirements in this chapter.

NEW SECTION

WAC 182-546-0125 Ambulance transportation—Definitions. The following definitions and those found in chapter 182-500 WAC apply to ambulance transportation services.

"Advanced life support (ALS)" - See RCW 18.73.030.

"Advanced life support (ALS) assessment" - Means an assessment performed by ALS trained personnel as part of an emergency response that was necessary because the client's reported conditions at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in an ambulance transport or determination that the client requires an ALS level of service or that the transport will be reimbursed at the ALS rate.

"Advanced life support, Level 1 (ALS1)" - Means the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.

"Advanced life support, Level 1 (ALS1) emergency" - Means medically necessary ALS1 services, as previously specified, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider is called, it responds immediately.

"Advanced life support, Level 2 (ALS2)" - Means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations

of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

(a) Endotracheal intubation;
(b) Cardiac pacing;
(c) Chest decompression;
(d) Creation of a surgical airway;
(e) Manual defibrillation/cardioversion;
(f) Placement of central venous line; or
(g) Placement of intraosseous line.

"Advanced life support (ALS) intervention" - Means a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician intermediate, emergency medical technician advanced, or paramedic.

"Aid vehicle" - See RCW 18.73.030.

"Air ambulance" - Means a helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service.

"Allowable costs" - For the ground emergency medical transportation (GEMT) program only, allowable costs means an expenditure that meets the test of the appropriate Executive Office of the President of the United States, Office of Management and Budget (OMB) Circular.

"Ambulance" - Means a ground vehicle or aircraft designed and used to transport the ill and injured, provide personnel, facilities, and equipment to treat clients before and during transportation, and licensed in accordance with RCW 18.73.140.

"Bariatric patient" - Means a patient whose weight, height, or width exceeds the capacity standards of a normal ambulance gurney.

"Bariatric transport unit" - Means a specially equipped ambulance designed for the transportation of bariatric patients.

"Base rate" - Means the agency's minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, waiting time, and the normal overhead costs of doing business. The base rate excludes mileage.

"Basic life support (BLS)" - Means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined in chapter 18.73 RCW. The ambulance must be staffed by a person qualified as an emergency medical technician-basic (EMT basic) according to department of health (DOH) regulations. BLS does not require the ability to provide or deliver invasive medical procedures and services.

"Basic life support (BLS) emergency" - BLS services provided in an emergency response.

"Bed-confined" - Means the client is unable to perform all of the following actions:

(a) Get up from bed without assistance;
(b) Unable to bear weight or ambulate;
(c) Sit in a chair or wheelchair.

"Behavioral health disorder" - Means mental disorders and substance use disorders.

"Bordering city hospital" - Means a licensed hospital in a designated bordering city (see WAC 182-501-0175).

"Brokered transportation" - Means nonemergency transportation arranged by a broker under contract with the agency, to or from covered health care services for an eligible client (also, see "Transportation provider" in WAC 182-546-5100).

"By report" - See WAC 182-500-0015.

"Chemical dependency professional (CDP)" - See substance use disorder professional (SUDP).

"Children's long-term inpatient program (CLIP)" - Means psychiatric residential treatment provided as a result of judicial commitment or review of the CLIP committee for children five through seventeen years of age.

"Closest and most appropriate" - The agency-contracted facility or level of care in which the expected clinical benefits (e.g., improved symptoms) outweigh the expected negative effect (e.g., adverse reactions) to such an extent that the treatment or transportation is justified. This facility may not necessarily be the closest provider based solely on driving distance.

"Conditional release" - Means a period of time the client is released from inpatient care to outpatient care, provided that the client continues to meet certain conditions according to RCW 71.05.340.

"Cost allocation plan (CAP)" - Means a document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The document also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received.

"Designated crisis responder (DCR)" - Means a behavioral health professional appointed by the county or other authority authorized in rule to perform duties specified in chapter 71.05 RCW and who has received chemical dependency training as determined by the division of behavioral health and recovery.

"Detention" or **"detain"** - Means the lawful confinement of a person, under chapter 71.05 RCW.

"Direct costs" - Means all costs identified specifically with a particular final cost objective in order to meet emergency medical transportation requirements. This includes unallocated payroll costs for personnel work shifts, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to delivering covered medical transportation services.

"Emergency medical service" - Means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting a client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

"Emergency medical transportation" - Means ambulance transportation during which a client receives necessary emergency medical services immediately prior to, or in transit to, an appropriate medical facility.

"Emergency response" - Means a BLS or ALS level of service that has been provided in immediate response to a 911 call or the equivalent.

"Evaluation and treatment facility" - See RCW 71.05.020.

"Federal financial participation (FFP)" - Means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) according to the state plan for medical assistance. Clients under Title 19, U.S. Health Resources and Services Administration (HRSA) are eligible for FFP.

"Gravely disabled" - Means a condition in which a person, as a result of a mental disorder, or as the result of the use of alcohol or other psychoactive chemicals:

(a) Is in danger of serious physical harm as a result of being unable to provide for personal health or safety; or

(b) Shows repeated and escalating loss of cognitive control over personal actions and is not receiving care essential for personal health or safety.

"Ground ambulance" - Means a ground vehicle designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation.

"Indirect costs" - Means the costs for a common or joint purpose benefiting more than one cost objective and allocated to each objective using an agency-approved indirect rate or an allocation methodology.

"Initial detention" - Means the period, up to seventy-two hours, in which a person is involuntarily placed in an evaluation and treatment facility under RCW 71.05.150 or 71.05.153 (see RCW 71.05.160). This period begins on the date and time the evaluation and treatment facility provisionally accepts the client for admission. See definition for "petition for initial detention."

"Interfacility" - Means transportation services between hospitals.

"Invasive procedure" - Means a medically necessary operative procedure in which skin or mucous membranes and connective tissues are cut or an instrument is introduced through a natural body orifice, e.g., an intubation tube. Invasive procedures include a range of procedures from minimally invasive (biopsy, excision) to extensive (organ transplantation). This does not include use of instruments for examinations or very minor procedures such as drawing blood.

"Involuntary Treatment Act (ITA)" - See chapters 71.05 and 71.34 RCW.

"Less restrictive alternative treatment" - Means a program of individualized treatment in a less restrictive setting than inpatient treatment and that includes the services described in RCW 71.05.585.

"Lift-off fee" - Means either of the two base rates the agency pays to air ambulance providers for transporting a client. The agency establishes separate lift-off fees for helicopters and airplanes.

"Loaded mileage" - Means the distance the client is transported in the ambulance.

"Medical control" - Means the medical authority upon which an ambulance provider relies to coordinate prehospital emergency services, triage, and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan, by the department of health's (DOH) contracted medical program director, of the region in which the ambulance service is provided.

"Medical attestation" - Means the medical professional is attesting to the fact that the client has a condition that justifies medical transportation and the level of care that is specified by BLS or ALS services and supplies. The condition must also be such that other means of transportation (such as taxi, bus, car, or other means) would be harmful to the client. (See WAC 182-500-0070 for additional information - Medically necessary definition.)

"Nonemergency ambulance transportation" - Means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services in transit, or the use of an air ambulance to or from an out-

of-state health care service when the out-of-state health care service and air ambulance transportation are prior authorized by the agency. Nonemergency ambulance transportation is usually scheduled or prearranged. See definitions for "prone or supine transportation."

"Parent" - For the purpose of family initiated treatment under RCW 71.34.600 through 71.34.670, means a legal guardian, a person that has been given authorization to make health care decisions for the adolescent, a kinship caregiver who is involved in caring for the adolescent, or another relative who is responsible for the health care of the adolescent who may be required to provide a declaration under penalty of perjury stating that they are a relative responsible for the health care of the adolescent under RCW 9A.72.085.

