PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: July 24, 2019
TIME: 9:50 AM

WSR 19-15-150

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 18-11-091 **; or**

☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**

☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**

☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject)
182-531-1740 Treat and refer services.
182-546-0200 Scope of coverage for ambulance transportation.
182-546-0250 Ambulance services the department does not cover.
182-546-0400 General limitations on payment for ambulance services.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
August 27, 2019	10:00 AM	Health Care Authority Cherry Street Plaza **Sue Crystal Conf Rm 106A** 626 8th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than August 28, 2019 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: (360) 586-9727
Other:
By (date) August 27, 2019

Assistance for persons with disabilities:
Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: Telecommunication Relay Services (TRS): 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) August 23, 2019

Purpose of the proposal and its anticipated effects, including any changes in existing rules: This rulemaking is necessary to implement E2SHB 1358 which directs the agency to adopt standards for the reimbursement of health care services provided to eligible clients by fire departments pursuant to a community assistance referral and education services program under RCW 35.21.930. The standards must allow payment for covered health care services provided to individuals whose medical needs do not require ambulance transport to an emergency department.

Reasons supporting proposal: See Purpose statement.

Statutory authority for adoption: RCW 41.05.021, 41.05.160, E2SHB 1358

Statute being implemented: RCW 41.05.021, 41.05.160, E2SHB 1358

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Amy Emerson	PO Box 42716, Olympia WA 98504-2716	360-725-1348
Implementation:	Abigail Cole	PO Box 42716, Olympia WA 98504-2716	360-725-1835
Enforcement:	Abigail Cole	PO Box 42716, Olympia WA 98504-2716	360-725-1835

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

☒ No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The creation of WAC 182-531-1740, and the amendments to WACs 182-546-0200,-250, and -0400 do not impose additional compliance costs or requirements on providers.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: July 24, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

NEW SECTION

WAC 182-531-1740 Treat and refer services. (1) The purpose of treat and refer services is to reduce the number of avoidable emergency room transports, i.e., transports that are nonemergency or nonurgent.

(2) Treat and refer services are covered health care services for a client who has accessed 911 or a similar public dispatch number, and whose condition does not require ambulance transport to an emergency department based on the clinical information available at the time of service.

(3) Treat and refer services can be provided by any city and town fire department, fire protection district organized under Title 52 RCW, regional fire protection service authority organized under chapter 52.26 RCW, provider of emergency medical services that levy a tax under RCW 84.52.069, and federally recognized Indian tribe.

(4) To receive payment for covered health care services provided to clients under this section, an entity that meets the criteria in subsection (3) of this section must be an enrolled medicaid provider with an active core provider agreement for the service period specified in the claim, and have an established community assistance referral and education services program under RCW 35.21.930.

(a) Prior to billing and receiving payment, participating providers must submit a participation agreement and attestation form to the agency certifying their compliance with RCW 35.21.930.

(b) Providers must immediately notify the agency if they no longer meet the requirements of RCW 35.21.930. Providers who no longer meet the requirements of the program and continue to bill and receive payment under the program must return any overpayment under RCW 41.05A.170.

(5) Treat and refer services must be documented in a standard medical incident report that includes a clinical or mental health assessment.

(6) The health care professionals providing treat and refer services must:

(a) Be state-certified emergency medical technicians, state-certified advanced emergency medical technicians, or state-certified paramedics under chapters 18.71 and 18.73 RCW;

(b) Be under the supervision and direction of an approved medical director according to RCW 35.21.930(1); and

(c) Not perform medical procedures they are not trained and certified to perform, according to RCW 35.21.930(1).

(7) Entities that meet the criteria in subsections (3) and (4) of this section must retain the standard medical incident report in subsection (5) of this section according to WAC 182-502-0020.

(8) Payments under this section are subject to review and audit under chapter 182-502A WAC.

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

WAC 182-546-0200 Scope of coverage for ambulance transportation. (1) The ambulance program is a medical transportation service. The ((~~medical assistance administration (MAA)~~)) 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 ((~~388-501-0060~~)) 182-501-0060);

(b) Medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0005 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 appropriate ((~~MAA-contracted~~)) agency-contracted medical provider of ((~~MAA-covered~~)) agency-covered services; or

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

(2) ((~~MAA~~)) 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 ((~~MAA~~)) the agency. See WAC ((~~388-546-0250~~)) 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 ambulance trip due to a lack of medical necessity, ((~~MAA~~)) the agency requires the provider when billing ((~~MAA~~)) the agency for that trip to:

(a) Report the third party determination on the claim; and

(b) Submit documentation showing that the trip meets the medical necessity criteria of ((~~MAA~~)) the agency. See WAC ((~~388-546-1000 and 388-546-1500~~)) 182-546-1000 and 182-546-1500 for requirements for nonemergency ambulance coverage.

(4) ((~~MAA~~)) 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 ((~~MAA~~)) the agency determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the air ambulance transportation must be prior authorized by ((~~MAA~~)) the agency. See WAC ((~~388-546-1500~~)) 182-546-1500 for nonemergency air ambulance coverage.

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

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

WAC 182-546-0250 Ambulance services the ((~~department~~)) agency does not cover. (1) The ((~~department~~)) 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 ((~~388-546-1000~~)) 182-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC ((~~388-546-4000~~)) 182-546-4000(2));

(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 ((~~388-546-0500~~)) 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 ((~~department~~)) agency does not cover the ambulance service, except as provided in WAC ((~~388-546-0500(2)~~)) 182-546-0500(2) and 182-531-1740 Treat and refer services.

(3) The ((~~department~~)) agency evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC ((~~388-501-0160~~)) 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 ((~~department~~)) agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The ((~~department~~)) agency approves such requests when medically necessary, according to the provisions of WAC ((~~388-501-0165 and 388-501-0169~~)) 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 ((~~388-502-0160~~)) 182-502-0160 are met.

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

WAC 182-546-0400 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) 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) 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.