RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 23, 2024
TIME: 9:15 AM

WSR 24-21-163

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

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 revising these rules to remove the requirement that physician assistants work under the supervision of a physician and to make other related housekeeping changes.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-501-0135, 182-531-0425, 182-531-1300, 182-531-1720, 182-534-0200, 182-552-0001
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 24-19-099 on September 18, 2024 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended		Repealed	____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	New	____	Amended	6	Repealed	____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Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	6	Repealed	____

Date Adopted: October 23, 2024	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 23-14-073, filed 6/29/23, effective 8/1/23)

WAC 182-501-0135 Patient review and coordination (PRC). (1) **Patient review and coordination (PRC)** is a health and safety program that coordinates care and ensures clients enrolled in PRC use services appropriately and in accordance with agency rules and policies.

(a) PRC applies to medical assistance fee-for-service (FFS) clients and managed care organization (MCO) enrollees.

(b) PRC is authorized under federal medicaid law by 42 U.S.C. 1396n (a)(2) and 42 C.F.R. 431.54.

(2) **Definitions.** Definitions found in chapter 182-500 WAC and WAC 182-526-0010 apply to this section. The following definitions apply to this section:

"Agency's designee" – See WAC 182-500-0010.

"Appropriate use" - Use of health care services that are safe and effective for a client's health care needs.

"Assigned provider" - An agency-enrolled health care provider or one participating with an agency-contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for an FFS client or MCO enrollee in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a prescriber of controlled substances, and a hospital for nonemergency services.

"At-risk" - A term used to describe one or more of the following:

(a) A client with a medical history of:

(i) Seeking and obtaining health care services at a frequency or amount that is not medically necessary; or

(ii) Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

(b) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

(i) Indications of forging or altering prescriptions;

(ii) Referrals from medical personnel, social services personnel, or MCO personnel about inappropriate behaviors or practices that place the client at risk;

(iii) Noncompliance with medical or drug and alcohol treatment;

(iv) Paying cash for medical services that result in a controlled substance prescription or paying cash for controlled substances;

(v) Arrests for diverting controlled substance prescriptions;

(vi) Positive urine drug screen for illicit street drugs or nonprescribed controlled substances;

(vii) Negative urine drug screen for prescribed controlled substances; or

(viii) Unauthorized use of a client's services card for an unauthorized purpose.

"Care management" - Services provided to MCO enrollees with multiple health, behavioral, and social needs to improve care coordination, client education, and client self-management skills.

"Client" – See WAC 182-500-0020.

"Conflicting" - Drugs or health care services that are incompatible or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated" - A medical treatment, procedure, or medication that is inadvisable or not recommended or warranted.

"Duplicative" - Applies to the use of the same or similar drugs and health care services without due medical justification. Example: A client receives health care services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

"Emergency department information exchange (EDIE)" - An internet-delivered service that enables health care providers to better identify and treat high users of the emergency department and special needs patients. When patients enter the emergency room, EDIE can proactively alert health care providers through different venues such as fax, phone, email, or integration with a facility's current electronic medical records.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency services" - See 42 C.F.R. 438.114.

"Fee-for-service" or **"FFS"** – See WAC 182-500-0035.

"Fee-for-service client" or **"FFS client"** – A client not enrolled in an agency-contracted MCO.

"Just cause" - A legitimate reason to justify the action taken including, but not limited to, protecting the health and safety of the client.

"Managed care organization (MCO) enrollee" - A medical assistance client enrolled in, and receiving health care services from, an agency-contracted managed care organization (MCO).

"Prescriber of controlled substances" - Any of the following health care professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, Uniform Controlled Substance Act) for a legitimate medical purpose:

(a) A physician under chapter 18.71 RCW;

(b) A physician assistant under chapter 18.71A RCW;

(c) An osteopathic physician under chapter 18.57 RCW; and

(d) ((~~An osteopathic physician assistant under chapter 18.57A RCW; and~~

~~(e)~~)) An advanced registered nurse practitioner under chapter 18.79 RCW.