"Petition for initial detention" - A document required by the superior court of Washington for admission of the client by the evaluation and treatment facility. This form is available on the Washington state superior court mental proceedings rules web page.

"Petition for revocation of a conditional release or less restrictive treatment" - Means a document completed by a designated crisis responder (DCR).

"Point of destination" - Means a health care facility generally equipped to provide the necessary medical, nursing, or behavioral health care necessary to treat the client's injury, illness, symptoms, or complaint.

"Point of pickup" - Means the location of the client at the time the client is placed on board the ambulance or transport vehicle.

"Prehospital care" - Means an assessment, stabilization, and emergency medical care of an ill or injured client by an emergency medical technician, paramedic, or other person before the client reaches the hospital.

"Prone or supine transportation" - Means transporting a client confined to a stretcher or gurney, with or without emergency medical services being provided in transit.

"Public institution" - Means a facility that is either an organizational part of a government entity or over which a governmental unit exercises final administrative control, (e.g., city/county jails and state correctional facilities).

"Publicly owned or operated" - Means an entity that is owned or operated by a unit of government. The unit of government is a state, city, county, special purpose district, or other governmental unit in the state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in the Indian Self-Determination and Education Assistance Act, Section 4.

"Qualifying expenditure" - Means an expenditure for covered services provided to an eligible beneficiary.

"Secure withdrawal management and stabilization facility" - Means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder.

"Service period" - Means July 1st through June 30th of each Washington state fiscal year.

"Shift" - Means a standard period of time assigned for a complete cycle of work as set by each participating provider.

"Specialty care transport (SCT)" - Means interfacility (hospital-to-hospital or hospital-to-skilled nursing facility) transportation of a critically injured or ill client by a ground ambulance vehicle under

the command of ALS-trained personnel with additional training above the level of a paramedic.

"Standing order" - Means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or attending physician.

"Substance use disorder professional (SUDP)" - Means a person certified as a substance use disorder professional by the department of health (DOH) under chapter 18.205 RCW.

"Transfer-down" - Means a transfer from a higher level facility to a facility of lower or equivalent level of care, or back to the original point of pickup (e.g., referring hospital or skilled nursing facility).

"Transfer-up" - Means a transfer from one hospital to a hospital of higher level care when the transfer and discharging hospital has inadequate facilities or care, or appropriate personnel to provide the necessary medical services required by the client.

"Trip" - Means a transportation one-way from the point of pickup to the point of destination by an authorized transportation provider.

AMENDATORY SECTION (Amending WSR 18-12-091, filed 6/5/18, effective 7/6/18)

WAC 182-546-0150 Ambulance transportation—Client eligibility ((for ambulance transportation)). (1) ((~~Except for people in the Family Planning Only and TAKE CHARGE programs, fee-for-service clients are eligible for ambulance transportation to covered services with the following limitations:~~)) Clients are eligible for ambulance transportation to covered services subject to the requirements and limitations in this chapter.

(a) ((~~People~~)) Clients in the following ((~~Washington apple health~~)) programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 182-501-0175:

(i) Medical care services (MCS) as described in WAC 182-508-0005;

(ii) Alien emergency medical (AEM) services as described in ((~~chapter 182-507~~)) WAC 182-507-0115.

(b) ((~~People in the apple health~~)) Clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and ((~~apple health~~)) medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 182-546-0400((~~(5)~~)) (4).

(2) ((~~People enrolled in an agency-contracted managed care organization (MCO) must coordinate:~~

~~(a) Ground ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter; and~~

~~(b) Air ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter.~~

~~(3) People~~)) Clients enrolled in the agency's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with the agency's requirements. The agency pays for covered services for these ((~~people~~)) clients according to the agency's published

billing guides ((~~and provider alerts~~)) including, but not limited to, the *Tribal Health Billing Guide*.

((~~(4)~~)) (3) People under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to people who are being detained involuntarily for ((~~mental~~)) behavioral health treatment and being transported to or from bordering cities. See ((~~also WAC 182-546-4000~~)) WAC 182-546-4100 through 182-546-4300.

((~~(5)~~)) (4) See WAC 182-546-0800 and 182-546-2500 for additional limitations on out-of-state coverage and coverage for ((~~people~~)) clients with other insurance.

((~~(6)~~)) (5) The agency does not pay for ambulance services for ((~~jail inmates and people~~)) persons living in ((~~a~~)) public institutions, correctional ((~~facility~~)) facilities, and local jails, including people in work-release status with the following exceptions:

(a) If an incarcerated person is put on a legal ITA hold, the ITA eligibility supersedes the incarcerated status;

(b) If an incarcerated person is admitted to an inpatient care facility (not the emergency department), and must be transported to a second inpatient care facility to obtain the services needed. See WAC 182-503-0505(5).

(6) Clients in family planning only programs are not eligible for ambulance transportation services.

AMENDATORY SECTION (Amending WSR 19-19-090, filed 9/18/19, effective 10/19/19)

WAC 182-546-0200 Ambulance transportation—Scope of coverage ((~~for ambulance transportation~~)). (1) The ambulance program is a medical transportation service. The medicaid agency pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see WAC 182-501-0060);

(b) Medically necessary as defined in WAC ((~~182-500-0005~~)) 182-500-0070 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The ((~~nearest~~)) closest and most appropriate agency-contracted medical provider of agency-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) The agency limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ((~~ambulance service is not covered by the~~)) agency does not cover the ambulance service. See WAC 182-546-0250 (1) and (2) for noncovered ambulance services.

(3) If medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambu-

lance trip due to a lack of medical necessity, the agency requires the provider when billing the agency for that trip to:

(a) ((~~Report~~)) Attach the third-party determination ((~~on~~)) to the claim; and

(b) Submit documentation showing that the trip meets the agency's medical necessity criteria ((~~of the agency~~)). See WAC 182-546-1000 and 182-546-1500 for requirements for nonemergency ambulance coverage.

(4) The agency covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when the agency determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the agency must prior authorize the air ambulance transportation ((~~must be prior authorized by the agency~~)). See WAC 182-546-1500 for nonemergency air ambulance coverage.

(5) See also WAC 182-531-1740 Treat and refer services.

AMENDATORY SECTION (Amending WSR 19-19-090, filed 9/18/19, effective 10/19/19)

WAC 182-546-0250 Ambulance transportation—Noncovered services ((~~the agency does not cover~~)). (1) The medicaid agency does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 182-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC ((~~182-546-4000(2)~~)) 182-546-4100 through 182-546-4300);

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC 182-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the agency does not cover the ambulance service, except as provided in WAC 182-546-0500(2) and 182-531-1740 Treat and refer services.

(3) The agency evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The agency approves such requests when medically necessary, according to the provisions of WAC 182-501-0165 and 182-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 182-502-0160 are met.

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

WAC 182-546-0300 Ambulance transportation—General requirements for ambulance providers. (1) Ambulances must be licensed, operated, and equipped according to applicable federal, state, and local statutes, ordinances and regulations. An air ambulance provider must have a current Federal Aviation Administration (FAA) air carrier operating certificate, or have a contractual relationship with an operator with a valid medical certificate.

(2) Ambulances must be staffed and operated by appropriately trained and certified personnel((~~. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and 18.73.170.~~

~~(3) The medical assistance administration (MAA) requires providers of ambulance services to document medical justification for transportation and related services billed to MAA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of the transportation. MAA may review the client record to ensure MAA's~~)) in accordance with chapter 18.73 RCW.

