

WAC 182-543-2000 Eligible providers and provider requirements.

(1) The medicaid agency pays qualified providers for medical equipment and repairs on a fee-for-service basis as follows:

(a) Providers who are enrolled with medicare for medical equipment and related repair services;

(b) Qualified complex rehabilitation technology (CRT) suppliers who are enrolled with medicare;

(c) Medical equipment dealers and pharmacies who are enrolled with medicare, and have a national provider identifier (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy;

(f) Physicians who provide medical equipment in the office; and

(g) Out-of-state prosthetics and orthotics providers who meet their state regulations.

(2) Providers and suppliers of medical equipment must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Have the proper business license and be certified, licensed and bonded if required, to perform the services billed to the agency;

(c) Have a valid prescription for the medical equipment.

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at <https://www.hca.wa.gov/billers-providers/forms-and-publications>;

(B) Be written by a physician as defined in WAC 182-500-0085 and meet the face-to-face encounter requirements described in WAC 182-551-2040;

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the medical equipment. Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual-eligible clients when medicare is the primary payer and the agency is being billed for only the copay, only the deductible, or both, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Provide only new equipment to clients, which include full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Provide documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

(g) Bill the agency using only the allowed procedure codes listed in the agency's published medical equipment billing guide.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Part 440.70; 42 U.S.C. section 1396 (b)(i)(27). WSR 18-24-021, § 182-543-2000, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-15-073, § 182-543-2000, filed

7/14/17, effective 8/14/17. Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2000, filed 3/25/14, effective 4/25/14. Statutory Authority: RCW 41.05.021 and Affordable Care Act (ACA) - 76 Fed. Reg. 5862, 42 C.F.R. Parts 405, 424, 447, 455, 457, and 498. WSR 12-15-015, § 182-543-2000, filed 7/10/12, effective 9/1/12. WSR 11-14-075, recodified as § 182-543-2000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2000, filed 6/29/11, effective 8/1/11; WSR 07-17-062, § 388-543-2000, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]