



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JUN 27 2011

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-010

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of Washington State Plan Amendment (SPA) Transmittal Number 11-010. This amendment combines the amount, duration, and scope of its rehabilitation benefits (OT, PT, Speech) into one therapy rehabilitation benefit for individuals over the age of 21.

This SPA is approved effective April 1, 2011.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Jan Mertel at (206) 615-2317 or Jan.Mertel@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

cc: Douglas Porter, Administrator, State Medicaid Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-10	2. STATE Washington
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One):			
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2011 (\$4,848,000)	
		b. FFY 2012 (\$9,380,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
Attachment 3.1-A pgs 18a, 23, 29(P&I)		Attachment 3.1-A pgs 18a, 23, 29(P&I)	
Attachment 3.1-B pgs 18a, 25, 29, 24 (P&I)		Attachment 3.1-B pgs 18a, 25, 29 (P&I)	
Attachment 34.19-B pg 6(P&I)		Attachment 34.19-B pg 6(P&I)	
		Attachments 3.1A and 3.1-B, remove page 18a from plan (P&I)	
10. SUBJECT OF AMENDMENT:			
Therapy Services			
11. GOVERNOR'S REVIEW (Check One):			
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☒ OTHER, AS SPECIFIED: Exempt			
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Susan N. Dreyfus		Ann Myers	
14. TITLE: Secretary		Department of Social and Health Services	
15. DATE SUBMITTED: 3-31-11		Medicaid Purchasing Administration	
		626 8 th Ave SE MS: 45504	
		POB 5504	
		Olympia, WA 98504-5504	
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: MAR 31 2011		18. DATE APPROVED: JUN 27 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2011		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Carol J.C. Peverly		Associate Regional Administrator	
23. REMARKS:		Division of Medicaid & Children's Health	
6/16/11 - Pen and Ink (P&I) changes authorized by the State.			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

7. Home health care services (cont.)

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

Medical supplies, equipment and appliances must be:

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

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

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

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

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

Medically necessary therapies are covered with the following limitations, allowed per client per calendar year:

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

Additional services are covered with prior authorization on a case-by-case basis when a client meets the State's medical necessity criteria.

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
- a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.
 - b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).
 - c. Limitations do not apply for clients under the age of 21 under EPSDT.
 - d. Prior authorization is required to exceed set limits for clients twenty-one (21) years of age and older as follows:
 - (1) For physical therapy (PT) services beyond one PT evaluation and 24 units (approximately 6 hours) PT per calendar year, per client.
 - (2) For occupational therapy (OT) services beyond one OT evaluation and 24 OT units (approximately 6 hours) per calendar year, per client.
 - (3) For speech therapy (ST) services beyond one speech evaluation and 6 units/visits of speech therapy per calendar year, per client.
 - e. Under 42 CFR 440.110(a), physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.
 - f. Under 42 CFR 440.110(b), occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers.
 - g. Under 42 CFR 440.110(c), services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

7. Home health services (cont.)

(5) Supervised by the nurse or therapist biweekly in the client's home.

(6) Exceptions are made on a case-by-case basis.

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

Medical supplies, equipment and appliances must be:

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

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

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

d. Other Medical services supplies, equipment and appliances

- (1) The Oxygen and Respiratory Therapy Services Program provides medically necessary oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home, when the services are medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

7. d. Home health services (cont.)

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

- One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.

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

Limitations described below do not apply to the Medical Nutrition Program for clients under the age of twenty-one (21) under EPSDT. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on clients meeting the State's medical necessity criteria.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

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

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

Medically necessary therapies are covered with the following limitations, allowed per client per calendar year:

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Additional services are covered with prior authorization on a case-by-case basis when a client meets the State's medical necessity criteria.

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WASHINGTON

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 - g. Under 42 CFR 440.110(c), services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WASHINGTON

III. Physician Services

- A. For physician services, the Medicaid agency pays the lesser of the usual and customary charge or a fee based on a published agency fee schedule. The usual and customary charge is the fee charged by a physician to his/her patients.

The agency's rates were set as of 7/1/10 and are effective for dates of services on or after that date. All rates are published on the agency's website.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website.

- B. Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB).

The MFSDB relative value units (RVU) are geographically adjusted each year by the statewide average Geographic Practice Cost Indices (GPCI) for Washington State as published annually in the Federal Register. The adjusted RVU are multiplied by a service-specific conversion factor to derive a fee for each procedure.

The Medicaid agency currently has unique conversion factors for Children's primary health care services, including office visits and EPSDT screens; Adult primary health care, including office visits; Maternity services, including antepartum care, deliveries, and postpartum care; Anesthesia services; Laboratory services; Radiological services; Surgical services; Consultations; etc. The agency establishes budget neutrality each year when determining its conversion factors, then updates the conversion factors by any increase or decrease mandated by the Legislature.

- C. When no MFSDB RVU exists, the Medicaid agency may apply a set fee to the procedure or determine payment based on documentation by the provider. The agency determines a set fee for drugs administered in the provider's office based on a percentage of the Average Wholesale Price (AWP) as determined by Medicare. The agency determines a set fee for those professional procedures without an assigned RVU by either assigning a proxy RVU based on similar procedures, or by reviewing the medical documentation of the procedure and paying a percentage of the provider's usual and customary charge. Those procedures without RVU's are updated annually with publication of the MFSDB RVU in the Federal Register.