DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

APR 0 7 2010

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

**RE: Washington State Plan Amendment (SPA) Transmittal Number #09-013**

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services has completed its review of State Plan Amendment (SPA) Transmittal Number #09-013.

This amendment creates a Professional Service Supplemental Payment program. The supplemental payment will be paid for professional services performed by qualified, licensed professionals. The purpose of the supplemental payment program is to ensure access to essential professional services for Medicaid beneficiaries through care provided by qualified hospitals.

This SPA is approved effective July 1, 2009, as requested by the State.

I appreciate the significant amount of work that your staff dedicated to getting this SPA approved and the cooperative way in which we achieved this much-desired outcome. If you have any questions concerning this SPA, please contact me at (206) 615-2515 or have your staff contact Mary Jones at (360) 486-0243 or Mary.Jones2@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Douglas Porter, Assistant Secretary, Health and Recovery Services Administration

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: 09-013

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: July 1, 2009

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:
42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $ 4.28 million
b. FFY 2010 $ 16.98 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pages 7a ~~& 7b~~, 43, 44 (pti)
Attachment 3.1-A, pages 17, 18, 18a, 20, 29, 43 (pti)
Attachment 3.1-B, pages 17, 18, 18a, 21, 29, 43 (pti)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pgs 7 (pti)
Attachment 3.1-A, pgs. 17, 18, 18a, 20, 29, 43 (pti)
Attachment 3.1-B, pgs. 17, 18, 21, 29, 43 (pti)

10. SUBJECT OF AMENDMENT:
Professional Services Supplemental Payment

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: Susan N. Dreyfus

14. TITLE: Secretary

15. DATE SUBMITTED: Aug. 3, 2009

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: AUG - 3 2009

18. DATE APPROVED: APR 0 7 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 0 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Carol J. C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

1.07.10 - State authorized pen & ink changes.
3.09.10 - State authorized pen & ink changes.
3.24.10 - State authorized pen & ink changes.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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5. a. Physicians' services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.
- A maximum of three hours of critical care per client per day.
- For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are covered to deliver services.
- More than one physician may be covered to deliver services if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).
- In the emergency room, only one physician is covered to deliver services.

(2) Newborn care and neonatal intensive care unit (NICU) services.
- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(3) Osteopathic manipulative therapy.
Up to ten osteopathic manipulations per client, per calendar year.

(4) Physical exams:
Routine physical exams are covered in specific instances, including but not limited to:
- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

(5) Physician care plan oversight.
Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(6) Physician standby services.
Must:
- Be requested by another physician;
- Involve prolonged physician attendance without direct (face-to-face) patient contact; and
- Exceed 30 minutes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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5. a. Physicians' services (continued)

(7) Physician visits.

Limited to:

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services that are provided during the follow-up period for a surgery are covered only if the services are performed on an emergency basis and are unrelated to the original surgery.

(8) Psychiatric services.

- For adults: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.

- For children: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twenty hours per calendar year. Includes family or group psychotherapy.

- Psychiatric diagnostic interview examinations – one in a calendar year unless an additional evaluation is medically necessary.

Prior authorization is required for additional services that are medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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5. a. Physicians' services

(9) Clients participating in the department-approved smoking cessation program may receive prescription medications.

(10) Physiatry services
- The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
- The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- The Department does not limit covered physical therapy services for clients 20 years of age and younger.
- For adults:
  - 1 physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year
  - 48 physical therapy program units per calendar year
  - 2 DME needs assessments (in addition to the 48 program unit limitation) per calendar year
  - 1 wheelchair needs assessment (in addition to the DMS needs assessments) per calendar year
  - Prior authorization is required for additional program units that are medically necessary

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services

(1) Foot care is covered only for specific medical conditions that must be treated by an M.D., D.O., or podiatrist.

(2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.

b. Optometrists' services

(1) Frames, lenses, and contact lenses must be ordered from the department's contractor.

(2) The department covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:
- Every 24 months for asymptomatic adults 21 years or older; and
- Every 12 months for asymptomatic children 20 years or younger, and clients identified by the Department as developmentally disabled.

