



RULE-MAKING ORDER PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 07, 2025

TIME: 7:59 AM

WSR 25-10-096

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 revised these rules to provide more clarity on the business license requirement to become a medicaid enrolled provider.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-502-0010, 182-502-0016
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: None

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 25-08-008 on March 20, 2025 (date).
Describe any changes other than editing from proposed to adopted version: None

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Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____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New	_____	Amended	_____	Repealed	_____
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The number of sections adopted on the agency's own initiative:

New	_____	Amended	<u>2</u>	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	<u>2</u>	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>2</u>	Repealed	_____

Date Adopted: May 7, 2025

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-502-0010 When the medicaid agency enrolls. (1) Nothing in this chapter obligates the medicaid agency to enroll any eligible health care professional, health care entity, supplier, or contractor of service who requests enrollment.

(2) To enroll as a provider (as defined in WAC 182-500-0085) with the agency, a health care professional, health care entity, supplier, or contractor of service (~~((rendering services in the state of Washington (persons or entities providing services out of Washington state see WAC 182-502-0120 and 182-501-0175)))~~) must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to the requirements of:

(i) Washington state laws and rules ((, or, if exempt under federal law, according to the laws and rules of any other)) if the services are to be provided in Washington state;

((b) Be enrolled with medicare, when required in specific program rules;)) (ii) The state laws and rules where the provider renders services if located outside of the state of Washington;

(b) Have a current state business license as required according to the state laws and rules in the state where the services are to be provided;

(c) Have current professional liability coverage, individually or as a member of a group, to the extent the health care professional, health care entity, supplier or contractor is not covered by the Federal Tort Claims Act, including related rules and regulations;

(d) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(e) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(f) Sign, without modification, a core provider agreement (CPA) or nonbilling provider agreement, and a debarment form. Servicing providers are not required to sign as their enrollment is based upon being included under an organizational CPA or nonbilling provider agreement;

(g) Agree to accept the payment from the agency as payment in full in accordance with 42 C.F.R. § 447.15 requiring acceptance of state payment as payment in full (see also WAC 182-502-0160 billing a client);

(h) Fully disclose ownership, employees who manage, and other control interests (e.g., member of a board of directors or office), as requested by the agency. Indian health services clinics are exempt from this requirement;

(i) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(j) Pass the agency's screening process, including license verifications, database checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450.

(i) The agency uses the same screening level risk categories that apply under medicare.

(ii) For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare; and

(k) Pay an application fee, if required by CMS under 42 C.F.R. 455.460.

(3) Servicing providers performing services for a client must be enrolled under the billing providers' CPA or a nonbilling provider agreement.

(4) Only a licensed health care professional whose scope of practice under their licensure includes ordering, prescribing, or referring may enroll as a nonbilling provider.

AMENDATORY SECTION (Amending WSR 21-10-081, filed 5/3/21, effective 6/3/21)

WAC 182-502-0016 Continuing requirements. (1) To continue to provide services for eligible clients and be paid for those services, a provider must:

(a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(b) Provide all services according to federal and state laws and rules, medicaid agency billing instructions, provider alerts issued by the agency, and other written directives from the agency;

(c) Inform the agency of any changes to the provider's application or contract including, but not limited to, changes in:

(i) Ownership (see WAC 182-502-0018);

(ii) Address or telephone number;

(iii) The professional practicing under the billing provider number; or

(iv) Business name((-));

(d) Retain a current:

(i) Professional state license, registration, or certification ((or applicable business license for)) in accordance with the state law where the service is being provided, and update the agency of all changes;

(ii) State business license as required according to the state law where the service is being provided, and update the agency of all changes;

(e) Inform the agency in writing within seven calendar days of changes applicable to the provider's clinical privileges;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, disciplinary decision, disciplinary action or other action(s) including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Screen employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(h) Report immediately to the agency any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 182-502-0010 (2)(j) for information on the agency's screening process;

(i) Pass any portion of the agency's screening process as specified in WAC 182-502-0010 (2)(j) when the agency requires such information to reassess a provider;

(j) Maintain professional and general liability coverage to the extent the provider is not covered:

(i) Under agency, center, or facility professional and general liability coverage; or

(ii) By the Federal Tort Claims Act, including related rules and regulations((-));

(k) Not surrender, voluntarily or involuntarily, the provider's professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct;

(l) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice((-));

(m) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information including, but not limited to, disclosures;

(ii) Submitting forms as required by the agency including, but not limited to, a new core provider agreement; and

(iii) Passing the agency's screening process as specified in WAC 182-502-0010 (2)(j)((-));

(n) Comply with the employee education requirements regarding the federal and the state false claims recovery laws, the rights and protections afforded to whistleblowers, and related provisions in Section 1902 of the Social Security Act (42 U.S.C. 1396a(68)) and chapter 74.66 RCW when applicable. See WAC 182-502-0017 for information regarding the agency's requirements for employee education about false claims recovery.

(2) A provider may contact the agency with questions regarding its programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the agency's programs.

(3) The agency may refer the provider to the appropriate state health professions quality assurance commission.

(4) In addition to the requirements in subsections (1), (2), and (3) of this section, to continue to provide services for eligible clients and be paid for those services, residential treatment facilities that provide substance use disorder (SUD) services (also see chapter 246-337 WAC) must:

(a) Not deny entry or acceptance of clients into the facility solely because the client is prescribed medication to treat SUD;

- (b) Facilitate access to medications specific to the client's diagnosed clinical needs, including medications used to treat SUD;
- (c) Make any decisions regarding adjustments to medications used to treat SUD after individual assessment by a prescribing provider;
- (d) Coordinate care upon discharge for the client to continue without interruption the medications specific to the client's diagnosed clinical needs, including medications used to treat SUD. See RCW 71.24.585.