"Primary care provider" or **"PCP"** - A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant (PA) who supervises, coordinates, and provides health care services to a client, initiates referrals for specialty and ancillary care, and maintains the client's continuity of care.

(3) **Clients selected for PRC review.** The agency or agency's designee selects a client for PRC review when either or both of the following occur:

(a) An agency or MCO claims utilization review report indicates the client has not used health care services appropriately; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals to the agency or MCO.

(4) **Clients not selected for PRC review.** Clients are not reviewed or placed into the PRC program when they:

(a) Are in foster care;

(b) Are covered under state-only funded programs;

(c) Do not have medicaid as the primary payor; or

(d) Are covered under the alien emergency medical (AEM) program, according to WAC 182-507-0115.

(5) **Prior authorization.** When an FFS client is selected for PRC review, the prior authorization process as defined in WAC 182-500-0085 may be required:

(a) Before or during a PRC review; or

(b) When the FFS client is currently in the PRC program.

(6) **Review for placement in the PRC program.** When the agency or MCO selects a client for PRC review, the agency or MCO staff, with clinical oversight, reviews either the client's medical history or billing history, or both, to determine if the client has used health care services at a frequency or amount that is not medically necessary (42 C.F.R. 431.54(e)).

(7) **Usage guidelines for PRC placement.** Agency or MCO staff use the following usage guidelines to initiate review for PRC placement. A client may be reviewed for placement in the PRC program when the review shows the usage is not medically necessary and either the client's medical history or billing history, or both, documents any of the following:

(a) Any two or more of the following conditions occurred in a period of 90 consecutive calendar days in the previous 12 months. The client:

(i) Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice;

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received 10 or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers not located in the same clinic or practice;

(v) Received similar services in the same day not located in the same clinic or practice; or

(vi) Had 10 or more office visits;

(b) Any one of the following occurred within a period of 90 consecutive calendar days in the previous 12 months. The client:

(i) Made two or more emergency department visits;

(ii) Exhibits "at-risk" usage patterns;

(iii) Made repeated and documented efforts to seek health care services that are not medically necessary; or

(iv) Was counseled at least once by a health care provider, or an agency or MCO staff member with clinical oversight, about the appropriate use of health care services;

(c) The client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the 90-day review period; or

(d) The client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous 12 months:

(i) Using health care services in a manner that is duplicative, excessive, or contraindicated; or

(ii) Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice.

(8) **PRC review results.** As a result of the PRC review, the agency or MCO may take any of the following steps:

(a) Determine that no action is needed and close the client's file;

(b) Send the client and, if applicable, the client's authorized representative a one-time only written notice of concern with informa-

tion on specific findings and notice of potential placement in the PRC program; or

(c) Determine that the usage guidelines for PRC placement establish that the client has used health care services at an amount or frequency that is not medically necessary, in which case one or more of the following actions take place:

(i) The MCO:

(A) Refers the MCO enrollee:

(I) For education on appropriate use of health care services; or

(II) To other support services or agencies; or

(B) Places the MCO enrollee into the PRC program for an initial placement period of no less than 24 months. For MCO enrollees younger than 18 years of age, the MCO must get agency approval before placing the MCO enrollee into the PRC program; or

(ii) The agency places the FFS client into the PRC program for an initial placement period of no less than 24 months.

(9) **Initial placement in the PRC program.**

(a) When an FFS client is initially placed in the PRC program, the agency places the FFS client for no less than 24 months with a primary care provider (PCP) for care coordination and a pharmacy for all medication prescriptions and one or more of the following types of health care providers:

(i) Prescriber of controlled substances if different than PCP;

(ii) Hospital for nonemergency services unless referred by the assigned PCP or a specialist. An FFS client may receive covered emergency services from any hospital;

(iii) Another qualified provider type, as determined by agency program staff on a case-by-case basis; or

(iv) Additional pharmacies on a case-by-case basis.

