



RULE-MAKING ORDER

CR-103E (July 2011)
(Implements RCW 34.05.350)

Agency: Health Care Authority, Washington Apple Health

Emergency Rule Only

Effective date of rule:

Emergency Rules

- Immediately upon filing.
- Later (specify)

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

- Yes
 - No
- If Yes, explain:

Purpose: These rules are necessary to: 1) add new section for coverage of alcohol and substance misuse counseling through screening, brief intervention, and referral to treatment (SBIRT); 2) new section for coverage for tobacco cessation counseling for pregnant clients; 3) add habilitative services under covered services; 4) remove oral health care services for emergency conditions for clients 21 and older from the covered section as a result of adult dental benefit restoration in Chapter 182-535 WAC, effective January 1, 2014; 5) remove routine or nonemergency medical and surgical dental services for clients 21 years of age and older from the noncovered section; 6) updated who can bill for physician-related and health care professional services; 7) added naturopathic physicians to list of who can bill for osteopathic manipulative treatment; 8) remove limitations on the number of mental health visits for kids and adults and expand the list of qualified providers for adults; 9) add new section for coverage of telemedicine

Citation of existing rules affected by this order:

Repealed: 182-531-1025
 Amended: 182-531-0100, 182-531-0150, 182-531-0250, 182-531-0800, 182-531-1050, 182-531-1400
 Suspended:

Statutory authority for adoption: RCW 41.05.021; 41.05.160; 3ESSB 5034 (section 213, Chapter 4, Laws of 2013)

Other authority:

EMERGENCY RULE

Under RCW 34.05.350 the agency for good cause finds:

- That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
- That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.
- That in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012, or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this finding: These emergency rules are necessary to continue the current emergency rule adopted under WSR 14-11-018 and meet the requirements in 3ESSB 5034, section 213, Chapter 4, Laws of 2013, 63rd Legislature, effective January 1, 2014. The agency continues with the permanent rulemaking process which was initiated under WSR 13-17-107 (CR-101). The agency held a Public Hearing on the permanent rules (filed under WSR 14-22-109) on December 9, 2014, and plans to file the final rule before the end of the year.

Date adopted:

December 23, 2014

NAME (TYPE OR PRINT)

Kevin M. Sullivan

SIGNATURE

TITLE

HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED

DATE: December 23, 2014

TIME: 4:11 PM

WSR 15-01-184

(COMPLETE REVERSE SIDE)

**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	<u>2</u>	Amended	<u>5</u>	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

The number of sections adopted in the agency's own initiative:

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

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

New	<u>1</u>	Amended	<u>1</u>	Repealed	<u>1</u>
-----	----------	---------	----------	----------	----------

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	<u>3</u>	Amended	<u>6</u>	Repealed	<u>1</u>

WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1) The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

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

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

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC (~~182-501-0065~~) 182-501-0165.

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

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

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

(b) Allergen immunotherapy services;

~~((b))~~ (c) Anesthesia services;

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

~~((d))~~ (e) Emergency physician services;

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

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

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

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

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

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

~~((j))~~ (l) Office visits;

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

~~((l))~~ (n) Osteopathic treatment services;

~~((m))~~ (o) Pathology and laboratory services;

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

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

~~((p))~~ (r) Primary care services;

~~((q))~~ (s) Psychiatric services (~~, provided by a psychiatrist~~);

~~((r))~~ (t) Psychotherapy services (~~for children as provided in~~) WAC 182-531-1400;

~~((s))~~ (u) Pulmonary and respiratory services;

~~((t))~~ (v) Radiology services;

~~((u))~~ (w) Surgical services;

~~((v))~~ Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth,

illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment;

~~(w) Oral health care services for emergency conditions for clients twenty one years of age and older, except for clients of the division of developmental disabilities (refer to WAC 182-531-1025); and~~

~~(x) Other outpatient physician services.)~~ (x) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment; and

(y) Other outpatient physician services.

(5) The agency covers physical examinations for ~~((medical assistance))~~ clients only when the physical examination is one or more of the following:

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

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

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

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

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) Except as provided in WAC 182-531-0100 and subsection (2) of this section, the medicaid agency does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Hysterectomy performed solely for the purpose of sterilization;

(e) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(f) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165;

(g) Hair transplantation;

(h) Marital counseling or sex therapy;

(i) More costly services when the medicaid agency determines that less costly, equally effective services are available;

(j) Vision-related services as follows:

(i) Services for cosmetic purposes only;

(ii) Group vision screening for eyeglasses; and

(iii) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to

reduce or eliminate the need for eyeglass or contact lens correction. This refractive surgery does not include intraocular lens implantation following cataract surgery.

