Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

October 27, 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0014.

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number WA 15-0014. This SPA updated the effective date for fee schedules for various programs and incorporated language to eliminate quarterly SPA submissions that simply updated the effective date.

This SPA is approved with an effective date of April 1, 2015.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact James Moreth at James.Moreth@cms.hhs.gov or (360) 943-0469.

Sincerely,

[redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2015.10.27 16:52:33 -07'00'

David L. Meacham
Associate Regional Administrator

cc:
Ann Myers, HCA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0014**

2. STATE: Washington

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, 2015

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:
1902(a) of the Social Security Act P & I

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $0
b. FFY 2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B pages 15, 19, 23, 23a (new), 24, 24a, 24b, 28a, 30, 37, ~~38~~, 39, 40, 41, ~~42~~, 45
New P&I
Att. 4-19-(B) page1 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-B pages 15, 19, 23, 24, 24a, 24b, 28a, 30, 37, ~~38, 39, 40, 41, 42~~, 45
P&I
Att. 4-19-(B) page 1 (P&I)

10. SUBJECT OF AMENDMENT
Fee Schedule Effective Date Updates for April 1, 2015

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
6-25-15

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6-25-15

18. DATE APPROVED: 10/27/15

PLAN APPROVED – ONE [redacted]AL OFFICIAL

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Date: 2015.10.27 16:54:48 -07'00'

19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/2015

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:
7/23/14: The state authorizes P&I change to box 8 and 9

8/19/15: The state authorizes P & I change to box 6

9/24/15: The state authorizes P&I change to box 8 and 9

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN.

I. General

A. The state Medicaid agency, the Health Care Authority (the agency), will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus cost of materials.

B. The agency maintains data indicating the allowed charges for claims made by providers. Such data will be made available to the Secretary of Health and Human Services upon request.

C. Payment methods are identified in the various sections of Attachment 4.19-B, and are established and designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population. Payment for extraordinary items or services under exception to policy is based upon agency approval and determination of medical necessity.

D. Participation in the program is limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee structure.

E. State payment will not exceed upper limits as described in regulations found in 42 CFR 447.300 through 447.371. Any increase in a payment structure that applies to individual practitioner services is documented in accordance with the requirements of 42.CFR 447.203.

F. Providers, including public and private practitioners, are paid the same rate for the same service, except when otherwise specified in the State Plan.

G. Agency fee schedules are published on the agency's website at http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont)

VII. Optometrists Services (Vision Care Services and Eyeglasses)

A. Ophthalmologists, optometrists, and opticians

Ophthalmologists, optometrists, and opticians are authorized to provide vision care services within their scope of practice.

The agencypays the lesser of the usual and customary charge or a fee based on an agencyfee schedule for authorized medically necessary vision care services.

The fees for the codes under Vision Care Services are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the agency uses CMS-established relative value units (RVUs) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor, service descriptions, and their effective dates are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

B. Frames, lenses and contact lenses

Frames, lenses and contact lenses must be ordered from the agency's contractor.

The amount paid for authorized medically necessary frames, lenses and contact lenses is the agency's contracted price with the contractor.

Competitive bid: Frames, lenses, and contact lens services are based on a contract price established through competitive bidding in accordance with section 1915(a)(1)(B) of the Act and regulations at 42 CFR 431.54(d).

Reimbursement rates are based on cost plus mark-up negotiated with the contractor. The rates are included in the contract. The contract is published on the state's contracts website at
https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=12303

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services

A. Home Health

1. Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Each year the state updates those per-visit rates using the state's annually published vendor rate adjustment factor.

   The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for these services.

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

2. Other Supplies and Services used in the home and other setting

   The agency's reimbursement rates include:
   - Any adjustments or modifications to the equipment that are either required within three months of the delivery date, or are covered under the manufacturer's warranty
   - Pick-up, delivery, or associated costs such as mileage, travel time, or gas
   - Telephone calls
   - Shipping, handling, and postage
   - Fitting and setting up
   - Maintanence of rented equipment
   - Instructions to the client or client's caregiver about the safe and proper use of the equipment and supplies

   The equipment, supplies, and services for parenteral nutrition, home infusion therapy, oxygen, and respiratory care are reimbursed using the CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services that are not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services and supplies. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

G. Family Planning Services

The fees for the codes under Family Planning Services are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the agency uses CMS-established relative value units (RVUs) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor, service descriptions, and their effective dates are found in Supplement 3 to Attachment 4.19-B.

Codes not valued under the RVU methodology, are reimbursed using CMS DMEPOS Fee Schedule, flat fee (based upon market value, other states' fees, budget impacts, etc.), acquisition cost (the cost of the actual item being billed), or an Average Wholesale Price (AWP) less a specified percentage. AWP for drug products is provided by the Washington State drug file contractor.

Family Planning providers participating with Medicaid in the PHS 340B drug discount purchasing are paid at actual acquisition cost; with agency-approved 340B dispensing fees for selected hormone-based contraceptive products.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services.See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

H. Extended Services for Pregnant Women Through the Sixty-Day Postpartum Period

Services include maternity support services, outpatient alcohol and drug treatment, rehabilitation alcohol and drug treatment services, genetic counseling, and smoking cessation counseling. The agencypays the lesser of the usual and customary charge or a fee based on an agency fee schedule.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for dates of service on and after April 1, 2015. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

I. Private Duty Nursing Services

Private duty nursing services consist of four or more hours of continuous skilled nursing services provided in the home to eligible clients who are 17 years of age or younger with complex medical needs that cannot be managed within the scope of intermittent home health services. The agency will authorize private duty nursing services up to a maximum of 16 hours per day, restricted to the least costly, equally effective amount of care. Nursing rates for services provided in the home setting are flat rates and based on comparable nursing rates.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for services provided on and after April 1, 2015. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