(b) Based on a medical necessity determination, the agency may make an exception to PRC rules when in the best interest of the client. See WAC 182-501-0165 and 182-501-0160.

(c) When an MCO enrollee is initially placed in the PRC program, the MCO restricts the MCO enrollee for no less than 24 months with a primary care provider (PCP) for care coordination and a primary pharmacy for all medication prescriptions and one or more of the following types of health care providers:

(i) Prescriber of controlled substances if different than PCP;

(ii) Hospital for nonemergency services unless referred by the assigned PCP or a specialist. An MCO enrollee may receive covered emergency services from any hospital;

(iii) Another qualified provider type, as determined by MCO program staff on a case-by-case basis; or

(iv) Additional pharmacies on a case-by-case basis.

(10) **MCO enrollees changing MCOs.** MCO enrollees:

(a) Remain in the same MCO for no less than 12 months for initial placement and whenever the enrollee changes MCOs, unless:

(i) The MCO enrollee moves to a residence outside the MCO's service area and the MCO is not available in the new location;

(ii) The MCO enrollee's assigned PCP no longer participates with the MCO and is available in another MCO, and the MCO enrollee wishes to remain with the current provider;

(iii) The MCO enrollee is in a voluntary enrollment program or a voluntary enrollment county;

(iv) The MCO enrollee is in the address confidentiality program (ACP), indicated by P.O. Box 257, Olympia, WA 98507; or

(v) The MCO enrollee is an American Indian/Alaska Native.

(b) Placed in the PRC program must remain in the PRC program for no less than 24 months regardless of whether the MCO enrollee changes MCOs or becomes an FFS client.

(11) **Notifying the client about placement in the PRC program.** When the client is initially placed in the PRC program, the agency or the MCO sends the client and, if applicable, the client's authorized representative, a written notice that:

(a) Informs the client of the reason for the PRC program placement;

(b) Informs the client of the providers the client has been assigned to;

(c) Directs the client to respond to the agency or MCO to take the following actions if applicable:

(i) Change assigned providers, subject to agency or MCO approval;

(ii) Submit additional health care information, justifying the client's use of health care services; or

(iii) Request assistance, if needed, from agency or MCO program staff; and

(d) Informs the client of administrative hearing or appeal rights (see subsection (16) of this section).

(12) **Selection and role of assigned provider.** A client has a limited choice of providers.

(a) The following providers are not available:

(i) A provider who is being reviewed by the agency or licensing authority regarding quality of care;

(ii) A provider who has been suspended or disqualified from participating as an agency-enrolled or MCO-contracted provider; or

(iii) A provider whose business license is suspended or revoked by the licensing authority.

(b) For a client placed in the PRC program, the assigned:

(i) Provider(s) must be located in the client's local geographic area, in the client's selected MCO, and be reasonably accessible to the client.

(ii) PCP supervises and coordinates health care services for the client, including continuity of care and referrals to specialists when necessary.

(A) The PCP:

(I) Provides the plan of care for clients that have documented use of the emergency department for a reason that is not deemed to be an emergency medical condition;

(II) Files the plan of care with each emergency department that the client is using or with the emergency department information exchange; and

(III) Makes referrals to behavioral health treatment for clients who are using the emergency department for behavioral health treatment issues.

(B) The assigned PCP must be one of the following:

(I) A physician;

(II) An advanced registered nurse practitioner (ARNP); or

(III) A licensed physician assistant (PA)((~~, practicing with a supervising physician~~)).

(iii) Prescriber of controlled substances prescribes all controlled substances for the client;

(iv) Pharmacy fills all prescriptions for the client; and

(v) Hospital provides all hospital nonemergency services.