(k) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 182-531-1750;

(l) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(m) Physical examinations or routine checkups, except as provided in WAC 182-531-0100;

(n) Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300, as follows:

(i) Routine foot care, such as but not limited to:

(A) Treatment of tinea pedis;

(B) Cutting or removing warts, corns and calluses; and

(C) Trimming, cutting, clipping, or debriding of nails.

(ii) Nonroutine foot care, such as, but not limited to treatment of:

(A) Flat feet;

(B) High arches (cavus foot);

(C) Onychomycosis;

(D) Bunions and tailor's bunion (hallux valgus);

(E) Hallux malleus;

(F) Equinus deformity of foot, acquired;

(G) Cavovarus deformity, acquired;

(H) Adult acquired flatfoot (metatarsus adductus or pes planus);

(I) Hallux limitus.

(iii) Any other service performed in the absence of localized illness, injury, or symptoms involving the foot;

(o) Except as provided in WAC 182-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services((~~-~~));

(p) Nonmedical equipment;

(q) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas; and

(r) Bilateral cochlear implantation(~~;-and~~

~~(s) Routine or nonemergency medical and surgical dental services provided by a doctor of dental medicine or dental surgery for clients twenty one years of age and older, except for clients of the developmental disabilities administration in the department of social and health services)).~~

(2) The medicaid agency covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

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

WAC 182-531-0250 Who can provide and bill for physician-related and health care professional services. ((~~1~~) The following enrolled

~~providers are eligible to provide and bill for physician-related and health care professional services which they provide to eligible clients:~~

- ~~(a) Advanced registered nurse practitioners (ARNP);~~
- ~~(b) Federally qualified health centers (FQHCs);~~
- ~~(c) Health departments;~~
- ~~(d) Hospitals currently licensed by the department of health;~~
- ~~(e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;~~
- ~~(f) Licensed marriage and family therapists, only as provided in WAC 388-531-1400;~~
- ~~(g) Licensed mental health counselors, only as provided in WAC 388-531-1400;~~
- ~~(h) Licensed radiology facilities;~~
- ~~(i) Licensed social workers, only as provided in WAC 388-531-1400 and 388-531-1600;~~
- ~~(j) Medicare certified ambulatory surgery centers;~~
- ~~(k) Medicare certified rural health clinics;~~
- ~~(l) Providers who have a signed agreement with the department to provide screening services to eligible persons in the EPSDT program;~~
- ~~(m) Registered nurse first assistants (RNFA); and~~
- ~~(n) Persons currently licensed by the state of Washington department of health to practice any of the following:~~
 - ~~(i) Dentistry (refer to chapter 388-535 WAC);~~
 - ~~(ii) Medicine and osteopathy;~~
 - ~~(iii) Nursing;~~
 - ~~(iv) Optometry; or~~
 - ~~(v) Podiatry.)~~

(1) The health care professionals and health care entities listed in WAC 182-502-0002 and enrolled with the agency can bill for physician-related and health care professional services that are within their scope of practice.

(2) The department does not pay for services performed by any of the ((following practitioners:

- ~~(a) Acupuncturists;~~
- ~~(b) Christian Science practitioners or theological healers;~~
- ~~(c) Counselors, except as provided in WAC 388-531-1400;~~
- ~~(d) Herbalists;~~
- ~~(e) Homeopaths;~~
- ~~(f) Massage therapists as licensed by the Washington state department of health;~~
- ~~(g) Naturopaths;~~
- ~~(h) Sanipractors;~~
- ~~(i) Social workers, except those who have a master's degree in social work (MSW), and:~~
 - ~~(i) Are employed by an FQHC;~~
 - ~~(ii) Who have prior authorization to evaluate a client for bariatric surgery; or~~
 - ~~(iii) As provided in WAC 388-531-1400.~~
- ~~(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0002; or~~
- ~~(k) Any other licensed practitioners providing services which the practitioner is not:~~

(i) Licensed to provide; and
(ii) Trained to provide)) health care professionals listed in WAC 182-502-0003.

(3) The ((department)) agency pays ((practitioners listed in subsection (2) of this section)) eligible providers for physician-related

services if those services are mandated by, and provided to, clients who are eligible for one of the following:

- (a) The EPSDT program;
- (b) A medicaid program for qualified medicare beneficiaries (QMB); or
- (c) A waiver program.

