

**WAC 182-502-0110 Conditions of payment and prior authorization requirements—Medicare coinsurance, copayments, and deductibles.** (1)

The following people are eligible for benefits under this section:

(a) Dual-eligible clients enrolled in categorically needy Washington apple health programs;

(b) Dual-eligible clients enrolled in medically needy Washington apple health programs; or

(c) Clients enrolled in the qualified medicare beneficiary (QMB) program.

(2) The agency pays the medicare coinsurance, copayments, and deductibles for Part A, Part B, and medicare advantage Part C for an eligible person under subsection (1) of this section:

(a) Up to the published or calculated medicaid-only rate; and

(b) If the provider accepts assignment for medicare payment.

(3) If a medicare Part A recipient has remaining lifetime reserve days, the agency pays the deductible and coinsurance amounts up to the allowed amount as calculated by the agency.

(4) If a medicare Part A recipient has exhausted lifetime reserve days during an inpatient hospital stay, the agency pays the deductible and coinsurance amounts up to the agency-calculated allowed amount minus any payment made by medicare, and any payment made by the agency, up to the outlier threshold. Once the outlier threshold is reached, the agency pays according to WAC 182-550-3700.

(5) If medicare and medicaid cover the service, the agency pays:

(a) The deductible and coinsurance up to medicare or medicaid's allowed amount, whichever is less; or

(b) For long-term civil commitments, as defined in WAC 182-500-0065, the greater of medicare or medicaid's allowed amount, minus what medicare paid.

(6) If only medicare covers the service, the agency pays the deductible and coinsurance up to the agency's allowed amount established for a QMB client, and at zero for a non-QMB client.

(7) If a client exhausts medicare benefits, the agency pays for medicaid-covered services under Title 182 WAC and the agency's billing instructions.

(8) When medicaid requires prior authorization for a service covered by both medicare and medicaid:

(a) Medicaid does not require prior authorization when the client's medicare benefit is not exhausted.

(b) Medicaid does require prior authorization when the client's medicare benefit is exhausted. See also WAC 182-501-0050(5).

(9) Providers must meet the timely billing requirements under WAC 182-502-0150 in order to be paid for services.

(10) Payment for services is subject to postpayment review.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-17-167, § 182-502-0110, filed 8/24/22, effective 9/24/22; WSR 17-06-063, § 182-502-0110, filed 2/28/17, effective 3/31/17; WSR 16-13-157, § 182-502-0110, filed 6/22/16, effective 7/23/16. WSR 11-14-075, recodified as § 182-502-0110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. WSR 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]