(c) A client placed in the PRC program must remain with the assigned providers for 12 months after the assignments are made, unless:

(i) The client moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's local geographic area and is no longer reasonably accessible to the client;

(iii) The provider refuses to continue to serve the client;

(iv) The client did not select the provider. The client may request to change an assigned provider once within 30 calendar days of the assignment;

(v) The MCO enrollee's assigned PCP no longer participates with the MCO. In this case, the MCO enrollee may select a new provider from the list of available providers in the MCO network or follow the assigned provider to the new MCO; or

(vi) The client is in the address confidentiality program (ACP), indicated by P.O. Box 257, Olympia, WA 98507.

(d) When an assigned prescribing provider no longer contracts with the agency or the MCO:

(i) All prescriptions from the provider are invalid 30 calendar days following the date the contract ends; and

(ii) The client must choose or be assigned another provider according to the requirements in this section.

(13) **PRC placement.**

(a) The initial PRC placement is no less than 24 consecutive months.

(b) The second PRC placement is no less than an additional 36 consecutive months.

(c) Each subsequent PRC placement is no less than 72 consecutive months.

(14) **Agency or MCO review of a PRC placement period.** The agency or MCO reviews a client's use of health care services before the end of each PRC placement period described in subsection (13) of this section using the guidelines in subsection (7) of this section.

(a) The agency or MCO assigns the next PRC placement if the usage guidelines for PRC placement in subsection (7) of this section apply to the client.

(b) When the agency or MCO assigns a subsequent PRC placement, the agency or MCO sends the client and, if applicable, the client's authorized representative, a written notice informing the client:

(i) Of the reason for the subsequent PRC program placement;

(ii) Of the length of the subsequent PRC placement;

(iii) That the current providers assigned to the client continue to be assigned to the client during the subsequent PRC placement;

(iv) That all PRC program rules continue to apply;

(v) Of administrative hearing or appeal rights (see subsection (16) of this section); and

(vi) Of the rules that support the decision.

(c) The agency or MCO may remove a client from PRC placement if the client:

(i) Successfully completes a treatment program that is provided by a substance use disorder (SUD) service provider certified by the agency under chapter 182-538D WAC;

(ii) Submits documentation of completion of the approved treatment program to the agency; and

(iii) Maintains appropriate use of health care services within the usage guidelines described in subsection (7) of this section for six consecutive months after the date the treatment ends; or

(iv) Successfully stabilizes due to the usage of treatment medications including, but not limited to, Buprenorphine.

(d) The agency or MCO determines the appropriate placement for a client who has been placed back into the program.

(e) A client remains placed in the PRC program regardless of change in eligibility program type or change in address.

(15) **Client financial responsibility.** A client placed in the PRC program may be billed by a provider and held financially responsible for nonemergency health care services obtained from a nonpharmacy provider when the provider is not an assigned or appropriately referred provider as described in subsection (12) of this section. See WAC 182-502-0160.

(16) **Right to administrative hearing or appeal.**

(a) An FFS client who disagrees with an agency decision regarding placement or continued placement in the PRC program has the right to an administrative hearing regarding this placement. An FFS client must request an administrative hearing from the agency within 90 days of the written notice of placement or continued placement to exercise this right.

(b) An MCO enrollee who disagrees with an MCO decision regarding placement or continued placement in the PRC program has a right to appeal this decision in the same manner as an adverse benefit determination under chapter 182-538 WAC.

(c) The agency conducts an administrative hearing according to chapter 182-526 WAC.

(d) A client who requests an administrative hearing or appeal within 10 calendar days from the date of the written notice of an initial PRC placement will not be placed in the PRC program until ordered by an administrative law judge (ALJ) or review judge.

(e) A client who requests an administrative hearing or appeal more than 10 calendar days from the date of the written notice of initial PRC placement will remain placed in the PRC program until a final administrative order is entered that orders the client's removal from the program.

(f) A client who requests an administrative hearing or appeal in all other cases and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(g) An ALJ may rule the client be placed in the PRC program prior to the date the record is closed and before the date the initial order is issued based on a showing of just cause.