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

WAC 182-531-0800 Laboratory and pathology physician-related services. (1) The ((department)) medicaid agency reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The ((department)) agency includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) The ((department)) agency reimburses only one blood drawing fee per client, per day. The ((department)) agency allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) The ((department)) agency reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) The ((department)) agency reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the ((department)) agency reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

- (i) A clinic;
- (ii) A hospital laboratory;
- (iii) An independent laboratory; or
- (iv) A physician's office.

(6) The ((department)) agency allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The ((department)) agency reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The ~~((department))~~ agency reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) The ~~((department))~~ agency does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) The ~~((department))~~ agency does not cover for drug screens to monitor ~~((any of the following:~~

~~(a)) for program compliance in either a residential or outpatient drug or alcohol treatment program(;~~

~~(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or~~

~~(c) Suspected drug use by clients in a residential setting, such as a group home)).~~

(10) The ~~((department))~~ agency may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill the ~~((department))~~ agency directly. The ~~((department))~~ agency does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

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

WAC 182-531-1050 Osteopathic manipulative treatment. (1) The ~~((department reimburses))~~ medicaid agency pays for osteopathic manipulative therapy (OMT) only when ~~((OMT is))~~:

(a) Provided by an osteopathic physician licensed under chapter 18.71 RCW(;

~~(2) The department reimburses OMT only when the provider bills))~~
or naturopathic physicians licensed under chapter 246-836 WAC; and

(b) Billed using the appropriate CPT codes that involve the number of body regions involved.

~~((3))~~ (2) The ~~((department))~~ agency allows an osteopathic physician or naturopathic physician to bill the ~~((department))~~ agency for an evaluation and management (E&M) service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

~~((4))~~ (3) The ~~((department))~~ agency limits ~~((reimbursement))~~ payment for manipulations to ten per client, per calendar year. ~~((Reimbursement))~~ Payment for each manipulation includes a brief evaluation as well as the manipulation.

~~((5))~~ (4) The ~~((department))~~ agency does not ~~((reimburse))~~ pay for physical therapy services performed by osteopathic physicians or naturopathic physicians.

WAC 182-531-1400 Psychiatric physician-related services and other professional mental health services. (~~(1) The mental health services covered in the medical benefits described in this section are separate from the mental health services covered by the mental health managed care system administered under the authority of the mental health division pursuant to chapter 388-865 WAC. The department covers outpatient mental health services with the following limitations:~~

~~(a) For clients eighteen years of age and younger:~~

~~(i) The department pays for only one hour per day, per client, up to a total of twenty hours per calendar year, including the psychiatric diagnostic evaluation and family therapy visits that are medically necessary to the client's treatment;~~

~~(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric advanced registered nurse practitioners (ARNP) in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and~~

~~(iii) The mental health services must be provided in an outpatient setting by a psychiatrist, psychologist, psychiatric ARNP, social worker, marriage and family therapist, or mental health counselor who must:~~

~~(A) Be licensed, in good standing and without restriction, by the department of health under their appropriate licensure; and~~

~~(B) Have a minimum of two years experience in the diagnosis and treatment of clients eighteen years of age and younger and their families, including a minimum one year under the supervision of a mental health professional trained in child and family mental health. A licensed psychiatrist may provide these services and bill the department without meeting this requirement.~~

~~(b) For clients nineteen years of age and older:~~

~~(i) The department pays for only one hour per day, per client, up to a total of twelve hours per calendar year, including family or group therapy visits;~~

~~(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric ARNPs in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and~~

~~(iii) The mental health services must be provided by a psychiatrist in an outpatient setting.~~

~~(2) The department covers inpatient mental health services with the following limitations:~~

~~(a) Must be provided by a psychiatrist;~~

~~(b) Only the total time spent on direct psychiatric client care during each visit; and~~

~~(c) One hospital call per day for direct psychiatric client care, including making rounds. Making rounds is considered direct client care and includes any one of the following:~~

~~(i) Individual psychotherapy up to one hour;~~

~~(ii) Family/group therapy; or~~

(iii) Electroconvulsive therapy.

(3) With the exception of medication management, the department covers other mental health services described in this section with the limitation of one per client, per day regardless of location or provider type.

(4) The department pays psychiatrists when the client receives a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) The department covers psychiatric diagnostic interview evaluations at the limit of one per provider, per calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the department.

(6) The department does not cover psychiatric sleep therapy.