(3) Providers of ambulance services must:

(a) Meet the requirements of chapter 182-502 WAC and this chapter; and

(b) Document the medical necessity for transportation and related services billed to the medicaid agency. This documentation must be kept in the provider's file and include adequate descriptions of the severity and complexity of the client's condition at the time of the transportation and services, interventions, and supplies provided to the client prior to loading and in transit. The documentation must be made available for the agency to review upon request to ensure the agency's medical necessity criteria ((~~were~~)) are met.

AMENDATORY SECTION (Amending WSR 19-19-090, filed 9/18/19, effective 10/19/19)

WAC 182-546-0400 Ambulance transportation—General limitations on payment for ambulance services. (1) In accordance with WAC

182-502-0100(8), the agency pays providers the lesser of the provider's usual and customary charges or the maximum allowable rate established by the agency. The agency's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) ((~~The agency:~~

~~(a) Pays providers under fee-for-service for ground ambulance services provided to a client who is enrolled in an agency-contracted managed care organization (MCO).~~

~~(b) Pays providers under fee-for-service for air ambulance services provided to a client who is enrolled in an agency-contracted MCO.~~

~~(3)~~)) The agency does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. The agency pays for loaded mileage only as follows:

(a) The agency pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) The agency pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

((~~(4)~~)) (3) The agency does not pay for ambulance services if:

(a) The client is not transported, unless the services are provided under WAC 182-531-1740 Treat and refer services;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 182-546-0500(2)).

((~~(5)~~)) (4) For clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs, the agency's payment is as follows:

(a) If medicare covers the service, the agency pays the lesser of:

(i) The full coinsurance and deductible amounts due, based upon medicaid's allowed amount; or

(ii) The agency's maximum allowable for that service minus the amount paid by medicare.

(b) If medicare does not cover or denies ambulance services that the agency covers according to this chapter, the agency pays its maximum allowable fee; except the agency does not pay for clients on the qualified medicare beneficiaries (QMB) only program.

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

WAC 182-546-0425 Ambulance ((~~coverage~~)) transportation—During inpatient hospital((s)) stays. (1) The ((~~medical assistance administration (MAA)~~)) medicaid agency does not ((~~cover~~)) pay separately for ambulance transportation ((~~services under fee-for-service~~)) when a client remains as an inpatient client ((~~in a~~)) at the admitting hospital and the transportation to ((~~and/or~~)) or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such services is the

responsibility of the admitting hospital, ((~~whether MAA pays the hospital under the diagnosis-related group (DRG) or ratio of costs-to-charges (RCC) method~~)) regardless of the payment method the agency uses to pay the hospital.

(2) **Hospital-to-hospital transfers.** Except as provided in subsections (3) and (5) of this section, ((~~MAA~~)) the agency does not ((~~cover hospital to hospital~~)) pay for hospital-to-hospital transfers of ((~~clients under fee-for-service~~)) a client when ambulance transportation is requested solely to:

(a) Accommodate a physician's or other health care provider's preference for facilities;

(b) Move the client closer to family or home (i.e., for personal or family convenience); or

(c) Meet insurance requirements or hospital/insurance agreements.

(3) ((~~MAA covers under fee-for-service~~)) **Transfer-up services.** The agency pays for transfer-up ambulance transportation ((~~for a client being transferred from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required by the client. MAA covers~~)) services as follows:

(a) Air ambulance transportation ((~~for hospital transfers only if~~)) only when transportation by ground ambulance would cause sufficient delay as to endanger the client's life or ((~~health~~)) substantially impair the client's health (e.g., in major trauma cases).

(b) Air ambulance transportation for medical and surgical procedures only and not for diagnostic purposes.

(c) The reason for ((~~transferring a client from one hospital to another, as well as the need for air ambulance transport, if applicable,~~)) the transfer-up must be clearly documented in the client's hospital chart and in the ambulance trip report.

(4) ((~~MAA does not cover under fee-for-service ambulance transportation for a client being transferred from a hospital providing a higher level of care to a hospital providing a lower level of care, except as allowed under subsection (5) of this section.~~

~~(5) MAA considers requests for fee-for-service ambulance coverage under the provisions of WAC 388-501-0160 (exception to rule) for transportation of a client from an intervening hospital to the discharging hospital. MAA evaluates such requests based on clinical considerations and cost-effectiveness. MAA's decision under the provisions of WAC 388-501-0160 is final. The reason for transferring a client from a hospital to another medical facility must be clearly documented in the client's hospital chart and in the ambulance trip record.~~

~~(6)~~)) **Transfer-down services.** The agency pays for ground ambulance transfer-down services with a signed physician certification statement (PCS) or a nonphysician certification statement (NPCS).

(5) **Specialty care transport (SCT)** ((~~is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. MAA~~)). The agency pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport, provided:

(a) The criteria for covered hospital transfers ((~~under fee-for-service~~)) are met; and

(b) ((~~There is a written reimbursement agreement between the ambulance provider and SCT personnel. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, MAA~~

~~pays the provider at the basic life support (BLS) rate.~~)) The SCT is from an acute care hospital to another acute care hospital.

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

WAC 182-546-0450 ((~~Payment for~~)) Ambulance transportation—Ground ambulance ((~~services~~))—Payment. (1) The ((~~medical assistance administration (MAA)~~)) medicaid agency pays for two levels of service for ground ambulance transportation: Basic life support (BLS) and advanced life support (ALS):

(a) A BLS ambulance trip is one in which the client ((~~requires and~~)) receives basic, noninvasive medical services at the scene ((~~and/or en route from the scene of the acute and emergent illness or injury~~)), point-of-pickup, or in transit to a hospital or other appropriate treatment facility. ((~~Examples of basic medical services are: Controlling bleeding, splinting fracture(s), treating for shock, and performing cardiopulmonary resuscitation (CPR).~~))

(b) An ALS ambulance trip is one in which the client requires ((~~and receives~~)) more complex life-saving services at the scene ((~~and/or en route from the scene of the acute and emergent illness or injury~~)), point-of-pickup, or in transit to a hospital or other appropriate treatment facility. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel ((~~on-board~~)) must provide the advanced medical services ((~~in~~)) on board a properly equipped vehicle as defined by chapter ((~~18.83~~)) 18.73 RCW. Examples of complex medical services or ALS procedures ((~~are~~)) include, but are not limited to, the following:

(i) Administration of medication by intravenous push/bolus or by continuous infusion;
(ii) Airway intubation;
(iii) Cardiac pacing;
(iv) Chemical restraint;
(v) Chest decompression;
(vi) Creation of surgical airway;
(vii) Initiation of intravenous therapy;
(viii) Manual defibrillation/cardioversion;
(ix) Placement of central venous line; and
(x) Placement of intraosseous line.

(2) ((~~MAA~~)) The agency pays for ambulance services (BLS or ALS) based on the client's ((~~actual~~)) medical condition and the ((~~level of~~)) medical services ((~~needed and~~)) provided immediately prior to or during the trip.

(a) Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify ((~~a~~)) an ambulance trip for ((~~MAA~~)) the agency's payment at the ALS level of service unless ALS services were provided on-scene or in transit to the treatment facility.

(b) A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided ((~~en route~~)) on-scene or in transit to the treatment facility.

(c) An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client ((~~en route~~)) in transit to the treatment facility.

