



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSR 16-13-009; 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).

- Original Notice
- Supplemental Notice to WSR _____
- Continuance of WSR _____

Title of rule and other identifying information:

WAC 182-543-0500 DME, CRT, P&O, Medical Supplies – General
 WAC 182-543-2000 DME, CRT, P&O, Medical Supplies – Eligible providers & provider requirements
 WAC 182-543-5000 DME, CRT, P&O, Medical Supplies – Covered – Prosthetics/orthotics
 WAC 182-545-200 Outpatient rehabilitation

Hearing location:

Health Care Authority
 Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
 626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
 or directions can be obtained by calling: (360) 725-1000

Date: **October 25, 2016** Time: **10:00 a.m.**

Submit written comments to:

Name: HCA Rules Coordinator
 Address: PO Box 45504, Olympia WA, 98504-5504
 Delivery: 626 – 8th Avenue, Olympia WA 98504
 e-mail arc@hca.wa.gov
 fax (360) 586-9727

by **5:00 pm on October 25, 2016**

Assistance for persons with disabilities: Contact Amber Lougheed by **October 21, 2016**
 e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349
 TTY (800) 848-5429 or 711

Date of intended adoption: Not sooner than October 26, 2016 (Note: This is **NOT** the **effective** date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The agency is amending these rules to comply with new federal rules under 42 CFR Part 440 requiring that medical supplies, equipment and supplies be prescribed by physicians and other allowed non-physician practitioners, and that the agency inform clients of their right to appeal an adverse agency action. The agency is also amending these rules to add occupational therapists to the list of eligible prosthetic and orthotics providers.

Reasons supporting proposal: See purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160, 42 CFR Part 440

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED

DATE: September 13, 2016

TIME: 3:13 PM

WSR 16-19-032

DATE
September 13, 2016

NAME
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

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

Name of proponent: Health Care Authority

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Chantelle Diaz	PO Box 42716, Olympia WA, 98504-2716	(360) 725-1842
Implementation....Erin Mayo and Jean Gowen	PO Box 45506, Olympia WA, 98504-5506	(360) 725-1729
Enforcement.....Erin Mayo and Jean Gowen	PO Box 45506, Olympia WA, 98504-5506	(360) 725-1729

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No. Explain why no statement was prepared.

Under RCW 19.85.025(3), the agency is not required to prepare a small business economic impact statement for amendments made to comply with 42 CFR Part 440 (effective July 1, 2016). If these rules are not adopted, the State cannot claim a federal match for certain home health services, resulting in lost funding for the agency. For the addition of occupational therapists to the list of eligible prosthetic and orthotics providers, the agency has determined that the proposed change does not impose a disproportionate cost impact on small businesses or nonprofits.

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 ()

e-mail

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.

WAC 182-543-0500 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—General. (1) The federal government considers durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, and medical supplies to be optional services under the medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The medicaid agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(2) The agency covers the DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter.

(3) The agency pays for DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies when they are:

(a) Covered;

(b) Within the scope of the client's medical program (see WAC 182-501-0060 and 182-501-0065);

(c) Medically necessary, as defined in WAC 182-500-0070;

(d) Prescribed by a physician(~~(, advanced registered nurse practitioner (ARNP), naturopathic physicians, or physician assistant certified (PAC))~~) as defined in WAC 182-500-0085, and within the scope of ((his or her)) the provider's licensure, except for dual-eligible ((medicare/medicaid clients when medicare is the primary payer and the agency is being billed for a co-pay and/or deductible only)) clients whose deductible and coinsurance the agency pays under WAC 182-502-0110;

(e) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions (~~(and provider notices))~~);

(f) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions (~~(and provider notices))~~); and

(g) Provided and used within accepted medical or physical medicine community standards of practice.

(4) The agency requires prior authorization (PA) for covered DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization (EPA) process.

(a) The agency evaluates (~~(requests requiring prior authorization))~~ PA requests on a case-by-case basis to determine medical necessity, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-543-7000, 182-543-7100, and 182-543-7300 for specific details regarding authorization.

(5) The agency bases its determination about which DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services require (~~(prior authorization (PA) or expedited prior au-~~

~~thorization (EPA))~~ PA or EPA on utilization criteria (see WAC 182-543-7100 for PA and WAC 182-543-7300 for EPA). The agency considers all of the following when establishing utilization criteria:

- (a) Cost;
- (b) The potential for utilization abuse;
- (c) A narrow therapeutic indication; and
- (d) Safety.

(6) The agency evaluates a request for any item listed as noncovered in this chapter under ~~((the provisions of))~~ WAC 182-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-543-0100 for EPSDT rules).

(7) The agency may terminate a provider's participation with the agency ~~((according to))~~ under WAC 182-502-0030 and 182-502-0040.