(3) The department covers medically necessary contact lenses, as defined in chapter 388-544 WAC. Normal replacement for contact lenses is every 12 months.

(4) Exceptions to numbers (2) and (3) above will be considered for all individuals based on medical necessity.

(5) For individuals under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r), subject to determination of medical necessity and prior authorization by the Department.

6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, radiological technicians, opticians, and licensed non-nurse midwives, These practitioners are limited to services within their scope of practice and specialty area.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

c. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) Prior Authorization is required for physical therapy (PT) when the client is:
- 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis, or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.

(2) Prior Authorization is required for occupational therapy (OT) when the client is:
- 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.

(3) Prior Authorization is required for speech therapy (ST) when the client is:
- 21 years of age and older and requires services beyond one speech evaluation and 12 speech visits per year per client; or
- 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 speech visits per year per client.

d. Physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.

e. Occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers.

f. Services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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13. d. 7 Rehabilitative services/Mental health services (cont.)

*"Social worker"* means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

*"Child psychiatrist"* means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

*"Psychiatric nurse"* means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

*"Counselor"* means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee. A "counselor", engaging in the practice of counseling, can include an agency affiliated counselor, certified counselor, or certified adviser. Specific qualifications and licensing/certification requirements are described in chapter 18.19 RCW and chapter 246-810 WAC.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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5. a. Physicians' Services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.

- A maximum of three hours of critical care per client per day.
- For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are covered to deliver services.
- More than one physician may be covered to deliver services if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).
- In the emergency room, only one physician is covered to deliver services.

(2) Hospital visits. No payment for visits on those days that exceed the allowed length of stay unless an extension was requested and has been approved.

(3) Newborn care and neonatal intensive care unit (NICU) services.

- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(4) Osteopathic manipulative therapy.

Up to ten osteopathic manipulations per client, per calendar year.

(5) Physical exams:

Routine physical exams are covered in specific instances, including but not limited to:

- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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5. a. Physicians' services (cont.)

(6) Physician care plan oversight.
Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(7) Physician standby services.
Must:
- Be requested by another physician;
- Involve prolonged physician attendance without direct (face-to-face) patient contact; and
- Exceed 30 minutes.

(8) Physician visits.
Limited to:
- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services that are provided during the follow-up period for a surgery are only covered if the services are performed on an emergency basis and are unrelated to the original surgery.

Prior authorization is required for additional services that are medically necessary.

(9) Psychiatric services:
- For adults: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.
- For children: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twenty hours per calendar year. Includes family or group psychotherapy.
- Psychiatric diagnostic interview examinations – one in a calendar year unless an additional evaluation is medically necessary.

Prior authorization is required for additional services that are medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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5. a. Physicians' services (cont.)

(10) Physiatry services

- The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
- The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- The Department does not limit covered physical therapy services for clients 20 years of age and younger.
- For adults:
  - 1 physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year
  - 48 physical therapy program units per calendar year
  - 2 DME needs assessments (in addition to the 48 program unit limitation) per calendar year
  - 1 wheelchair needs assessment (in addition to the DMS needs assessments) per calendar year
  - Prior authorization is required for additional program units that are medically necessary

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, radiological technicians, , opticians, and licensed non-nurse midwives, These practitioners are limited to services within their scope of practice and specialty area.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors.

Children's mental health outpatient services may be provided up to twenty hours per calendar year, subject to medical necessity. Prior authorization is required for additional services that are medically necessary.

(1) HRSA does not cover services provided by:
- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives
- To participate in home births and in birthing centers, midwives must be a Department-approved provider.

(3) Psychologists.
- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.

(4) Intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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11. Physical therapy and related services

a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.
b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).
c. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) Prior Authorization is required for physical therapy (PT) when the client:
- Is 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis; or
- Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.

(2) Prior Authorization is required for occupational therapy (OT) when the client:
- Is 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
- Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.