(3) ((~~MAA's base rate includes: Necessary personnel and services; oxygen and oxygen administration; intravenous supplies and IV administration reusable supplies, disposable supplies, required equipment, and waiting time. MAA does not pay separately for chargeable items/services that are provided to the client based on standing orders.~~

~~(4) MAA pays ground ambulance providers the same mileage rate, regardless of the level of service. Ground ambulance mileage is paid when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.~~

~~(5) MAA pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. Acceptable reasons for allowable extra mileage include, but are not limited to:~~

~~(a) A hospital was on "divert" status and not accepting patients; or~~

~~(b) A construction site caused a detour, or had to be avoided to save time.~~

~~(6) When multiple ambulance providers respond to an emergency call, MAA pays only the ambulance provider that actually furnishes the transportation.~~

~~(7) MAA pays for an extra attendant, when the ground ambulance provider documents in the client's file the justification for the extra attendant, and that the extra attendant is on-board for the trip because of one or more of the following:~~

~~(a) The client weighs three hundred pounds or more;~~

~~(b) The client is violent or difficult to move safely;~~

~~(c) The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained during the trip; or~~

~~(d) More than one client is being transported, and each requires medical attention and/or close monitoring.~~

~~(8) MAA pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting MAA clients. To be paid, providers must document the toll(s) by attaching the receipt(s) for the toll(s) to the claim.~~)) An assessment and other intervention performed on-scene with no resulting transport does not qualify for payment from the agency, except when the client dies after treatment but before transport as provided in WAC 182-546-0500(2).

(4) The agency pays ground ambulance providers for mileage as follows:

(a) Loaded mileage only.

(b) Actual mileage incurred for covered trips (i.e., from the point-of-pickup to the destination) based on trip odometer readings.

(i) The agency uses the Washington state department of transportation's (WSDOT) mileage chart. The WSDOT mileage chart indicates shortest distance between points, including the use of the ferry system.

(ii) The agency uses alternative sources to calculate distance traveling when the origin or destination points are not listed in the WSDOT's mileage chart.

(iii) If the ferry system is the normal route for travel but is not used, the reason must be documented on the claim form when billing the agency. In this case, normal means the shortest route.

(iv) Miles traveled by the ferry. To be paid, providers must report by statute miles using the Washington state department of transportation (WSDOT) ferry route mileage chart located on the WSDOT website. Providers must thoroughly document the ferry route used, including a copy of the ferry ticket.

(5) The agency's base rate includes:

(a) Necessary personnel and services;

(b) Oxygen and oxygen administration; and

(c) Intravenous supplies and intravenous administration reusable supplies, disposable supplies, required equipment, and waiting time.

(6) The agency pays ground ambulance providers the same rate for mileage, regardless of the level of service (ALS or BLS). An odometer reading showing a fraction of a mile (partial mile) at the conclusion of a transport must be rounded up to the next whole unit (one mile). The agency pays for mileage when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

(7) The agency pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. All records are subject to agency review. Acceptable reasons for allowable extra mileage include, but are not limited to:

(a) The initial destination hospital was on "divert" status and not accepting patients; or

(b) A road construction project or other major obstacle caused a detour, or had to be avoided to save time.

(8) When multiple ambulance providers respond to an emergency call, the agency pays only the ambulance provider who actually provides the transportation.

(9) The agency pays for an extra attendant when the ground ambulance provider documents in the client's file the justification for the extra attendant and the extra attendant is on board for the trip because of one or more of the following:

(a) The client weighs three hundred pounds or more;

(b) The client is violent or difficult to move safely;

(c) The client is being transported for ITA purposes and the client must be restrained during the trip; or

(d) More than one client is being transported, and each requires medical attention or close monitoring.

(10) The agency pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting clients. Receipts must be attached to the claim submission for reimbursement. All ferry and bridge toll documentation must be kept in the client's file and made available to the agency for six years from the date of service in accordance with WAC 182-502-0020.

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

WAC 182-546-0500 Ambulance transportation—Ground ambulance—Payment ((~~for ground ambulance services~~)) in special circumstances. (1) When more than one client is transported in the same ground ambulance at the same time, the ((~~provider must bill the medical assistance administration (MAA)~~)) medicaid agency:

(a) Pays the ambulance providers at a reduced base rate for the ((~~additional~~)) second client((~~, and~~)) who is being transported in the ambulance for medical treatment. This rate is set at seventy-five percent of the base rate for the applicable level of service (ALS or BLS) for the first client;

(b) ((~~No mileage charge for the additional client.~~)) Does not pay the ambulance provider a separate mileage charge for the second client being transported in the ambulance for medical treatment. The total payable mileage for the transport is from the first point of pickup.

(2) ((~~MAA~~)) The agency pays an ambulance provider at the appropriate base rate (BLS or ALS) if no transportation takes place because the client died ((~~at the scene of the illness or injury but~~)) before transport could occur but after the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. ((~~See WAC 388-546-0450(1) for examples of medical interventions associated with each base rate.~~)) The intervention(s)/supplies provided must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies ((~~at the scene of the illness or injury~~)) after medical interventions/supplies are provided but before transport takes place.

(3) In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets ((~~MAA's~~)) the agency's fee schedule definition of an ALS intervention, the BLS provider may bill ((~~MAA~~)) the agency the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists. The provider must give ((~~MAA~~)) the agency a copy of the agreement upon request. If ((~~there is no~~)) a written agreement does not exist between the BLS and ALS entities, ((~~MAA~~)) the agency will pay only for the BLS level of service. Only one ambulance provider may bill the agency for the transport.

(4) In ((~~areas~~)) ambulance service areas/jurisdictions that distinguish between residents and nonresidents, ((~~MAA must be billed~~)) the provider must bill the agency the same rate for ambulance services provided to a client in a particular jurisdiction as would be billed ((~~by that provider to the general public in~~)) for ambulance services to residents of the same jurisdiction.

AMENDATORY SECTION (Amending WSR 19-08-058, filed 3/29/19, effective 5/1/19)

WAC 182-546-0510 GEMT program overview. (1) The ground emergency medical transportation (GEMT) program permits publicly owned or operated providers to receive cost-based payments for emergency ground

ambulance transportation of ((~~medicaid fee-for-service~~)) clients as described in subsection (2) of this section.

(2) This program is for clients under Title XIX of the federal Social Security Act and the Affordable Care Act (ACA) only. Participating providers do not receive supplemental payments for transporting:

(a) Medicaid applicants; or

(b) Medicare/medicaid ((~~recipients~~)) clients with dual eligibility.

(3) The cost-based payment, when combined with the amount received from all other sources of reimbursement for medicaid, must not exceed one hundred percent of allowable costs.

(4) Fire departments/districts must use the approved CAP of their local government. If the local government does not have a CAP, they must use the Centers for Medicare and Medicaid Services (CMS)-approved cost report.

(5) The state general fund cannot be used for GEMT cost-based payments.

AMENDATORY SECTION (Amending WSR 19-08-058, filed 3/29/19, effective 5/1/19)

WAC 182-546-0515 GEMT provider participation and qualifications. (1) Participation in the program by a GEMT provider is voluntary.

(2) To qualify under this program and receive supplemental payments, a participating provider must:

(a) Provide ground emergency transportation services to ((~~medicaid fee-for-service~~)) clients as described in WAC 182-546-0510(2).

(b) Be publicly owned or operated as defined in WAC ((~~182-546-0505~~)) 182-546-0125.

(c) Be enrolled as a medicaid provider, with an ((~~active~~)) approved core provider agreement, for the service period specified in the claim.

(d) Submit a participation agreement.

(e) Renew GEMT participation annually by submitting ((~~a participation agreement and~~)) the Centers for Medicare and Medicaid Services (CMS)-approved cost report to the agency.

AMENDATORY SECTION (Amending WSR 19-08-058, filed 3/29/19, effective 5/1/19)

WAC 182-546-0520 GEMT supplemental payments. (1) The agency makes supplemental payments for the uncompensated and allowable costs incurred while providing GEMT services to ((~~medicaid fee-for-service~~)) clients, as defined by the United States Office of Management and Budget (OMB).

(a) The amount of supplemental payments, when combined with the amount received from all other sources of reimbursement from the medicaid program, will not exceed one hundred percent of allowable costs.

