

**WAC 182-552-1400 Respiratory care—Reimbursement—General. (1)**

The medicaid agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for covered respiratory care provided on a fee-for-service (FFS) basis as follows:

(a) To medicaid agency-enrolled medical equipment and supplies providers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the agency's current respiratory care medicaid billing guide; and

(b) In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignment.

(2) The medicaid agency may adopt policies, procedure codes, and rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary to:

(i) Assure that payments are sufficient to enlist providers and maintain access to care and services; or

(ii) Comply with legislative budget directives.

(3) The medicaid agency's maximum payment for respiratory care is the lesser of either of the following:

(a) Provider's usual and customary charges; or

(b) Established rates, except as provided in WAC 182-502-0110(3).

(4) The medicaid agency is the payer of last resort for clients with medicare or third-party insurance.

(5) The medicaid agency does not pay for respiratory care provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

(6) The medicaid agency's payment rate for covered oxygen and respiratory equipment and supplies includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery or are covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up and delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, and postage;

(e) Maintenance for rented equipment including, but not limited to, testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting or setup, or both; and

(g) Instruction to the client or client's caregiver in the appropriate use of the respiratory care.

(7) Respiratory care equipment, supplies, and related repairs and labor charges that are supplied to eligible clients under the following payment methodologies are included in those methodologies and are not reimbursed under fee-for-service (FFS):

(a) Hospice provider's per diem reimbursement;

(b) Hospital's diagnosis-related group (DRG) reimbursement;

(c) Managed care organization's capitation rate;

(d) Skilled nursing facilities per diem rate; and

(e) Professional service's resource-based relative value system reimbursement (RBRVS) rate.

(8) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique

identifier of the respiratory care equipment, and warranty period, available to the medicaid agency upon request.

(9) The dispensing provider who furnishes respiratory care equipment or supplies to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any equipment or supply that the medicaid agency considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The respiratory care equipment or supply continues to be medically necessary.

(10) If rental respiratory equipment or supplies must be replaced during the warranty period, the medicaid agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the respiratory equipment or supply provided to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The respiratory care equipment or supply continues to be medically necessary.

(11) The medicaid agency does not pay for respiratory care equipment and supplies, or related repairs and labor charges under FFS when the client is any of the following:

(a) An inpatient hospital client;

(b) Terminally ill and receiving hospice care; or

(c) Enrolled in a risk-based MCO that includes coverage for such items or services, or both.

(12) The medicaid agency rescinds any purchase order for a prescribed item if the equipment or supply was not supplied to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by an MCO.

(13) See also WAC 182-543-9000 for general reimbursement.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 431.16 Section 1903 (i)(27) of the Social Security Act. WSR 19-21-087, § 182-552-1400, filed 10/14/19, effective 11/14/19. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-1400, filed 6/25/12, effective 8/1/12.]