RULE-MAKING ORDER
EMERGENCY RULE ONLY

CR-103E (December 2017)
(Implements RCW 34.05.350 and 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 20, 2023
TIME: 10:31 AM

WSR 23-19-095

Agency: Health Care Authority

Effective date of rule:

Emergency Rules

☐ Immediately upon filing.

☒ Later (specify) October 1, 2023

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

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending these rules to align with Section 11405 of the Inflation Reduction Act (IRA) of 2022 (Pub. L. 117-169), which requires states to cover approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-531-0150, 182-531-0950
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: Pub. L. 117-169, Sec. 11405

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.

Reasons for this finding: The agency is filing these emergency rules because the Inflation Reduction Act (IRA) requires Apple Health (Medicaid) to begin covering adult travel vaccines recommended by ACIP beginning October 1, 2023. This new coverage also preserves the health, safety, and welfare of Apple Health clients. The agency began the permanent rulemaking under WSR 23-16-097, filed July 31, 2023, and will be filing the Proposed Rule Making for a public hearing soon. This emergency filing is necessary while the permanent rulemaking process is completed.

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Federal statute:	New	____	Amended	2	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

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

New ____ Amended ____ Repealed ____

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

New ____ Amended ____ Repealed ____

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

New ____ Amended 2 Repealed ____

The number of sections adopted using:

Negotiated rule making: New ____ Amended ____ Repealed ____

Pilot rule making: New ____ Amended ____ Repealed ____

Other alternative rule making: New ____ Amended ____ Repealed ____

Date Adopted: September 20, 2023	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 22-07-105, filed 3/23/22, effective 4/23/22)

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) The medicaid agency evaluates a request for noncovered services in this chapter under WAC 182-501-0160. In addition to noncovered services found in WAC 182-501-0070, except as provided in subsection (2) of this section, the agency does not cover:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility or sexual dysfunction. This includes procedures for donor ovum, donor sperm, gestational carrier, and reversal of vasectomy or tubal ligation;

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

(e) Cosmetic treatment or surgery, except as provided in WAC 182-531-0100 (4)(x);

(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 which the client cannot self-administer and therefore are 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 including, 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 including, 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) ((~~Vaccines recommended or required for the sole purpose of international travel. This does not include routine vaccines administered according to current centers for disease control (CDC) advisory committee on immunization practices (ACIP) immunization schedule for adults and children in the United States; and~~
~~(s)~~)) Early elective deliveries as defined in WAC 182-500-0030.
(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 Washington apple health program for qualified **medicare** beneficiaries (QMBs); or
(c) A waiver program.

AMENDATORY SECTION (Amending WSR 17-21-040, filed 10/12/17, effective 11/12/17)

WAC 182-531-0950 Office and other outpatient physician-related services. (1) The medicaid agency pays eligible providers for the following:
(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and
(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 182-531-0500.
(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (1) of this section and follow the requirements in WAC 182-501-0169.
(3) See the agency's physician-related services billing instructions for procedures that are included in the office call and that cannot be billed separately.
(4) Using selected diagnosis codes, the agency reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.
(5) The agency may reimburse providers for injection procedures and/or injectable drug products only when:
(a) The injectable drug is administered during an office visit; and
(b) The injectable drug used is from office stock and which was purchased by the provider from a pharmacy, drug manufacturer, or drug wholesaler.

(6) The agency does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) The agency does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; the agency does reimburse an administrative fee.

(8) The agency reimburses immunizations as follows:

(a) For immunizations that are not part of the vaccines for children program through the department of health, the agency reimburses for the immunization:

(i) At the medicare Part B drug file price; or

(ii) When a medicare Part B price is not available, the agency uses the point-of-sale actual acquisition cost (POS AAC) rate effective July 1st of each year; or

(iii) Invoice cost.

(b) The agency reimburses a separate administration fee for these immunizations.

(c) Covered immunizations are listed in the professional administered drugs ((~~and physician related/professional services~~)) fee schedule((~~s~~)).

((~~(d) Refer to WAC 182-531-0150 (1)(r) for vaccines recommended or required for the sole purpose of international travel.~~))

(9) The agency reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) The agency does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. The agency does pay separately for the administration of these injections when they are provided on the same day as an E&M service. The agency does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. The agency reimburses separately for the drug(s).

(b) The agency does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, the agency pays an administrative fee. The agency reimburses separately for the drug.

(c) The agency reimburses injectable drugs at **acquisition cost.** The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by the agency. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing the agency for the following drugs:

(i) Classified drugs where the billed charge to the agency is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to the agency is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) The agency reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent

times, the agency reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) The agency covers the antigen, the antigen preparation, and an administration fee.

(e) The agency reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) The agency reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) The agency reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on medicare Part B pricing, or POS AAC, maximum allowable cost (MAC), or invoice cost;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The National Drug Code (NDC).

(12) Notwithstanding the provisions of this section, the agency reserves the option of determining drug pricing for any particular drug based on the best evidence available to the agency, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) The agency may request an invoice as necessary.