(7) The department covers electroconvulsive therapy and narcosynthesis only when performed by a psychiatrist.

(8) The department pays psychiatric ARNPs only for mental health medication management and diagnostic interview evaluations provided to clients nineteen years of age and older.

(9) The department covers interactive, face to face visits at the limit of one per client, per day, in an outpatient setting. Interactive, face to face visits may be billed only for clients age twenty and younger.

(10) The client or licensed health care provider may request a limitation extension only when the client exceeds the total hour limit described in subsection (1) of this section, and for no other limitation of service in this section. The department will evaluate these requests in accordance with WAC 388-501-0169.

(11) DSHS providers must comply with chapter 388-865 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the mental health division or the appropriate regional support network (RSN).

(12) Accepting payment under more than one contract or agreement with the department for the same service for the same client constitutes duplication of payment. If a client is provided services under multiple contracts or agreements, each provider must maintain documentation identifying the type of service provided and the contract or agreement under which it is provided to ensure it is not a duplication of service.) (1) The mental health services covered in this section are different from the mental health services covered under chapter 388-865 WAC, community mental health and involuntary treatment programs administered by the department of social and health services' division of behavioral health and recovery.

(2) The medicaid agency covers professional inpatient and outpatient mental health services not covered under chapter 388-865 WAC according to this section.

Inpatient mental health services

(3) For hospital inpatient psychiatric admissions, providers must comply with the department of social and health services (DSHS) rules in chapter 388-865 WAC, Community mental health and involuntary treatment programs.

(4) The agency covers professional inpatient mental health services as follows:

(a) When provided by a psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), or psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(b) One hospital call per day for direct psychiatric client care. The agency pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. The agency considers services rendered during rounds to be direct client care services and may include, but are not limited to:

(i) Individual psychotherapy up to one hour;

(ii) Family/group therapy; or

(iii) Electroconvulsive therapy.

(c) One electroconvulsive therapy or narcosynthesis per client, per day when performed by a psychiatrist only.

Outpatient mental health services

(5) The agency covers outpatient mental health services when provided by the following licensed health care professionals in good standing with the agency and who are without restriction by the department of health under their appropriate licensure:

(a) Psychiatrist;

(b) Psychologists;

(c) Psychiatric advanced registered nurse practitioner (ARNP) or psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(d) Mental health counselors;

(e) Independent clinical social workers;

(f) Advanced social workers; or

(g) Marriage and family therapists.

(6) With the exception of licensed psychiatrists and psychologists, qualified health care professionals who treat clients eighteen years of age and younger must have a minimum of two years' experience in the diagnosis and treatment of clients eighteen years of age and younger, including one year of supervision by a mental health professional trained in child and family mental health.

(7) The agency does not limit the total number of outpatient mental health visits the licensed health care professional can provide.

(8) The agency covers outpatient mental health services with the following limitations, subject to the provision of WAC 182-501-0169:

(a) One psychiatric diagnostic evaluation, per provider, per client, per calendar year, unless significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the agency.

(b) One individual or family/group psychotherapy visit, with or without the client, per day, per client, per calendar year.

(c) One psychiatric medication management service, per client, per day, in an outpatient setting when performed by one of the following:

(i) Psychiatrist;

(ii) Psychiatric advanced registered nurse practitioner (ARNP);

or

(iii) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC).

(9) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for outpatient mental health services when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

(10) The agency requires the appropriate place of service for mental health services. If the client meets the regional support network (RSN) access to care standards, or subsequent standards, the cli-

ent must be referred to the RSN for an assessment and possible treatment.

(11) If during treatment there is an indication that the client meets the RSN access to care standards, an assessment must be conducted. This assessment may be completed by either a health care professional listed in subsection (5) of this section or a representative of the RSN.

(12) To support continuity of care, the client may continue under the care of the provider until an RSN can receive the client.

(13) After the client completes fifteen mental health visits under this benefit, the provider must submit to the agency a written attestation that the client has been assessed for meeting access to care standards.

(14) To be paid for providing mental health services, providers must bill the agency using the agency's current published billing instructions.

(15) The agency considers acceptance of multiple payments for the same client for the same service on the same date to be a duplication of payment. Duplicative payments may be recouped by the agency under WAC 182-502-0230. To prevent duplicative payments, providers must keep documentation identifying the type of service provided and the contract or agreement under which it is provided.

