WAC 182-502-0005 Core provider agreement (CPA). (1) The agency only pays claims submitted for services provided by or on behalf of:

(a) A health care professional, health care entity, supplier or contractor of service that has an approved core provider agreement (CPA) with the agency;

(b) A servicing provider enrolled under an approved CPA with the agency; or

(c) A provider who has an approved agreement with the agency as a nonbilling provider in accordance with WAC 182-502-0006.

(2) Servicing providers performing services for a client must be enrolled under the billing providers' CPA.

(3) Any ordering, prescribing, or referring providers must be enrolled in the agency's claims payment system in order for any services or supplies ordered, prescribed, or referred by them to be paid. The national provider identifier (NPI) of any referring, prescribing, or ordering provider must be included on the claim form. Refer to WAC 182-502-0006 for enrollment as a nonbilling provider.

(4) For services provided out-of-state, refer to WAC 182-501-0180, 182-501-0182, and 182-501-0184.

(5) The agency does not pay for services provided to clients during the CPA application process or application for nonbilling provider process, regardless of whether the agency later approves or denies the application, except as provided in subsection (6) of this section or WAC 182-502-0006(5).

(6) Enrollment of a provider applicant is effective on the date the agency approves the provider application.

(a) A provider applicant may ask for an effective date earlier than the agency's approval of the provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

(i) Earlier than the effective date of any required license or certification; or

(ii) More than 365 days prior to the agency's approval of the provider application.

(b) The chief medical officer or designee may approve exceptions as follows:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need as determined by the agency's chief medical officer or designee.

(c) For federally qualified health centers (FQHCs), see WAC 182-548-1200. For rural health clinics (RHCs), see WAC 182-549-1200.

(d) Exceptions granted under this subsection (6) do not supersede or otherwise change the agency's timely billing requirements under WAC 182-502-0150.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-21-061, § 182-502-0005, filed 10/12/23, effective 11/12/23. Statutory Authority: 42 C.F.R. 455.410, RCW 41.05.021. WSR 13-19-037, § 182-502-0005, filed 9/11/13, effective 10/12/13. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455 subpart E Provider Screening and Enrollment requirements. WSR 12-12-032, § 182-502-0005, filed 5/29/12, effective 7/1/12. WSR

11-14-075, recodified as § 182-502-0005, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0005, filed 5/9/11, effective 6/9/11.]