(8) The agency evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under ~~((the provisions of))~~ WAC 182-501-0165.

(9) If a client disagrees with an agency decision under this section, the client may request an administrative hearing under chapter 182-526 WAC.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2000 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service basis as follows:

(a) DME providers who are enrolled with medicare for DME and related repair services;

(b) Qualified CRT suppliers who are enrolled with medicare for DME and related repair services;

(c) Medical equipment dealers who are enrolled with medicare, pharmacies who are enrolled with medicare, and home health agencies under their national provider ~~((indicator))~~ identifier (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy;

(f) Physicians who provide medical equipment and supplies in the office. The agency may pay separately for medical supplies, subject to

the provisions in the agency's resource-based relative value scale fee schedule; and

~~((f))~~ (g) Out-of-state ~~((orthotics and))~~ prosthetics and orthotics providers who meet their state regulations.

(2) Providers and suppliers of DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related items must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Be a physician as defined in WAC 182-500-0085, or a nonphysician practitioner as defined in WAC 182-500-0075;

~~((and/or))~~ (c) Have the proper business license and be certified, licensed ~~((and/or))~~ and bonded if required, to perform the services billed to the agency;

~~((e))~~ (d) Have a valid prescription for the DME;

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at: <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>;

(B) Be written by a physician ~~((, advanced registered nurse practitioner (ARNP), naturopathic physician, or physician's assistant certified (PAC)))~~ as defined in WAC 182-500-0085;

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual-eligible ~~((medicare/medicaid))~~ clients when medicare is the primary payer and the agency is being billed for ~~((the copay and/or deductible only))~~ only the copay, only the deductible, or both, subsection (2)(a) of this section does not apply.

~~((d))~~ (e) Provide instructions for use of equipment;

~~((e) Furnish))~~ (f) Provide only new equipment to clients ~~((that)),~~ which include ~~((s))~~ full manufacturer and dealer warranties. See WAC 182-543-2250(3);

~~((f) Furnish))~~ (g) Provide documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

~~((g))~~ (h) Bill the agency using only the allowed procedure codes listed in the agency's published DME and related supplies, prosthetics and orthotics, medical supplies and related items billing instructions.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-5000 Covered—Prosthetics/orthotics. (1) The agency covers, without prior authorization (PA), the following prosthetics and orthotics, with stated limitations:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - One every five years.

(b) Preparatory, above knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot plaster socket, molded to model - One per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - One per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - One per twelve-month period, per limb.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - One per twelve-month period, per limb.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(2) The agency pays only licensed prosthetic and orthotic providers to supply prosthetics and orthotics. This licensure requirement does not apply to the following:

(a) ~~((Selected prosthetics and orthotics that do not require specialized skills to provide; and))~~ Providers who are not required to have specialized skills to provide select orthotics, but meet DME and pharmacy provider licensure requirements;

(b) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy; and

(c) Out-of-state providers, who must meet the licensure requirements of that state.

(3) The agency pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), that meet the definition of prosthetic or orthotic ~~((as defined))~~ in WAC 182-543-1000 and are prescribed ~~((per))~~ under WAC 182-543-1100 and 182-543-1200.

(4) The agency pays for repair or modification of a client's current prosthesis. To receive payment, all of the following must be met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has submitted supporting documentation; and

(c) The repair ~~((is warranted))~~ must have a warranty for a minimum of ninety days.

(5) ~~((The agency requires the client to take responsibility))~~ Clients are responsible for routine maintenance of ~~((a))~~ their prosthetic or orthotic. If ~~((the))~~ a client does not have the physical or mental ability to perform ~~((the))~~ this task, ~~((the agency requires))~~ the client's caregiver ~~((to be responsible))~~ is responsible for routine maintenance of the prosthetic or orthotic. The agency requires ~~((prior authorization))~~ PA for extensive maintenance to a prosthetic or orthotic.

(6) For prosthetics dispensed for ~~((purely))~~ cosmetic reasons only, see WAC 182-543-6000 ~~((, Noncovered DME))~~ DME and related supplies, medical supplies and related services—Noncovered.

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the agency(~~(, as defined in WAC 182-500-0010,)~~) to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible (~~(persons)~~) clients:

- (a) A physiatrist;
- (b) A licensed occupational therapist;
- (c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
- (d) A licensed physical therapist;
- (e) A physical therapist assistant supervised by a licensed physical therapist;
- (f) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;
- (g) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate; and
- (h) A licensed optometrist to provide vision occupational therapy only.

(2) (~~(Persons)~~) Clients covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter.

(3) (~~(Persons who are)~~) Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through (~~(his or her)~~) their agency-contracted MCO.

