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State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0013

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

November 2, 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0013

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number WA 15-0013. This SPA updated the provider types who may prescribe complex rehabilitative technology.

This SPA is approved with an effective date of April 1, 2015.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact James Moreth at James.Moreth@cms.hhs.gov or (360) 943-0469.

Sincerely,

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Frank A. Schneider
Acting Associate Regional Administrator

cc:
Ann Myers, SPA Coordinator

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
15-0013

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2015

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

1902(a) of the Social Security Act P&I

7. FEDERAL BUDGET IMPACT:

- a. FFY 2015 \$0
b. FFY 2016 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-A pgs 23, 24
Att. 3.1-B pg 24 , 25 (P&I)
Att. 4.19-B pg 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

Att. 3.1-A pgs 23, 24
Att. 3.1-B pg 24 , 25 (P&I)
Att. 4.19-B pg 13

10. SUBJECT OF AMENDMENT

Complex Rehabilitative Technology Providers

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED: 4-17-15

16. RETURN TO:

Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
4/17/15

18. DATE APPROVED:
11/02/2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/01/2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Frank A. Schneider

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

- 10/07/15: State authorizes P&I change to boxes 8 and 9
10/23/15: State authorizes P&I change to box 6

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 7. Home health care services (cont.)
 - c. Medical supplies, equipment and appliances suitable for use in the home in accordance with 42 CFR 440.70.

Medical supplies, equipment and appliances must be:

- Medically necessary;
- In the client’s plan of care; and
- Ordered by the treating physician and renewed annually:

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

- Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
- Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment that have set limitations, require prior approval (PA) to exceed those limitations.

Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for clients under age 21 under EPSDT. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on medical necessity.

- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Training and education provided to groups limited to 1 hour (or 4 units) per day

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home health care services (cont.)

Limitations for physical, occupational, and speech therapy

The following therapy units are limited as follows, per client per year:

- Physical and occupational therapy – 24 units (approximately 6 hours)
- Speech therapy – 6 units (approximately 6 hours)

All of the following are limited to 1 per client per calendar year:

- Physical and occupational therapy
 - Evaluations
 - Re-evaluation at time of discharge
 - Wheelchair management. Assessment is limited to 4 15-minute units per assessment.
- Speech therapy
 - Evaluations of speech fluency, speech sound production, swallowing function, and oral speech device
 - With language comprehension and expression
 - Behavioral and qualitative analysis of voice and resonance
 - Speech language pathology re-evaluation at time of discharge

Limitations do not apply for clients under age 21 under EPSDT.

Additional services are covered with prior authorization on a case-by-case basis when medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

7. Home health services (cont.)

- (5) Supervised by the nurse or therapist biweekly in the client's home.
- (6) Exceptions are made on a case-by-case basis.

c. Medical supplies, equipment and appliances suitable for use in the home in accordance with 42 CFR 440.70.

Medical supplies, equipment and appliances must be:

- Medically necessary;
- In the client's plan of care; and
- Ordered by the treating physician and renewed annually.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

- Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
- Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment which have set limitations, require prior approval (PA) to exceed those limitations.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN**

V. Medically Necessary Durable Medical Equipment and Supplies, and Medically Necessary Non-Durable Medical Equipment and Supplies

Qualified providers are paid for covered medically necessary durable medical equipment and supplies (DME) and medically necessary non-durable medical equipment and supplies (Non-DME), repairs, and related services provided to eligible clients. The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule.

DME is reimbursed using CMS DMEPOS Fee Schedule less a specified percentage. As of April 2012, this reduction was 3.5 percent as a result of a negotiated agreement with providers. For those items and services not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges)..

For those covered items and services not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Certain healthcare services which include treatment, equipment, related supplies, and drugs require prior authorization (PA) as a precondition for provider reimbursement. The agency evaluates a request for an authorization of a health care service on a case-by-case basis. Providers must obtain prior authorization (PA) when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

Items not included on the state fee schedule are not covered. Requests for non-covered items will be reviewed according to the agency's "Exception to Rule" process.

The agency does not pay DME providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during inpatient stay are paid through the inpatient payment.

The agency's reimbursement for covered DME includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment and/or supplies.

All rates, including current and prior rates, are published and maintained on the agency's website at <http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx>.