(b) If the participating provider does not have any uncompensated care costs, then the participating provider will not receive payment under this program.

(2) The total payment is equal to the participating provider's allowable costs of providing the services.

(a) The participating provider must certify the uncompensated expenses using the cost reporting process described under WAC 182-546-0525. This cost reporting process allows medicaid to obtain federal matching dollars to be distributed to participating providers.

(b) The participating provider must:

(i) Include the expenditure in its budget.

(ii) Certify that the claimed expenditures for the GEMT services are eligible for FFP and that the costs were allocated to the appropriate cost objective according to the cost allocation plan.

(iii) Provide evidence, specified by the agency, supporting the certification.

(iv) Submit data, specified by the agency, determining the appropriate amounts to claim as expenditures qualifying for FFP.

AMENDATORY SECTION (Amending WSR 19-08-058, filed 3/29/19, effective 5/1/19)

WAC 182-546-0525 GEMT claim submission and cost reporting. (1) Each participating provider is responsible for submitting claims to the agency for services provided to eligible clients. Participating providers must submit the claims according to the rules and billing instructions in effect at the time the service is provided.

(2) On an annual basis, participating providers must certify and allocate their direct and indirect costs as qualifying expenditures eligible for FFP.

(3) The claimed costs must be necessary to carry out GEMT.

(4) Participating providers must complete cost reporting according to the Centers for Medicare and Medicaid Services (CMS)-approved cost identification principles and standards such as the most current editions of the CMS *Provider Reimbursement Manual* and the United States Office of Management and Budget Circular (OMB) Circular A-87.

(5) Participating providers must completely and accurately document the CMS-approved cost report as required under OMB Circular A-87 Attachment A.

(6) Participating providers must allocate direct and indirect costs to the appropriate cost objectives as indicated in the cost report instructions.

(7) Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to ground emergency ambulance services provided. Services do not include fire suppression.

(8) Revenues received directly, such as foundation grants and money from private fund-raising, are not eligible for certification because such revenues are not expenditures of a government entity.

(9) The sum of a participating provider's allowable direct and indirect costs are divided by the number of ground emergency medical transports to determine a participating provider's average cost per qualifying transport.

(10) Participating providers must complete an annual cost report documenting the participating provider's total CMS-approved, ((~~medic-~~

~~aid-allowable,~~)) direct and indirect costs of delivering medicaid-covered services using a CMS-approved cost-allocation methodology. Participating providers must:

(a) Submit the cost report within five months after the close of the service period.

(b) Request an extension to the cost report deadline in writing to the agency, if needed. The agency will review requests for an extension on a case-by-case basis.

(c) Provide additional documentation justifying the information in the cost report, upon request by the agency.

(d) Assure the agency receives the cost report or additional documentation according to WAC 182-502-0020.

(i) Participating providers must comply with WAC 182-502-0020 to receive the supplemental payment under this program.

(ii) The agency pays the claims for the following service period according to the agency's current ambulance fee schedule.

(11) The costs associated with releasing a client on the scene without transportation by ambulance to a medical facility are eligible for FFP and are eligible expenditures.

(12) Other expenses associated with the prehospital care are eligible costs associated with GEMT.

(13) Expenditures are not eligible costs until the services are provided.

AMENDATORY SECTION (Amending WSR 19-08-058, filed 3/29/19, effective 5/1/19)

WAC 182-546-0545 GEMT auditing. (1) ((~~Participating providers must follow the terms and conditions outlined in the agency's core provider agreement.~~

~~(2)~~)) The agency may conduct audit or investigation activities, as described under chapters 74.09 RCW and 182-502A WAC, to determine compliance with the rules and regulations of the core provider agreement, as well as of the GEMT program.

((~~(3)~~)) (2) If an audit or investigation is initiated, the participating provider must retain all original records and supporting documentation until the audit or investigation is completed and all issues are resolved, even if the period of retention extends beyond the required six-year period required under WAC 182-502-0020.

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

WAC 182-546-0600 Ambulance transportation—Procedure code modifiers. When billing the medicaid agency for ambulance trips, ambulance providers must use procedure code modifiers ((~~published by MAA when billing MAA for ambulance trips. The appropriate modifiers must be used for all services related to the same trip for the same client~~)).

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

WAC 182-546-0700 Ambulance transportation—Air ambulance—Payment ((limitations for air ambulance services)). (1) ((~~MAA~~)) The medicaid agency pays for air ambulance ((~~services only when all of the following apply:~~

~~(a) The necessary medical treatment is not available locally or the client's point of pick up is not accessible by ground ambulance;~~

~~(b) The vehicle and crew meet the provider requirements in WAC 388-546-0300 and 388-546-0800;~~

~~(c) The client's destination is an acute care hospital; and~~

~~(d) The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance; or~~

~~(e) The client's physical or medical condition is such that traveling on a commercial flight is not safe.~~

~~(2) MAA pays providers for one lift-off fee per client, per trip.~~

~~(3) Air mileage is based on loaded miles flown, as expressed in statute miles.~~

~~(4) Except as provided in WAC 388-546-0800(6), MAA pays for extra air mileage with sufficient justification. The reason for the added mileage must be documented in the client's record and the ambulance trip report. Acceptable reasons include, but are not limited to:~~

~~(a) Having to avoid a "no fly zone"; or~~

~~(b) Being forced to land at an alternate destination due to severe weather.~~

~~(5) MAA pays a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number of clients transported and bill MAA for the mileage portion attributable to each eligible client.~~

~~(6) If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, MAA limits its payment as follows:~~

~~(a) If air ambulance is used and the trip involves more than one lift off, MAA pays only one lift-off fee per client and the total of air miles. If an air ambulance transport for the same client involves both rotary and fixed wing aircraft, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.~~

~~(b) If both air and ground ambulances are used, MAA pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided in WAC 388-546-0800(6).~~

~~(7) MAA does not pay separately for individual services or an extra attendant for air ambulance transportation. MAA's lift-off fee and mileage payment includes all personnel, services, supplies, and equipment related to the transport.~~

~~(8) MAA does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has MAA's prior authorization for the transportation services and fees. If authorized, MAA's payment is based on the actual cost to provide the~~

~~service or at MAA's established rates, whichever is lower. MAA does not pay separately for items or services that MAA includes in the established rate(s).~~

~~(9) If MAA determines, upon review, that an air ambulance trip was not:~~

~~(a) Medically necessary, MAA may deny or recoup its payment and/or limit payment based on MAA's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or~~

~~(b) To the nearest available and appropriate hospital, MAA may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.~~

~~(10) Providers must have prior authorization from MAA for any nonemergency air transportation, whether by air ambulance or other mode of air transportation. Nonemergency air transportation includes scheduled transports to or from out-of-state treatment facilities.~~

~~(11) MAA uses commercial airline companies (i.e., MAA does not authorize air ambulance transports) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.~~

~~(12) MAA does not pay for air ambulance services if no transportation is provided.~~)) transportation for clients only when all of the following conditions are met:

(a) The client's medical condition requires immediate and rapid transportation beyond what ground ambulance can provide;

(b) The client's destination is an acute care hospital or appropriate trauma designated facility; and

(c) The vehicle and crew meet the requirements in WAC 182-502-0016 and this chapter.

(2) Other factors the agency may consider in payment decisions for air ambulance include:

(a) The point-of-pickup is not accessible by ground ambulance (e.g., mountain rescue);

(b) The necessary medical care is not available locally and time is of the essence; and

(c) The use of other means of air travel (e.g., commercial flight) is medically contraindicated.

(3) **Lift-off fee.** The agency pays a lift-off fee for each client being transported by air ambulance to an acute care facility for medical treatment.

