



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSR 16-11-094; or
- Expedited Rule Making--Proposed notice was filed as WSR _____; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice
- Supplemental Notice to WSR _____
- Continuance of WSR _____

Title of rule and other identifying information: Home Health Services

WAC 182-551-2000 General; WAC 182-551-2010 Definitions; 182-551-2020 Eligible persons; 182-551-2030 Skilled services- Requirements; 182-551-2100 Covered skilled nursing services; 182-551-2110 Covered specialized therapy; 182-551-2120 Covered aide services; 182-551-2125 Delivered through telemedicine; 182-551-2130 Noncovered services; 182-551-2200 Eligible providers; 182-551-2210 Provider requirements; 182-551-2220 Provider payments; WAC 182-500-0075 Medical assistance definitions- N.

Hearing location:

Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: (360) 725-1000

Date: **October 25, 2016** Time: **10:00 a.m.**

Date of intended adoption: Not sooner than October 26, 2016
(Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360) 586-9727

by **5:00 p.m. on October 25, 2016**

Assistance for persons with disabilities: Contact Amber Lougheed by October 21, 2016
e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349
TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The agency is amending these rules to comply with new federal regulations under 42 CFR 440 requiring that physicians document the occurrence of a face-to-face encounter (including through the use of telemedicine) within reasonable timeframes when ordering home health services for Medicaid eligible clients. The agency is also aligning these rules with the new final federal rules to clarify that home health services are not restricted to clients who are homebound or to services furnished solely in the home.

Reasons supporting proposal: See purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:
Amendment to 42 CFR Section 440.70
(effective July 1, 2016.)

DATE
September 13, 2016

NAME
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: **September 13, 2016**

TIME: **3:23 PM**

WSR 16-19-033

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: Health Care Authority

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Melinda Froud	PO Box 42716, Olympia WA, 98504-2716	(360) 725-1408
Implementation....Nancy Hite	PO Box 45506, Olympia WA 98504-5506	(360) 725-1611
Enforcement.....Nancy Hite	PO Box 45506, Olympia WA 98504-5506	(360) 725-1611

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No. Explain why no statement was prepared.

The agency is not required to prepare a small business economic impact statement under RCW 19.85.025(3), as this rulemaking is for the sole purpose of complying with an amendment to 42 CFR Section 440.70 (effective July 1, 2016). If these rules are not adopted, the State cannot claim a federal match for certain home health services, resulting in lost funding for the agency.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2000 ((~~Home health services~~))General. The purpose of the medicaid agency's home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in ~~((the client's residence))~~ a setting where the client's normal life activities take place, subject to the restrictions and limitations in subchapter II.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 182-514 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2010 ((~~Home health services~~))Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to subchapter II:

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

"Brief skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

- (a) An injection;
- (b) Blood draw; or
- (c) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

"Full skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

- (a) Observation;
- (b) Assessment;
- (c) Treatment;
- (d) Teaching;
- (e) Training;
- (f) Management; and
- (g) Evaluation.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in a setting where the patient's normal life activities take place ~~((of residence))~~.

"Home health aide" means a person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. These services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided (~~in the client's residence~~) on an intermittent or part-time basis by a medicare-certified home health agency with a current provider number in a setting where the client's normal life activities take place. See also WAC 182-551-2000.

"Long-term care" is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department of social and health services' (DSHS) division of developmental disabilities (DDD) or aging and long-term support administration (AL TSA) through home and community services (HCS).

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an ordering (~~licensed practitioner~~) physician and a home health agency provider. The plan describes the home health care to be provided (~~at the client's residence~~) in a setting where the client's normal life activities take place. See WAC 182-551-2210.

(~~"Residence" means a client's home or place of living. (See WAC 182-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through the medicaid agency's home health program.)~~)

"Review period" means the three-month period the medicaid agency assigns to a home health agency, based on the address of the agency's main office, during which the medicaid agency reviews all claims submitted by that home health agency.

"Specialized therapy" means skilled therapy services provided to clients that include:

- (a) Physical;
- (b) Occupational; or
- (c) Speech/audiology services.

(See WAC 182-551-2110.)

"Telemedicine" - For the purposes of WAC 182-551-2000 through 182-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through:

(a) The collection and transmission of clinical data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry; or

(b) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit.

AMENDATORY SECTION (Amending WSR 14-07-042, filed 3/12/14, effective 4/12/14)

WAC 182-551-2020 ((Home health services—))Eligible persons.

(1) Persons in the Washington apple health ((WAH)) fee-for-service programs listed in the table in WAC 182-501-0060 are eligible to receive home health services subject to the limitations described in this chapter. Persons enrolled in an agency-contracted managed care organization (MCO) receive all home health services through their designated plan.

(2) The agency does not cover home health services under the home health program for persons in the ((CNP-emergency)) categorically needy-emergency medical only and ((LCP-MNP-emergency)) medically needy-emergency medical only programs. The agency or its designee evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 182-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

(a) The person requires hospital care due to an emergency medical condition as described in WAC 182-500-0030; and

(b) The agency or its designee authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2030 ((Home health)) Skilled services—Requirements.

(1) The medicaid agency reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

(a) Meet the definition of "acute care" in WAC 182-551-2010.

(b) Provide for the treatment of an illness, injury, or disability.

(c) Be medically necessary as defined in WAC 182-500-0070.

