WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(1) The medicaid agency bases the payment methodology for most physician-related services on medicare's resource-based relative value scale (RBRVS). The agency obtains information used to update the agency's RBRVS from the centers for medicare and medicaid services (CMS) relative value unit (RVU) file.

(2) The agency updates and revises the RBRVS calculations during the agency's annual update.

(3) The agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by doing the following:

(a) First, determining the units of service and expenditures for a base period;

(b) Second, applying the latest medicare RVU obtained from the medicare physician fee schedule database (MPFSDB), as published in the CMS RVU file, and blended Washington (WA) geographic practice cost indices (GCPI) to obtain projected units of service for the new period;

(c) Third, multiplying the projected units of service by conversion factors to obtain estimated expenditures;

(d) Fourth, comparing expenditures obtained in (c) of this subsection with base period expenditure levels; and

(e) Fifth, adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the agency determines RBRVS RVUs by:

(i) First, multiplying the medicare RVU by the blended statewide geographic practice cost index (GPCI); and

(ii) Second, multiplying the sum of these products by the applicable conversion factor.

(b) For procedure codes with no RBRVS RVUs, the agency establishes maximum allowable fees, also known as "flat" fees.

(i) The agency does not use the conversion factor for these codes.

(ii) The agency updates flat fee reimbursement based on market research or when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) The agency reimburses for professional administered drug codes at the medicare Part B drug file price or using point-of-sale (POS) pricing methodology, described in WAC 182-530-7000, when there is no Part B rate. When the provider receives immunization materials from the department of health, the agency pays only a flat administrative fee for storage.

(B) The agency uses established medicare contractor rates.

(iii) For information regarding the agency's reimbursement of other supplies, see WAC 182-543-9000.

(c) For procedure codes with no RVU or maximum allowable fee, the agency reimburses "by report." The agency reimburses for by report codes at a percentage of the amount billed for the service.

(d) The agency adjusts composite rates annually when the codes that make up the composite rates are updated.

(5) The agency reviews RBRVS changes.
(6) The agency also makes fee schedule changes when:
(a) The legislature grants a vendor rate increase outside of the agency's annual update;
(b) There are coverage changes due to policy updates; or
(c) CMS adds or deletes procedure codes.
(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the agency applies the increase after calculating budget-neutral fees. The agency pays providers a higher reimbursement rate for primary health care evaluation and management (E&M) services that are provided to children age 20 and younger.
(8) The agency may adjust rates to maintain or increase access to health care services as directed by the legislature.
(9) The agency does not allow separate reimbursement for CMS bundled services.
(10) Variations of payment methodology which are specific to particular services, and which differ from the general payment methodology described in this section, are included in the sections dealing with those particular services.

CURRENT PROCEDURAL TERMINOLOGY (CPT)/HEALTHCARE FINANCING ADMINISTRATION (HCFA) MODIFIERS

(11) Certain services and procedures require modifiers for the agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-16-059, § 182-531-1850, filed 7/26/23, effective 8/26/23; WSR 21-23-050, § 182-531-1850, filed 11/10/21, effective 12/11/21; WSR 17-21-040, § 182-531-1850, filed 10/12/17, effective 11/12/17; WSR 17-04-039, § 182-531-1850, filed 1/25/17, effective 2/25/17. WSR 11-14-075, recodified as § 182-531-1850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-1850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]