AMENDATORY SECTION (Amending WSR 21-20-132, filed 10/6/21, effective 11/6/21)

WAC 182-531-0425 Collaborative care. (1) Under the authority of RCW 74.09.497, and subject to available funds, the medicaid agency covers collaborative care provided in clinical care settings.

(2) For the purposes of this section:

(a) **Collaborative care** means a specific type of integrated care where medical providers and behavioral health providers work together to address behavioral health conditions, including mental health conditions and substance use disorders.

(b) **Collaborative care model** is a model of behavior health integration that enhances usual clinical care by adding two key services:

(i) Care management support for clients receiving behavioral health treatment; and

(ii) Regular psychiatric or board certified addiction medicine consultation with the clinical care team, particularly for clients whose conditions are not improving.

(c) **Collaborative care team** means a team of licensed behavioral health professionals operating within their scope of practice who participate on the clinical care team along with the collaborative care billing provider to provide collaborative care to eligible clients. The team must include a collaborative care billing provider, a behavioral health care manager, and a psychiatric consultant. Professionals making up this team include, but are not limited to:

(i) Advanced registered nurses;

(ii) Substance use disorder professionals (SUDP);

(iii) Substance use disorder professional trainees (SUDPT) under the supervision of a certified SUDP;

(iv) Marriage and family therapists;

(v) Marriage and family therapist associates under the supervision of a licensed marriage and family therapist or equally qualified mental health practitioner;

(vi) Mental health counselors;

(vii) Mental health counselor associates under the supervision of a licensed mental health counselor, psychiatrist, or physician;

(viii) Physicians;

(ix) Physician assistants ((~~under the supervision of a licensed physician~~));

(x) Psychiatrists;

(xi) Psychiatric advanced registered nurses;

(xii) Psychologists;

(xiii) Registered nurses;

(xiv) Social workers;

(xv) Social worker associate-independent clinical, under the supervision of a licensed independent clinical social worker or equally qualified mental health practitioner; and

(xvi) Social worker associate-advanced, under the supervision of a licensed independent clinical social worker, advanced social worker, or equally qualified mental health practitioner.

(3) The behavioral health care manager is a designated licensed professional with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the treating medical provider.

(4) The collaborative care billing provider must meet all of the following:

(a) Be enrolled with the agency as one of the following:

(i) A physician licensed under Titles 18 RCW and 246 WAC;

(ii) An advanced registered nurse practitioner licensed under Titles 18 RCW and 246 WAC;

(iii) A federally qualified health center (FQHC);

(iv) A rural health clinic (RHC); or

(v) A clinic that is not an FQHC or RHC that meets the requirements of Titles 70 RCW and 247 WAC.

(b) Complete, sign, and return the Attestation for Collaborative Care Model, form HCA 13-0017, to the agency; and

(c) Agree to follow the agency's guidelines for practicing a collaborative care model.

(5) Providers of collaborative care must:

(a) Use a registry to track the client's clinical outcomes;

(b) Use at least one validated clinical rating scale;

(c) Ensure the registry is used in conjunction with the practice's electronic health records (EHR);

(d) Include a plan of care; and

(e) Identify outcome goals of the treatments.

(6) If a provider no longer meets the agreed upon requirements in the agency's Attestation for Collaborative Care Model, form HCA 13-0017, the provider must immediately notify the agency. The agency does not pay for collaborative care if a provider does not meet the agreed upon requirements.

(7) Providers are subject to post pay review by the agency. The agency may recoup payment if the provider is found to have not met the requirements for providing collaborative care as agreed to in the agency's Attestation for Collaborative Care Model, form HCA 13-0017.

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

WAC 182-531-1300 Foot care services for clients ((~~twenty-one~~)) 21 years of age and older. (1) This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients ((~~twenty-one~~)) 21 years of age and older.

