PROPOSED RULE MAKING

CR-102 (June 2024)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: October 04, 2024
TIME: 10:33 AM

WSR 24-21-019

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR 24-17-117 ; 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) 182-545-200, Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy)

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
November 26, 2024	10:00 AM	The Health Care Authority holds public hearings virtually without a physical meeting place	To attend the virtual public hearing, you must register in advance: https://us02web.zoom.us/webinar/register/WN_zumlUaSYRMWndsccsc_AQA If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing

Date of intended adoption: Not sooner than November 27, 2024 (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
Beginning (date and time) October 7, 2024, 8:00 AM
By (date and time) November 26, 2024, by 11:59 PM

Assistance for persons with disabilities:
Contact Johanna Larson
Phone 360-725-1349
Fax 360-586-9727
TTY Telecommunication Relay Service (TRS): 711
Email Johanna.Larson@hca.wa.gov
Other
By (date) November 8, 2024

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is amending WAC 182-545-200 to expand payment criteria for occupational therapy. Specifically, the agency is amending subsection (4)(j)(iv) to change "age two or younger" to "age six or younger."

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

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: None

Name of proponent: (person or organization) Health Care Authority
Type of proponent: ☐ Private. ☐ Public. ☒ Governmental.

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting	Brian Jensen	PO Box 42716, Olympia, WA 98504-2716	360-725-0815
Implementation	Dani Crawford	PO Box 45502, Olympia, WA 98504-5502	360-725-0983
Enforcement	Dani Crawford	PO Box 45502, Olympia, WA 98504-5502	360-725-0983

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 and Small Business Economic Impact Statement
Note: The Governor's Office for Regulatory Innovation and Assistance (ORIA) provides support in completing this part.

(1) Identification of exemptions:
This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). For additional information on exemptions, consult the exemption guide published by ORIA. 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 19.85.025(4). (Does not affect small businesses).

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

Explanation of how the above exemption(s) applies to the proposed rule: This rule proposal updates the criteria under which the medicaid agency pays for a client's outpatient rehabilitation. This rule proposal does not impose costs on businesses.

(2) Scope of exemptions: *Check one.*

☒ The rule proposal: Is fully exempt. *(Skip section 3.)* Exemptions identified above apply to all portions of the rule proposal.

☐ The rule proposal: Is partially exempt. *(Complete section 3.)* The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using this template from ORIA):

☐ The rule proposal: Is not exempt. *(Complete section 3.)* No exemptions were identified above.

(3) Small business economic impact statement: *Complete this section if any portion is not exempt.*

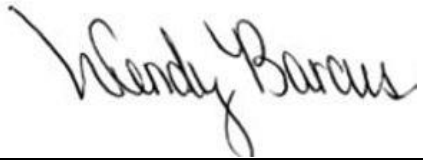
If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☐ No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs. _____

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact 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: October 4, 2024	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 24-14-044, filed 6/26/24, effective 7/27/24)

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the medicaid 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 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 licensed speech-language pathologist; and

(g) A licensed optometrist to provide vision occupational therapy only.

(2) 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) Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through 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); 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, under chapters 182-501 and 182-502 WAC and the agency's published billing instructions;

(g) Begun within 30 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

(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;

(iv) For children with disabilities, age ((~~two~~)) six 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; or

(v) When provided by licensed and certified behavioral health agencies as part of a mental health or substance use disorder treatment program.

(5) For eligible clients age 20 and younger, the agency covers unlimited outpatient rehabilitation.

(6) For clients age 21 and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for clients age 21 and older must:

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

(b) Include an ongoing management plan for the client or the client's caregiver to support timely discharge and continued progress.

(8) For eligible clients age 21 and older, the agency limits coverage of outpatient rehabilitation as follows:

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

(i) Without authorization:

(A) For clients needing occupational therapy to treat physical conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours; and

(B) For clients needing occupational therapy to treat behavioral health conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of occupational therapy to treat either the client's physical or behavioral health conditions may be available to continue treatment initiated under the original 24 units when the criteria below is met:

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

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

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

(II) Behavioral health conditions;

(III) Brain injury, which occurred within the past 24 months, with residual cognitive or functional deficits;

(IV) Burns - Second or third degree only;

(V) Cerebral vascular accident, which occurred within the past 24 months, with residual cognitive or functional deficits;

(VI) Lymphedema;

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

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

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

(X) Reflex sympathetic dystrophy;

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

(XII) Spinal cord injury that occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XIII) 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 is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of physical therapy may be available to continue treatment initiated under the original 24 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 24 months, with residual functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past 24 months, with residual functional deficits;

(V) Lymphedema;

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

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

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

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior 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 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 24 months, with residual cognitive 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 24 months, with residual functional deficits;

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

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

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

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

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

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

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

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

(f) 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 15 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 60 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) If the client does not meet the EPA clinical criteria in this section, the agency uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

(12) The agency evaluates limitation extension (LE) requests regarding scope, amount, duration, and frequency of covered health care services under WAC 182-501-0169. 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.

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

(14) 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.

(15) 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.