(a) When more than one client is transported in the same ambulance at the same time, each client must meet medical necessity criteria for the provider to receive a lift-off fee for each client transported.

(b) The agency does not pay a lift-off fee:

(i) For a client onboard an air ambulance when the client is not being transported for medical treatment (e.g., a mother accompanying a child to the hospital).

(ii) When the air ambulance is dispatched in response to a call but the client is not transported by the aircraft.

(4) **Statute miles.** The agency pays an air ambulance provider for statute miles incurred for covered trips by paying from the client's point-of-pickup to the point of destination.

(a) When more than one client requiring medical treatment is transported in the same air ambulance at the same time, the ambulance provider must divide the statute miles traveled by the number of cli-

ents being transported for medical treatment and bill the agency the mileage portion attributable to each client.

(b) The agency does not pay for mileage for a client who is traveling in an air ambulance but is not being transported for medical treatment (e.g., a mother accompanying a child to the hospital). Only the statute miles directly associated with the client transported for treatment may be billed to the agency.

(5) **Extra mileage.** The agency does not pay for extra mileage incurred during an air ambulance transport, except in an unusual circumstance. The unusual circumstance must be clearly described and documented in the ambulance trip report and the client's file. The exception for an unusual circumstance does not apply to nonemergency air transports that are prior authorized by the agency. Unusual circumstances for incurring additional air miles include, but are not limited to:

(a) Having to avoid a no fly zone;

(b) Being forced to land at an alternate destination due to severe weather; and

(c) Being diverted to another designated trauma facility.

(6) **Lift-off fee plus mileage.** The agency's payment for an air ambulance transport (lift-off fee plus mileage) includes all necessary personnel, services, supplies, and equipment. The agency does not make separate payment to air ambulance providers for unbundled services (e.g., pediatric ventilators).

(7) **More than one travel segment.** When an ambulance transport requires more than one travel segment (leg) to complete, the agency limits its payment for the transport as follows:

(a) If a fixed-wing aircraft is used and the transport involves more than one lift-off for the same client on the same trip (e.g., transportation from Spokane to Portland, but the aircraft makes a stop in the Tri-Cities), the agency pays the air ambulance provider for one lift-off fee for the client and the total air miles.

(b) For nonemergency air ambulance transports that are prior authorized by the agency, the negotiated rate includes both air and ground ambulance services, unless the agency's authorization letter specifically allows for ground ambulance services to be billed separately.

(8) **Nonemergency air transportation – Prior authorization and negotiated rate.** Nonemergency air ambulance transportation must be prior authorized by the agency.

(a) Nonemergency air ambulance transportation includes scheduled transports to or from out-of-state treatment facilities (see WAC 182-546-1500).

(b) Nonemergency air ambulance transportation that is prior authorized by the agency are paid a negotiated rate. The negotiated rate is an all-inclusive rate and may include transportation for a legally responsible family member or legal guardian accompanying the client being transported for medical treatment.

(9) The agency does not pay:

(a) For food, lodging, and other expenses of air ambulance personnel when a scheduled transport is delayed because of changes in the medical status of the client to be transported, weather conditions, or other factors;

(b) For fuel, maintenance and other aircraft-related expenses resulting from transportation delays because of changes in the medical status of the client to be transported, weather conditions, or other factors;

(c) Separately for ground ambulance services to and from airports and treatment facilities when these transportation services are specifically included in the negotiated air ambulance rate; and

(d) For canceled air ambulance transports, for any reason.

(10) The agency does not pay private organizations for volunteer medical air ambulance transportation services unless no other air ambulance option is available. The use of private, volunteer air transportation must be prior authorized by the agency to be payable. If authorized by the agency, the agency's payment for the transport is the lesser of:

(a) The provider's actual incurred and documented cost (e.g., fuel); or

(b) The agency's established rate (fee schedule).

(11) If the agency determines, upon review, that an air ambulance transport was not:

(a) Medically necessary, the agency may deny, recoup, or limit its payment to the amount the agency would have paid to a ground ambulance provider for the same distance traveled; or

(b) To the closest, most appropriate agency-contracted hospital, the agency may deny, recoup, or limit its payment to the maximum amount it would have paid an air ambulance provider for a transport to the nearest, most appropriate agency-contracted facility.

(12) The agency uses commercial airline companies whenever the client's medical condition permits the client to be transported safely by nonmedical or scheduled carriers.

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

WAC 182-546-0800 Ambulance transportation—Provided in another state or U.S. territory—Payment ((~~for ambulance services provided in another state or U.S. territory~~)). (1) The ((~~department~~)) medicaid agency pays for emergency ambulance transportation provided to ((~~eligible Washington state fee-for-service medical assistance~~)) clients who are in another state or U.S. territory ((~~when the emergency medical situation occurs~~)) according to the provisions of WAC ((~~388-501-0180, 388-501-0182, and 388-502-0120~~)) 182-501-0180, 182-501-0182, and 182-502-0120.

(2) To receive payment from the ((~~department~~)) agency, an out-of-state ambulance provider must:

(a) Meet the licensing requirements for Washington state and of the ambulance provider's home state or province; ((~~and~~))

(b) Have ((~~a signed~~)) an approved core provider agreement with the ((~~department~~)) agency.

(3) The ((~~department~~)) agency pays for emergency ambulance transportation provided out-of-state for ((~~an~~)) eligible ((~~Washington state medical assistance client under fee-for-service~~)) clients when the transport is:

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

(b) Medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070; and

(c) To the ((~~nearest~~)) closest, most appropriate treatment facility.

(4) The ((~~department~~)) agency does not pay for an ambulance transport provided in another state for a ((~~fee-for-service Washington state medical assistance~~)) client when:

(a) The client's medical eligibility program covers ((~~medical~~)) health care services within Washington state ((~~and/or~~)) or designated bordering cities only. See WAC ((~~388-546-0150 and 388-546-0200(5)~~)) 182-546-0150 and 182-546-0200(5);

(b) The ((~~ambulance~~)) transport was ((~~nonemergent~~)) nonemergency and was not prior authorized by the ((~~department~~)) agency.

(5) The ((~~department~~)) agency pays for emergency ambulance transportation at the lower of:

(a) The provider's billed amount; or

(b) The rate established by the ((~~department~~)) agency.

(6) ((~~To receive payment from the department for a nonemergency transport, an ambulance provider, who transports a Washington state medical assistance client to a facility that is out of state or brings a client into the state from a location that is out of state, must obtain prior authorization from the department.~~

~~(7) The department pays a negotiated rate for a medically necessary nonemergency interstate ambulance transport that the department has prior authorized. The ambulance provider is responsible for ensuring that all medical services necessary for the client's safety during the transport are available on-board the vehicle or aircraft. The contractual amount for a nonemergency air ambulance transport may include:~~

~~(a) The cost of medically necessary ground ambulance transport from the discharging facility to the point-of-pickup (airstrip); and~~

~~(b) The cost of medically necessary ground ambulance transport from the landing point (airstrip) to the receiving facility.~~

~~(8) The department does not pay to transport clients under the Involuntary Treatment Act (ITA) program to or from locations outside the state of Washington. For ITA purposes, transports to or from designated bordering cities are not covered. See WAC 388-546-4000.~~

~~(9) The department requires out-of-state ground ambulance providers who transport a Washington state medical assistance client into, within, or outside the state of Washington, to comply with RCW 18.73.180 regarding stretcher transportation.~~)) The agency does not pay for nonemergency (ground or air ambulance) transportation outside the state of Washington (i.e., both origin and destination points are outside the state's borders).

(7) An ambulance provider who transports a client to a facility outside the state (excluding designated bordering cities) or brings a client into the state from a location outside the state (excluding designated border cities) must obtain prior authorization from the agency for a nonemergency transport in order to be paid. See WAC 182-546-4000 for transports under the ITA.