(3) Prior Authorization is required for speech therapy (ST) when the client:
- Is 21 years of age and older and requires services beyond one Speech evaluation and 12 Speech visits per year per client; or
- Is 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 Speech visits per year per client.

d. Physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.
e. Occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specified required education, experience, and the state's application and examination process for these providers.
f. Services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WASHINGTON

13. d. 7 Rehabilitative services/Mental health services (cont.)

*"Social worker"* means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

*"Child psychiatrist"* means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

*"Psychiatric nurse"* means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

*"Counselor"* means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee. A "counselor", engaging in the practice of counseling, can include an agency affiliated counselor, certified counselor, or certified adviser. Specific qualifications and licensing/certification requirements are described in chapter18.19 RCW and chapter 246-810 WAC.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WASHINGTON

III. Physicians Services (continued)

F. Critical Care

1. Physicians will be reimbursed for a maximum of three hours of critical care per client per day.
2. More than one physician may be reimbursed if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).
3. In the emergency room, only one physician is reimbursed.
4. For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are reimbursed.
5. The agency's rates were set as of July 1, 2009 and are effective for services on or after that date. All rates are published on the agency's website. The fee schedule and any annual/periodic adjustments to the fee schedule are published at http://hrsa.dshs.wa.gov/RBRVS/Index.html
6. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of critical care services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WASHINGTON

XIX. Supplemental Payments for Certain Professional Services

A. Notwithstanding other provisions of this section, effective July 1, 2009, supplemental payments will be paid according to this subsection for professional services performed by qualified licensed professionals. The exception to this is trauma center professional services, which will continue to be paid as described in subsection III.D above. The purpose of the supplemental payments is to ensure access to essential professional services for Medicaid beneficiaries through the care provided by the University of Washington Medicine and the University of Washington School of Medicine, and at public hospitals or other public entities.

Qualified licensed professionals include physicians, physician assistants, advanced nurse practitioners, certified registered nurse anesthetists, nurse midwives, psychiatrists, psychologists, speech-language pathologists, physical therapists, occupational therapists, podiatrists, optometrists, social workers, dentists, audiologists, chemical dependency counselors, mental health professionals, opticians, and nutritionists who are eligible to receive payment for professional services under the state's approved Medicaid program, who are:

1. Licensed by the State of Washington, where applicable;

2. Enrolled as a State of Washington Medicaid provider; and

3. Either:

   (a) Employed by the University of Washington and/or a member of its affiliated physician practice plans; or

   (b) Employed by a public hospital or other public entity, when the public entity elects to participate.

B. A supplemental payment will be made for services provided by qualified licensed professionals and billed by a component or affiliate of the University of Washington or another public entity, including a public hospital, equal to the difference between the Medicaid payments otherwise made for the services and payments at the Average Commercial Rate. Only the professional component of a procedure is eligible for a supplemental payment. Payment will be made quarterly and will not be made prior to the delivery of services.

XIX. Supplemental Payments for Certain Professional Services (cont)

C. The Average Commercial Rate to be paid to qualified licensed professionals is determined as follows:

a. Compute Average Commercial Fee Schedule: For the most recently completed state fiscal year, compute the average commercial allowed amount per procedure code, including patient share amounts, for all commercial third party payers with negotiated fee schedules.

b. Calculate the Average Commercial Payment Ceiling: For each quarter of the current state fiscal year, multiply the Average Commercial Fee Schedule as determined in subsection III.F.3.a by the number of times each procedure code was paid to qualified licensed professionals on behalf of Medicaid beneficiaries as reported from the Medicaid Management Information System (MMIS). The sum of the product for all procedure codes subject to enhanced payment represents the Average Commercial Payment Ceiling.

D. The Medicaid Supplemental Payment to Qualified Licensed Professionals equals the difference between the Average Commercial Payment Ceiling for the quarter and the total Medicaid payments for the applicable procedure codes paid to qualified licensed professionals in the quarter on behalf of Medicaid beneficiaries, as reported from the MMIS. Medicaid volume and payments includes all available payments and adjustments.