(2) The department covers the foot care services listed in this section when those services are provided by any of the following health care providers and billed to the department using procedure codes and diagnosis codes that are within their scope of practice:

(a) Physicians or ((~~physician's assistants-certified (PA-C)~~)) physician assistants;

(b) Osteopathic physicians, surgeons, or ((~~physician's assistant-certified (PA-C)~~)) physician assistants;

(c) Podiatric physicians and surgeons; or

(d) Advanced registered nurse practitioners (ARNP).

(3) The department covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the department covers treatment if the criteria in subsection (4) of this section are met.

(4) The department pays for:

(a) Treatment of the following conditions of the lower extremities only when there is an acute condition, an exacerbation of a chronic condition, or presence of a systemic condition such as meta-

bolic, neurologic, or peripheral vascular disease and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain resulting in the inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified:

(i) Acute inflammatory processes such as, but not limited to tendonitis;

(ii) Circulatory compromise such as, but are not limited to:

(A) Lymphedema;

(B) Raynaud's disease;

(C) Thromboangiitis obliterans; and

(D) Phlebitis.

(iii) Injuries, fractures, sprains, and dislocations;

(iv) Gout;

(v) Lacerations, ulcerations, wounds, blisters;

(vi) Neuropathies (e.g., reflex sympathetic dystrophy, secondary to diabetes, charcot arthropathy);

(vii) Osteomyelitis;

(viii) Post-op complications;

(ix) Warts, corns, or calluses in the presence of an acute condition such as infection and pain effecting the client's ability to ambulate as a result of the warts, corns, or calluses and meets the criteria in subsection (4) of this section;

(x) Soft tissue conditions, such as, but are not limited to:

(A) Rashes;

(B) Infections (fungal, bacterial);

(C) Gangrene;

(D) Cellulitis of lower extremities;

(E) Soft tissue tumors; and

(F) Neuroma.

(xi) Nail bed infections (paronychia); and

(xii) Tarsal tunnel syndrome.

(b) Trimming and/or debridement of nails to treat, as applicable, conditions from the list in subsection (4)(a) of this section. The department pays for one treatment in a ((~~sixty~~)) 60-day period. The department covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) A surgical procedure to treat one of the conditions in subsection (4) of this section performed on the lower extremities, and performed by a qualified provider;

(d) Impression casting to treat one of the conditions in subsection (4) of this section. The department includes ((~~ninety~~)) 90-day follow-up care in the reimbursement;

(e) Custom fitted and/or custom molded orthotic devices to treat one of the conditions in subsection (4) of this section.

(i) The department's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) The department includes an evaluation and management (E&M) fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(5) The department does not pay for:

(a) The following radiology services:

(i) Bilateral X-rays for a unilateral condition; or

(ii) X-rays in excess of three views; or

(iii) X-rays that are ordered before the client is examined.

(b) Podiatric physicians or surgeons for X-rays for any part of the body other than the foot or ankle.

AMENDATORY SECTION (Amending WSR 19-22-017, filed 10/25/19, effective 11/25/19)

WAC 182-531-1720 Tobacco/nicotine cessation counseling. (1) The medicaid agency covers tobacco/nicotine cessation counseling when:

(a) Delivered by qualified providers through an agency-approved tobacco/nicotine cessation telephone counseling service;

(b) The client is pregnant or in the postpartum period as defined in 42 C.F.R. 435.170. The agency pays for face-to-face office visits for tobacco/nicotine cessation counseling for these clients with the following limits:

(i) Counseling must be provided by qualified physicians, advanced registered nurse practitioners (ARNPs), physician assistants((~~-certified (PA-Cs)~~)), naturopathic physicians, pharmacists, certified nurse-midwives (CNM), licensed midwives (LM), psychologists, or dentists;

(ii) Two tobacco/nicotine cessation counseling attempts are allowed every ((~~twelve~~)) 12 months. An attempt is defined as up to four tobacco/nicotine cessation counseling sessions; and

(iii) The agency does not cover more than one face-to-face tobacco/nicotine cessation counseling session per client, per day. The provider must keep written documentation in the client's record for each session.