(4) The agency pays for outpatient rehabilitation when the services are:

- (a) Covered;
- (b) Medically necessary;
- (c) Within the scope of the eligible person's medical care program;
- (d) Ordered by:
 - (i) A physician(~~(, physician assistant (PA), or an advanced registered nurse practitioner (ARNP))~~) as defined in WAC 182-500-0085; or
 - (ii) An optometrist, if the ordered services are for occupational therapy only.
- (e) Within currently accepted standards of evidence-based medical practice;
- (f) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions (~~(and provider notices)~~);
- (g) Begun within thirty calendar days of the date ordered;
- (h) Provided by one of the health professionals listed in subsection (1) of this section;
 - (i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions (~~(and provider notices)~~); and
 - (j) Provided as part of an outpatient treatment program:
 - (i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC;

(iii) In a neurodevelopmental center, as described in WAC 182-545-900; or

(iv) For children with disabilities, age two or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(5) For eligible (~~persons,~~) clients age twenty (~~years of age~~) and younger, the agency covers unlimited outpatient rehabilitation.

(6) For (~~persons~~) clients age twenty-one (~~years of age~~) and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for (~~persons~~) clients age twenty-one (~~years of age~~) and older must:

(a) Restore, improve, or maintain the person's level of function that has been lost due to medically documented injury or illness; and

(b) Include an on-going management plan for the (~~person and/or the person's~~) client or the client's caregiver to support timely discharge and continued progress.

(8) For eligible (~~adults,~~) clients age twenty-one (~~years of age~~) and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per person, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge;

and

(C) Twenty-four units of occupational therapy, ~~((+))~~ which ~~((equals))~~ is approximately six hours ~~((+))~~.

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition;

and

(B) The (~~person's~~) client's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual cognitive (~~and/or~~) or functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual cognitive (~~and/or~~) or functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures (~~which~~) that required surgical intervention, ~~or~~ (~~surgeries~~) surgery involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders (~~which~~) that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Swallowing deficits due to injury or surgery to face, head, or neck;

(XI) Spinal cord injury (~~which~~) that occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per person, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy, ~~((+))~~ which ~~((equals))~~ is approximately six hours~~((+))~~.

(ii) With expedited prior authorization, up to twenty-four additional units of physical therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual functional deficits;

(III) Burns - Second ~~((and/or))~~ or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures ~~((which))~~ that required surgical intervention, ~~((surgeries))~~ surgery involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders ~~((which))~~ that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polynneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior ~~((approved))~~ authorized by the agency.

(c) Speech therapy, per person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy, ~~((+))~~ which ~~((equals))~~ is approximately six hours~~((+))~~.

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Brain injury, which occurred within the past twenty-four months, with residual cognitive ~~((and/or))~~ or functional deficits;

(II) Burns of internal organs such as nasal oral mucosa or upper airway;

(III) Burns of the face, head, and neck - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Muscular-skeletal disorders such as complex fractures (~~(which)~~) that require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;

(VI) Neuromuscular disorders (~~(which)~~) that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polynneuritis (Guillain-Barre));

(VII) Speech deficit due to injury or surgery to face, head, or neck;

(VIII) Speech deficit (~~(which)~~) that requires a speech generating device;

(IX) Swallowing deficit due to injury or surgery to face, head, or neck; or

(X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior (~~(approved)~~) authorized by the agency.

(d) Durable medical equipment (DME) needs assessments, two per person, per year.

(e) Orthotics management and training of upper (~~(and/or)~~) or lower extremities, or both, two program units, per person, per day.

(f) (~~(Orthotic/prosthetic)~~) Orthotic or prosthetic use, two program units, per person, per year.

(g) Muscle testing, one procedure, per person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.

(h) Wheelchair needs assessment, one per person, per year.

(9) For the purposes of this chapter:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(10) For expedited prior authorization (EPA):

(a) A provider must establish that:

(i) The person's condition meets the clinically appropriate EPA criteria outlined in this section; and

(ii) The services are expected to result in a reasonable improvement in the person's condition and achieve the person's therapeutic individual goal within sixty calendar days of initial treatment;

(b) The appropriate EPA number must be used when the provider bills the agency;

(c) Upon request, a provider must provide documentation to the agency showing how the person's condition met the criteria for EPA; and

(d) A provider may request expedited prior authorization once per year, per person, per each therapy type.

(11) The agency evaluates (~~(a request for outpatient rehabilitation that is in excess of the limitations or restrictions, according to)~~) limitation extension (LE) requests under WAC 182-501-0169. (~~(Prior authorization may be requested)~~) Providers may submit LE requests for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) A new qualifying condition arises after the initial six visits are used.

(12) Duplicate services for outpatient rehabilitation are not allowed for the same person when both providers are performing the same or similar procedure(s).

(13) The agency does not pay separately for outpatient rehabilitation that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(14) The agency does not reimburse a health care professional for outpatient rehabilitation performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.