NEW SECTION

WAC 182-531-1710 Alcohol and substance misuse counseling. (1) The medicaid agency covers alcohol and substance misuse counseling through screening, brief intervention, and referral to treatment (SBIRT) services when delivered by, or under the supervision of, a qualified licensed physician or other qualified licensed health care professional within the scope of their practice.

(2) SBIRT is a comprehensive, evidence-based public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community health care settings: Primary care centers, hospital emergency rooms, and trauma centers.

(3) The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services or supervise qualified staff to deliver SBIRT services:

(a) Advanced registered nurse practitioners, in accordance with chapters 18.79 RCW and 246-840 WAC;

(b) Chemical dependency professionals, in accordance with chapters 18.205 RCW and 246-811 WAC;

(c) Licensed practical nurse, in accordance with chapters 18.79 RCW and 246-840 WAC;

(d) Mental health counselor, in accordance with chapters 18.225 RCW and 246-809 WAC;

(e) Marriage and family therapist, in accordance with chapters 18.225 RCW and 246-809 WAC;

(f) Independent and advanced social worker, in accordance with chapters 18.225 RCW and 246-809 WAC;

(g) Physician, in accordance with chapters 18.71 RCW and 246-919 WAC;

- (h) Physician assistant, in accordance with chapters 18.71A RCW and 246-918 WAC;
 - (i) Psychologist, in accordance with chapters 18.83 RCW and 246-924 WAC;
 - (j) Registered nurse, in accordance with chapters 18.79 RCW and 246-840 WAC;
 - (k) Dentist, in accordance with chapters 18.260 and 246-817; and
 - (l) Dental hygienists, in accordance with chapters 18.29 and 246-815 WAC.
- (4) To qualify as a qualified SBIRT provider, eligible licensed health care professionals must:
- (a) Complete a minimum of four hours of SBIRT training; and
 - (b) Mail or fax the SBIRT training certificate or other proof of training completion to the agency.
- (5) The agency pays for SBIRT as follows:
- (a) Screenings, which are included in the reimbursement for the evaluation and management code billed;
 - (b) Brief interventions, limited to four sessions per client, per provider, per calendar year; and
 - (c) When billed by one of the following qualified SBIRT health care professionals:
 - (i) Advanced registered nurse practitioners;
 - (ii) Mental health counselors;
 - (iii) Marriage and family therapists;
 - (iv) Independent and advanced social workers;
 - (v) Physicians;
 - (vi) Psychologists;
 - (vii) Dentists; and
 - (viii) Dental hygienists.
- (6) To be paid for providing alcohol and substance misuse counseling through SBIRT, providers must bill the agency using the agency's current published billing instructions.

NEW SECTION

- WAC 182-531-1720 Tobacco cessation counseling.** (1) The medicaid agency covers tobacco cessation services when delivered by qualified providers through the agency contracted quitline or face-to-face office visits for tobacco cessation for pregnant clients.
- (2) The agency pays for face-to-face office visits for tobacco cessation counseling for pregnant clients with the following limits:
- (a) When provided by physicians, advanced registered nurse practitioners (ARNPs), physician assistants-certified (PA-Cs), naturopathic physicians, and dentists;
 - (b) Two cessation counseling attempts (or up to eight sessions) are allowed every twelve months. An attempt is defined as up to four cessation counseling sessions.
- (3) To be paid for tobacco cessation counseling through SBIRT, providers must bill the agency using the agency's current published billing instructions.

NEW SECTION

WAC 182-531-1730 Telemedicine. (1) Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

(2) The medicaid agency does not cover the following services as telemedicine:

(a) E-mail, telephone, and facsimile transmissions;

(b) Installation or maintenance of any telecommunication devices or systems; and

(c) Purchase, rental, or repair of telemedicine equipment.

(3) **Originating site.** An originating site is the physical location of the client at the time the health care service is provided. The agency pays the originating site a facility fee per completed transmission. Approved originating sites are:

(a) Clinics;

(b) Community settings;

(c) Homes;

(d) Hospitals - Inpatient and outpatient; and

(e) Offices.

(4) **Distance site.** A distant site is the physical location of the health care professional providing the health care service.

(5) Program-specific policies regarding the coverage of telemedicine can be found in the agency's billing instructions.

(6) To be paid for providing health care services via telemedicine, providers must bill the agency using the agency's current published billing instructions.

(7) If a health care professional performs a separately identifiable service for the client on the same day as the telemedicine service, documentation for both services must be clearly and separately identified in the client's medical record.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-531-1025 Oral health care services provided by dentists for clients age twenty-one and older-General.