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

WAC 182-546-0900 Ambulance ((~~coverage in Canada, Mexico, and other countries~~)) transportation—Provided outside the United States and U.S. territories—Payment. The ((~~department~~)) medicaid agency

does not ((~~cover~~)) pay for ambulance transportation for eligible ((~~medical assistance~~)) clients traveling outside of the United States and U.S. territories. See WAC ((~~388-501-0184~~)) 182-501-0184 for ambulance coverage in British Columbia, Canada.

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

WAC 182-546-1000 ((~~Coverage for nonemergency ground~~)) Ambulance transportation—Nonemergency ground—Payment. ((~~(1) The medical assistance administration (MAA) pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:~~

~~(a) The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or~~

~~(b) The client's medical condition requires that he or she have basic ambulance level medical attention available during transportation, regardless of bed confinement.~~

~~(2) MAA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation as follows:~~

~~(a) For nonemergency, scheduled ambulance services that are repetitive in nature, the ambulance provider must obtain a written physician certification statement (PCS) from the client's attending physician certifying that the ambulance services are medically necessary. The PCS must specify the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services. The PCS must be dated no earlier than sixty days before the first date of service. A PCS for repetitive, nonemergency ambulance services is valid for sixty days as long as the client's medical condition does not improve. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.~~

~~(b) For nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider must obtain from the client's attending physician a signed PCS within forty-eight hours after the transport. The PCS must certify that the ambulance services are medically necessary.~~

~~(c) If the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed certificate of medical necessity form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has personal knowledge of the client's medical condition at the time the ambulance service was furnished. In lieu of the attending physician, one of the following may sign the certification form: a physician assistant, a nurse practitioner, a registered nurse, a clinical nurse specialist, or a hospital discharge planner. The signed certificate must be obtained from the alternate provider no later than twenty-one calendar days from the date of service.~~

~~(d) If, after twenty-one days, the ambulance provider is unable to obtain the signed PCS from the attending physician or alternate provider for nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider may submit a claim to MAA, as long as the provider is able to show acceptable documentation of the attempts to obtain the PCS.~~

~~(e) In addition to the signed certification statement of medical necessity, all other program criteria must be met in order for MAA to pay for the service.~~

~~(3) Ground ambulance providers may choose to enter into contracts with MAA's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs MAA would incur under subsection (1) of this section.~~)) (1) The medicaid agency pays for nonemergency ground ambulance transportation when a client is transferred to a higher level facility, or when all of the following requirements are met:

(a) The ambulance transportation is medically necessary. See subsection (3) of this section for documentation requirements.

(b) The agency pays for nonemergency ground ambulance transportation with a completed PCS or NPCS form.

(i) All requests for nonemergency transports must be directed to the client's primary or attending physician or health care team who will complete the physician certification statement (PCS) form or nonphysician certification statement (NPCS) form. See subsection (3) of this section. The PCS/NPCS form or medical documentation must be maintained in the client's file.

(ii) In the event that the provider is unable to obtain the PCS or NPCS, the provider must maintain evidence of the attempts to obtain the PCS or NPCS in the client's file.

(2) The agency pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

(a) The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or

(b) The client's medical condition requires that they have basic ambulance level medical attention available during transportation, regardless of bed confinement.

(3) For nonemergency ambulance services from a psychiatric unit within a hospital to a behavioral health facility, the ambulance provider must obtain a licensed mental health professional (LMHP) (e.g., psychiatrist, MSW) signed PCS or NPCS within forty-eight hours after the transport.

(4) The agency covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under the following circumstances:

(a) From any point of origin to the nearest hospital with the ability to provide the type and level of care necessary for the client's illness or injury.

(b) From a hospital to the client's home when the place of residence is a residential care facility, the client must be transported by stretcher in a prone or supine position, the client is morbidly obese, or medical attention/monitoring is required in transit.

(c) For a bed-confined client who is receiving renal dialysis for treatment of end stage renal disease (ESRD), from the place of origin

to the nearest facility with the ability to provide renal dialysis, including the return trip.

(5) The agency requires ambulance providers to thoroughly document the medical necessity for use of nonemergency ground ambulance transportation as follows:

(a) For scheduled, nonemergency ambulance services that are repetitive in nature, the ambulance provider must obtain a signed PCS from the client's attending physician or other designated medical professional certifying that the ambulance services are medically necessary. The PCS must specify the place of origin, destination, and the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services.

(b) A PCS for repetitive, nonemergency ambulance services (e.g., wound treatment center) is valid for sixty calendar days as long as the agency's medical necessity requirement for use of ambulance transportation is met. A new PCS is required every thirty calendar days after the initial sixty-day period for a client using repetitive, nonemergency ambulance services. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.

(c) For unscheduled, nonrepetitive, nonemergency ambulance services, the ambulance provider must obtain a signed PCS or NPCS within forty-eight hours after the transport. The PCS or NPCS must specify the place of origin and destination and certify that the ambulance services are medically necessary. If the provider is unable to obtain the signed PCS or NPCS within twenty-one calendar days following the date of transport from the attending physician or alternate provider, the provider must submit a claim to the agency. The provider must be able to show acceptable documentation of the attempts to obtain the PCS or NPCS.

(d) For an unscheduled, nonrepetitive, nonemergency ambulance service, if the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed nonphysician certification statement (NPCS) form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has knowledge of the client's medical condition at the time the ambulance service was furnished. One of the following members of the client's health care team may sign the certification form:

(i) A physician assistant;

(ii) A nurse practitioner;

(iii) A registered nurse;

(iv) A clinical nurse specialist;

(v) A hospital discharge planner;

(vi) A licensed practical nurse;

(vii) A social worker; or

(viii) A case manager.

(e) A copy of the signed PCS or NPCS must accompany the claim submitted to the agency.

(f) In addition to the signed PCS or NPCS, all other program criteria must be met in order for the agency to pay for the service.

(g) A signed PCS or NPCS must be attached to the claim submission for the following conditions:

(i) Altered mental status (i.e., alzheimer, dementia, acute psychosis, and suicide ideation - Not services that fall under the Involuntary Treatment Act;

(ii) Bariatric;

(iii) Bedbound (not able to stand or bear weight unassisted);
(iv) Continuous cardiac monitoring;
(v) Quadriplegic;
(vi) Requires a ventilator;
(vii) Requires continuous oxygen usage in transit; and
(viii) Tracheostomy (needed for prolonged respiratory support).

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

WAC 182-546-1500 ((~~Coverage for~~)) Ambulance transportation—Nonemergency air ((~~ambulance transportation~~))—Payment. (1) The ((~~medical assistance administration (MAA)~~)) medicaid agency pays for a nonemergency air ambulance transport only when the transport is prior authorized by ((~~MAA~~)) the agency.

(2) ((~~MAA~~)) The agency authorizes a nonemergency air ambulance transport only when the following conditions are met:

(a) The client's destination is an acute care hospital or approved rehabilitation facility; and

(b) The client's physical or medical condition is such that travel by any other means endangers the client's health; or

(c) Air ambulance is less costly than ground ambulance under the circumstances.

(3) ((~~MAA~~)) The agency requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical necessity justification and all supporting documentation must be ((~~submitted to MAA prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation~~)) received, evaluated, and approved by the agency before the air ambulance transport takes place.

(4) The agency pays a negotiated rate for a medically necessary nonemergency interstate air ambulance transportation that the agency has prior authorized. The air ambulance provider is responsible for ensuring that all medical services necessary for the client's health and safety during the transport are available on board the vehicle or aircraft.