(c) Provided through screening, brief intervention, and referral to treatment (SBIRT). To receive payment for tobacco/nicotine cessation counseling through SBIRT, providers must bill the agency using the agency's published billing instructions.

(2) A provider may prescribe pharmacotherapy for tobacco/nicotine cessation when the provider considers the treatment appropriate for the client. The agency covers certain pharmacotherapy for tobacco/nicotine cessation, including prescription drugs and over-the-counter (OTC) nicotine replacement therapy (NRT), as described in chapter 182-530 WAC.

AMENDATORY SECTION (Amending WSR 15-12-074, filed 5/29/15, effective 7/1/15)

WAC 182-534-0200 Enhanced payments for EPSDT screens for children in out-of-home placement. The medicaid agency pays providers an enhanced fee for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens provided to children in out-of-home placement. See the agency's EPSDT provider guide for specific billing code requirements, and see the agency's fee schedule for the fee.

(1) For the purposes of this section, out-of-home placement means temporary, ((~~twenty-four~~)) 24 hour per day, substitute care for a child:

(a) Placed away from the child's parents or guardians in licensed, paid, out-of-home care; and

(b) For whom the department of social and health services or a licensed or certified child placing agency has placement and care responsibility.

(2) The agency pays an enhanced fee to the providers listed in subsection (3) of this section for EPSDT screens provided to only those children in out-of-home placement.

(3) The following providers are eligible to perform EPSDT screens and bill the enhanced rate for children in out-of-home placement:

(a) EPSDT clinics;

(b) Physicians;

(c) Advanced registered nurse practitioners (ARNPs); and

(d) Physician assistants (PAs) ((~~working under a physician's guidance~~)).

(4) To be paid an enhanced fee, services furnished by the providers listed in subsection (3) of this section must meet the federal requirements for EPSDT screens at 42 C.F.R. Part 441 Subpart B.

(5) The provider must retain documentation of the EPSDT screens in the client's medical file. The provider must use the agency's Well Child Exam forms or provide equivalent information. The Well Child Exam forms include the required elements for an EPSDT screen. The Well Child Exam forms are available for downloading at no charge at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(6) The agency evaluates client files and payments made under this program. The agency may recover the enhanced payment amount when:

(a) The client was not in out-of-home placement as defined in subsection (1) of this section when the EPSDT screen was provided; or

(b) Documentation was not in the client's medical file (see subsection (5) of this section).

AMENDATORY SECTION (Amending WSR 19-21-087, filed 10/14/19, effective 11/14/19)

WAC 182-552-0001 Respiratory care—General. (1) The respiratory care, equipment, and supplies described in this chapter applies to:

(a) Medicaid clients who require respiratory care in their homes, community residential settings, and skilled nursing facilities;

(b) Providers who supply respiratory care to medicaid clients; and

(c) Licensed health care professionals whose scope of practice allows for the provision of respiratory care.

(2) The agency covers the respiratory care listed in this chapter according to the limitations and requirements in this chapter.

(3) The agency pays for respiratory care for medicaid clients when it is:

(a) Covered;

(b) Within the scope of the eligible client's medical care program;

(c) Medically necessary, as defined under chapter 182-500 WAC;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant ((~~certified (PAC)~~)) within the scope of ((~~his or her~~)) their licensure;

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

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

(g) Provided and used within accepted medical or respiratory care community standards of practice.

(4) The agency does not require prior authorization for requests for covered respiratory care for medicaid clients that meets the clinical criteria set forth in this chapter.

(5) The agency requires prior authorization for covered respiratory care for medicaid clients when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The agency evaluates requests requiring prior authorization on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-552-1300, 182-552-1325, 182-552-1350, and 182-552-1375 for specific details regarding authorization.

(6) The agency evaluates on a case-by-case basis for medical necessity and appropriateness items, procedures, and services that do not have an established procedure code available and which are billed using miscellaneous procedure codes.