J. Physical therapy, occupational therapy, and services for Individuals with speech, hearing and language disorders

The agency does not pay separately for therapy services that are included as part of payment for other treatments or programs.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for dates of service on and after April 1, 2015. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

K. Hearing Hardware

Payment for purchased hearing aids includes all of the following:

- A prefitting evaluation
- An ear mold
- A minimum of three post-fitting consultations

The agency sets rate for hearing hardware using CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services not listed on CMS DMEPOS Fee Schedule, the Medicaid agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

L. Prosthetics and Orthotics

The agency does not pay providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

Prosthetics and orthotics are reimbursed using CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

IX. Other Noninstitutional Services (cont)

M. Licensed or Otherwise State-Approved Freestanding Birthing Centers

The fees for the majority of codes under freestanding birthing centers are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under WAC 182-531-1850, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor descriptions are found in Supplement 3 to Attachment 4.19-B.

Codes not valued under the RVU methodology, are reimbursed using CMS DMEPOS Fee Schedule, flat fee (based upon market value, other state's fees, budget impacts, etc.), acquisition cost (the cost of the actual item being billed), or an Average Wholesale Price (AWP) less a specified percentage. AWP for drug products is provided by the Washington State drug file contractor.

The birthing center facility fee is consistent across birthing centers. This facility fee is based on statewide historical cost and is paid by fee schedule. Facility fee payments are made only when the delivery is performed in a facility licensed as a childbirth center by the Washington State Department of Health and approved by the agency. The facility fee includes all room charges for mother and baby, equipment, supplies, anesthesia administration, and paid medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, other x-rays, blood draws, or injections.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont)

N. Tobacco Cessation Counseling Services

The Medicaid agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for these services. Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

XIII. Targeted Case Management Services (cont)

B. Infant Case Management (ICM)

The agency provides infant case management services to Medicaid infants and their parent(s) for the direct benefit of the eligible infant from the time the infant is three months of age through the month of the infant's first birthday.

For the purpose of this program, the State defines a parent(s) as a person who resides with an infant, provides the day-to-day care, is authorized to make health care decisions, and is:

- ✓ The infant's natural or adoptive parent(s);
- ✓ A person other than a foster parent who has been granted legal custody of the infant; or
- ✓ A person who is legally obligated to support the infant.

Payment for Title XIX targeted case management services may not duplicate payments made to public agencies or private entities under other programs for this same purpose. If the eligible infant and family are involved in services for another targeted group, ICM is closed and case management for the other targeted group is initiated.

Targeted case management for ICM is billed on a per-visit basis, with each visit based on time increments of 15 minutes equaling one unit. Unit limitations are described in agency billing instructions.

Computation of the per-unit rate takes the following into consideration:

i. Relative value of targeted case management services provided by similar professionals in different settings;
ii. Historical expenditures for ICM services; and
iii. Other expenses related to provision of targeted case management services (e.g., travel time and associated travel costs, charting/documentation time, etc.)

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The agency's case management fee was set as of April 1, 2015, and is effective for dates of service on and after that date. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XIV. Hospice Services

A. Payment for hospice care is made to a designated hospice provider based on a daily rate. The rates are contingent on the type of service provided that day. The rates are based on the Medicaid guidelines and are wage adjusted.

The agency does not pay for face-to-face encounters to recertify a hospice client.

The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule, for the professional service provided for pediatric palliative care and for authorized medically necessary concurrent care services.

The agency reimburses hospice claims through the use of revenue codes used to bill for room and board and revenue codes used to bill for the hospice daily rate.

To determine the hospice daily rate, the agency uses CMS Hospice Wage Index and Medicaid Hospice Payment Rates as published by CMS. The room and board rates are set by the Department of Social and Health Services (DSHS).

For the clients residing in a hospice care center (HCC), the agency pays 95% of the nursing home room and board rate.

Pediatric palliative care (PPC) revenue code is adjusted only through a Vendor Rate Increase (VRI) that has been appropriated by the Washington State Legislature.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

The room and board rates are published on the DSHS website at http://www.aasa.dshs.wa.gov/professional/rates/reports/.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVIII. Mental Health Services

In the event that a contracted Regional Support Network's (RSN) contract to provide mental health services under a managed care delivery system is not continued, the agency will contract directly with eligible service providers under a fee-for-service agreement. Mental health fee-for-service rates are developed using the methodology below.

When possible, rates are developed using the RBRVS methodology. Rates are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

If Medicare does not cover a particular approved State Plan service, and thus no RVU exists, the agency examines the CMS-approved Medicaid fee-for-service rate schedules of other states' mental health care programs for comparability in program design, relative costs, and design structure to Washington's program. For those procedures that are substantially similar, another state's fee for the procedure is adopted.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services for those enrollees who reside in counties without an RSN. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XX. Telemedicine services

Payment for telemedicine services is made as follows:

- *Originating sites* (the physical location of the client at the time the service is provided) are paid a facility fee per completed transmission, according to the fee schedule. Approved originating sites are:
  - The office of a physician or practitioner.
  - Hospitals. Only outpatient hospital agencies are paid a facility fee; inpatient hospitals may not bill for an originating site fee.
  - Critical access hospitals (CAH).
  - Rural health centers (RHCs). The facility fee is not considered as an encounter and is not paid as such.
  - Federally qualified health centers (FQHCs). The facility fee is not considered as an encounter and is not paid as such.
- *Distant sites* (the physical location of the practitioner providing the service) are paid the current fee schedule amount for the service provided.

Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of telemedicine services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.