(5) Unless otherwise specified in the agency's authorization letter, the contractual amount for a nonemergency air ambulance transport includes:

(a) The cost of medically necessary ground transportation from the discharge facility to the point-of-pickup (airstrip); and

(b) The cost of medically necessary ground ambulance transportation from the landing point (airstrip) to the receiving facility.

(6) Payment for nonemergency air ambulance transportation clients may not exceed published fee schedule amounts, except when the agency expressly allows payment of a negotiated rate for a prior authorized nonemergency transport.

(7) Billing documentation must include a copy of the agency's authorization letter, adequate descriptions of the severity and complexity of the transport, and the medical interventions provided in transit.

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

WAC 182-546-2500 Ambulance transportation to ((~~or from~~)) out-of-state treatment facilities—Coordination of benefits. (1) The ((~~medical assistance administration (MAA)~~)) medicaid agency does not pay for a client's ambulance transportation to ((~~or from~~)) an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

(2) For clients who are otherwise eligible for out-of-state coverage under WAC ((~~388-546-0150~~)) 182-546-0150, but have other third-party insurance, ((~~MAA does~~)) the agency may not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

(a) Denies the client's request for medical services out-of-state ((~~for lack of medical necessity; or~~)) as not medically necessary;

(b) Denies the client's request for transportation ((~~for lack of medical necessity~~)) as not medically necessary; or

(c) Denies the client's requested mode of transportation as not medically necessary.

(3) For clients who are otherwise eligible for out-of-state coverage under WAC ((~~388-546-0150~~)) 182-546-0150, but have other third-party insurance, ((~~MAA~~)) the agency does not consider requests for transportation to or from out-of-state treatment facilities unless the client has ((~~tried all of the following:~~

~~(a)~~)) requested coverage of the benefit from ((~~his/her~~)) their primary insurer and been denied((~~;~~

~~(b) Appealed the denial of coverage by the primary insurer; and~~

~~(c) Exhausted his/her administrative remedies through the primary insurer~~)).

(4) If ((~~MAA~~)) the agency authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, ((~~MAA's~~)) the agency's liability is limited to the cost of the least costly means of transportation that does not jeopardize the client's health, as determined by ((~~MAA~~)) the agency in consultation with the client's referring physician.

(5) For clients eligible for out-of-state coverage but have other third-party insurance, ((~~MAA~~)) the agency considers requests for transportation to or from out-of-state treatment facilities under the provisions of WAC ((~~388-501-0165~~)) 182-501-0165.

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

WAC 182-546-3000 Ambulance transportation—Transporting qualified trauma cases. The ((~~department~~)) medicaid agency does not pay ambulance providers who meet department of health (DOH) criteria for participation in the statewide trauma network an additional amount for transports involving qualified trauma cases described in WAC ((~~388-550-5450~~)) 182-550-5450. Subject to the availability of trauma

care fund (TCF) monies allocated for such purpose, the ((~~department~~)) agency may make supplemental payments to these ambulance providers, also known as verified prehospital providers.

NEW SECTION

WAC 182-546-4100 Ambulance transportation—Behavioral health treatment—General. The medicaid agency pays for medically necessary ambulance transportation to and from a covered behavioral health service (see WAC 182-546-4300) subject to the conditions and limitations within this chapter. For purposes of Involuntary Treatment Act (ITA) and voluntary behavioral health services:

(1) The agency pays for transportation services for people involuntarily detained for behavioral health services when they have been assessed by a DCR and found to be one of the following:

(a) A danger to self;

(b) A danger to others;

(c) At substantial risk of inflicting physical harm upon the property of others; or

(d) Gravely disabled as a result of their behavioral health condition.

(2) The agency pays for ambulance transportation to take a client to and from an inpatient facility for behavioral health admission under the ITA.

(3) The agency pays for ambulance transportation services to take a client to the hospital for a voluntary inpatient behavioral health stay when medically necessary.

(4) The DCR authorizes the treatment destination based on the client's legal status.

NEW SECTION

WAC 182-546-4200 Ambulance transportation—Behavioral health treatment—Coverage. (1) To be considered an Involuntary Treatment Act (ITA) transport, a client's involuntary status must have resulted from:

(a) A petition for initial detention filed by a DCR (seventy-two hour hold); and

(b) Continued hospitalization (fourteen-day, ninety-day, or one hundred eighty-day holds) under order of the superior court in a community hospital (not for clients residing in western or eastern state hospitals); or

(c) A petition for revocation of a conditional release or less restrictive treatment agreement.

(2) ITA transportation for a client is covered:

(a) From:

(i) The site of initial detention;

(ii) A court competency hearing;

(iii) A local emergency room department;

(iv) An evaluation and treatment facility;

(v) A state hospital; and
(vi) A secured detoxification facility or crisis response center.
(b) To:
(i) A state hospital;
(ii) A less restrictive alternative setting (except home);
(iii) A court competency hearing;
(iv) A local emergency room department;
(v) An evaluation and treatment facility; and
(vi) A secured detoxification facility or crisis response center.
(c) When provided by an ambulance transportation provider or law enforcement.
(d) When transported to the closest and most appropriate destination or a place designated by the DCR and/or courts. The reason for a diversion to a more distant facility must be clearly documented in the client's file.
(3) **Children's long-term inpatient program (CLIP)** - Transportation provided to a children's long-term inpatient program (CLIP) facility is considered a form of nonemergency medical transportation and requires a physician certification statement (PCS) or nonphysician certification statement (NPCS).
(4) **Parent initiated treatment (PIT)** - Use of nonemergency ambulance transportation to an inpatient psychiatric facility for voluntary inpatient admission must be medically necessary at the time of transport. The agency requires a PCS or NPCS signed by a psychiatric registered nurse, psychiatric advanced registered nurse practitioner (ARNP), or psychiatric physician's assistant (PA). The PCS or NPCS form documents the client's medical condition at the time of the transport.
(5) **Persons without apple health or other coverage** - If the person does not have apple health or any third-party health insurance, and the person or the person's family cannot pay for transportation related to services in RCW 71.05.150 through 71.05.310 and 71.05.340:
(a) The ambulance provider may submit a claim to the agency for that person; and
(b) The claim must be accompanied by back-up documentation consistent with Washington superior court mental proceeding Rule 2.2 and show that the transport occurred within three days of the person's detention.

NEW SECTION

WAC 182-546-4300 Ambulance transportation—Behavioral health treatment—Reimbursement. (1) The agency, as payer of last resort, pays the transportation costs for clients that a Washington designated crisis responder (DCR) detains under the ITA on a seventy-two hour initial detention or five-day revocation hold until the client is discharged from the evaluation and treatment facility or admitted to a state-managed inpatient facility.
(2) The agency pays only when it determines that the involuntarily detained client:
(a) Does not have any other third-party liability (TPL) payment source; and

(b) When requiring the client to pay would result in a substantial hardship upon the client or the client's family. Refer to WAC 182-502-0160.

(3) The DCR must complete and sign a copy of the agency's authorization of Secure Ambulance Transportation Services to/from Behavioral Health Services form (HCA 42-0003) and must keep it in the client's file.

(4) The agency establishes payment for behavioral health related transportation services when the transportation provider complies with the agency's requirements for drivers, driver training, vehicle and equipment standards and maintenance. Providers must clearly identify ITA transportation on the claim when billing the agency.

(5) The agency does not pay for transportation costs to or from out-of-state or bordering cities for clients under the ITA program under any circumstance.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-546-0001	Definitions.
WAC 182-546-0505	GEMT definitions.
WAC 182-546-4000	Transportation coverage under the Involuntary Treatment Act (ITA).
WAC 182-546-4600	Ambulance transportation—Involuntary substance use disorder treatment—Ricky Garcia Act.