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 29, 2025
TIME: 2:23 PM

WSR 25-12-058

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) July 1, 2025 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending these rules to allow for the payment of services under the Apple Health program by certified anesthesiologist assistants (CAAs), as established in Chapter 18.71D RCW and adds other clarification about providers of anesthesia services.

The rules:

- Add qualified dentists or oral surgeons and certified anesthesiologist assistants to the list of qualified anesthesiologist providers eligible for reimbursement
- Replace the “department” with “medicaid agency” or “agency”
- Relocate anesthesia reimbursement provisions from section 182-531-0300 to section 182-531-0350
- Update the source of the base anesthesia unit (BAU) values
- Include the calculation of allowed anesthesia charges for more than one procedure and for add-on procedures
- Clarify that the agency does not reimburse attending surgeon for anesthesia services
- Describe reimbursement for multiple anesthesia providers present on a case and for anesthesia provided by a team

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-531-0300, 182-531-0350
Suspended:

Statutory authority for adoption: RCW 41.05.021, RCW 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 25-09-089 on April 17, 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Federal statute:	New	____	Amended	____	Repealed	____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	____

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	____	Amended	2	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: May 29, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 22-16-037, filed 7/27/22, effective 8/27/22)

WAC 182-531-0300 Anesthesia providers and covered physician-related services. The medicaid agency bases coverage of anesthesia services on medicare policies and the following rules:

(1) The agency reimburses providers for covered anesthesia services performed by a qualified anesthesiologist provider, which includes:

(a) Anesthesiologists as defined in RCW 18.71D.010;

(b) A doctor of medicine or osteopathy (other than an anesthesiologist);

(c) A dentist or oral surgeon who is qualified to administer anesthesia;

(d) Certified registered nurse anesthetists (CRNAs);

((~~(d) Oral surgeons with a special agreement with the agency to provide anesthesia services; and~~))

(e) Certified anesthesiologist assistants (CAAs); and

(f) Other providers who have a special agreement with the agency to provide anesthesia services.

(2) The agency covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The agency covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 182-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 182-531-1450; and

(e) Surgical procedures.

(4) For each ((~~client~~)) anesthesia case under the medical direction of an anesthesiologist, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the ((~~provider~~)) anesthesiologist does not perform((~~,~~)) are performed by a qualified ((~~individual as defined in the program operating instructions~~)) anesthesia provider as described in subsection (1) of this section;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The agency does not allow the anesthesiologist ((~~provider~~)) to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The agency requires the anesthesiologist ((~~provider~~)) to document in the client's medical record that the medical direction requirements in subsection (4) of this section were met.

(7) ((~~General anesthesia:~~

~~(a) When a provider performs multiple operative procedures for the same client at the same time, the agency reimburses the base anesthesia units (BAU) for the major procedure only.~~

~~(b) The agency does not reimburse the attending surgeon for anesthesia services.~~

~~(c) When more than one anesthesia provider is present on a case, the agency reimburses as follows:~~

~~(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive 50 percent of the allowed amount.~~

~~(ii) For anesthesia provided by a team, the agency limits reimbursement to 100 percent of the total allowed reimbursement for the service.~~)) For anesthesia reimbursement, see WAC 182-531-0350.

(8) Pain management:

(a) The agency pays CRNAs or anesthesiologists for pain management services.

(b) The agency allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The agency does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 182-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 182-533 WAC for more information about maternity-related services.

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

WAC 182-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) The ((~~department~~)) medicaid agency reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) The ((~~department~~)) agency calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: (BAU ×

((~~fifteen~~)) 15) + time) × (conversion factor divided by ((~~fifteen~~)) 15) = reimbursement.

(3) The ((~~department obtains BAU values from the relative value guide **(RVG)**, and updates them annually. The department and/or the anesthesia technical advisory group **(ATAG)** members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on~~)) agency obtains new BAU values from the most current Centers for Medicare and Medicaid Services (CMS) anesthesia base unit file and reviews them annually for updates.

(4) The ((~~department~~)) agency determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU ((~~RVSP~~)) to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

(5) The ((~~department~~)) agency calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the ((~~anesthesiologist, surgeon, or CRNA~~)) qualified anesthesia provider begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the ((~~anesthesiologist, surgeon, or CRNA~~)) qualified anesthesia provider is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) When more than one surgical procedure is performed at the same operative session, the agency uses the BAU of the major procedure to determine anesthesia **allowed charges.**

(7) The agency reimburses for add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

(8) The agency does not reimburse the attending surgeon for anesthesia services.

(9) When more than one anesthesia provider is present on a case, the agency reimburses as follows:

(a) The medical directing anesthesiologist receives 50 percent of the allowed amount;

(b) The CRNA or CAA under medical direction receives 50 percent of the allowed amount; and

(c) For anesthesia provided by a team, the agency limits reimbursement to 100 percent of the total allowed reimbursement for the service.

(10) The agency considers an anesthesiologist who supervises a resident anesthesiologist to be a teaching anesthesiologist and reimburses as follows:

(a) When supervising one resident only, the teaching anesthesiologist receives 100 percent of the allowed amount.

(b) When supervising two or more residents concurrently, the teaching anesthesiologist receives 50 percent of the allowed amount for each case supervised.

(11) The ((~~department~~)) agency changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as the ((~~department's~~)) agency's annual update.

((~~(7)~~)) (12) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as the ((~~department's~~)) agency's annual update, the ((~~department~~)) agency applies the increase after calculating the budget-neutral conversion factor.

((~~(8) When more than one surgical procedure is performed at the same operative session, the department uses the BAU of the major procedure to determine anesthesia **allowed charges**. The department reimburses for add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.~~))