(d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.

(e) Be the result of a client's face-to-face encounter with the ordering physician or a nonphysician practitioner, as defined in WAC 182-500-0075, within ninety days before or within thirty days after the start of services.

(i) The face-to-face encounter may be conducted by the ordering physician or a nonphysician practitioner, as defined in WAC 182-500-0075, who is working in collaboration with the ordering physician;

(ii) Nonphysician practitioners performing the face-to-face encounter must communicate the clinical findings to the ordering physician and document the clinical findings in the client's record;

(iii) The ordering physician responsible for ordering the services must:

(A) Document the face-to-face encounter, including justification that the services are related to the primary reason for home health; and

(B) Indicate the practitioner who conducted the encounter, if not the ordering physician, along with the date of the encounter.

(iv) The face-to-face encounter may occur through telemedicine.

(f) Be provided under a plan of care (POC), as defined in WAC 182-551-2010 and described in WAC 182-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.

~~((f))~~ (g) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical ((reason(s))) reason or reasons that the services should be provided ((in)) and why instructing the client would be most effectively done in a setting where the client's ((residence)) normal life activities take place instead of at an ordering ((licensed practitioner's)) physician's office, clinic, or other outpatient setting. ((This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short term basis.

~~(g))~~ (h) Be provided in a setting where the client's ((residence)) normal life activities take place.

(i) The medicaid agency does not reimburse for services ((if)) provided at ((the workplace, school, child day care)) a hospital, adult day care, skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or any other place ((that is not the client's place of residence)) contracted with the state and paid by another program for inpatient services that includes room and board.

(ii) Clients in residential facilities contracted with the state and paid by other programs, such as home and community programs to provide limited skilled nursing services, are not eligible for medicaid agency-funded, limited skilled nursing services unless the services are prior authorized under WAC 182-501-0165.

~~((h))~~ (i) Be provided by:

(i) A home health agency that is Title XVIII (medicare)-certified;

(ii) A registered nurse (RN) prior authorized by the medicaid agency when no home health agency exists in the area ((a client resides)) where the client's normal life activities take place; or

(iii) An RN authorized by the medicaid agency when the RN cannot contract with a medicare-certified home health agency.

(3) Homebound status is not required for an eligible client to receive home health services.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2100 ((Home health services))Covered skilled nursing services. (1) The medicaid agency covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. The medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and ap-

proves the services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165.

(2) The medicaid agency covers the following home health acute care skilled nursing services, subject to the limitations in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, if the services involve one or more of the following:

- (i) Observation;
- (ii) Assessment;
- (iii) Treatment;
- (iv) Teaching;
- (v) Training;
- (vi) Management; and
- (vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

- (i) An injection;
- (ii) Blood draw; or
- (iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

- (i) Is willing and capable of learning and managing the client's infusion care; or
- (ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

- (i) When provided by a medicaid agency-approved infant phototherapy agency; and
- (ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

- (i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;
- (ii) For up to three home health visits per pregnancy if:

(A) Enrollment in or referral to the following providers of first steps has been verified:

- (I) Maternity support services (MSS); or
- (II) Maternity case management (MCM); and
- (B) The visits are provided by a registered nurse who has either:
 - (I) National perinatal certification; or
 - (II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

(3) The medicaid agency limits skilled nursing visits provided to eligible clients to two per day.

AMENDATORY SECTION (Amending WSR 16-04-026, filed 1/25/16, effective 3/1/16)

WAC 182-551-2110 ((~~Home health services~~))Covered specialized therapy. The medicaid agency covers outpatient rehabilitation and ha-

ilitative services (~~in an in-home setting by a home health agency~~) by a home health agency in a setting where the client's normal life activities take place. Outpatient rehabilitation and habilitative services are described in chapter 182-545 WAC. Specialized therapy is defined in WAC 182-551-2010.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2120 (~~(Home health services)~~) Covered aide services. (1) The medicaid agency pays for one home health aide visit, per client per day.

(2) The medicaid agency reimburses for home health aide services, as defined in WAC 182-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

- (a) Skilled nursing services; or
- (b) Specialized therapy services.

(3) The medicaid agency covers home health aide services only when a registered nurse or licensed therapist visits the ~~((client's residence))~~ client at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide, in a setting where the client's normal life activities take place.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2125 (~~(Home health services)~~) Delivered through telemedicine. (1) The medicaid agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a ~~((diagnosis(es)))~~ diagnosis or diagnoses where there is a high risk of sudden change in clinical status which could compromise health outcomes.

(2) The medicaid agency pays for one telemedicine interaction, per eligible client, per day, based on the ordering ~~((licensed practitioner's))~~ physician's home health plan of care.

(3) To receive payment for the delivery of home health services through telemedicine, the services must involve:

(a) An assessment, problem identification, and evaluation which includes:

(i) Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering (~~licensed practitioner~~) physician regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral to the emergency room as needed.

(4) The medicaid agency does not require prior authorization for the delivery of home health services through telemedicine.

(5) The medicaid agency does not pay for the purchase, rental, or repair of telemedicine equipment.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2130 (~~(Home health services)~~) Noncovered services.

(1) The medicaid agency does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and (~~disability services~~) long-term support administration (~~(+ADSA)~~) (AL TSA).

(i) The medicaid agency considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for (~~(+ADSA)~~) AL TSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, the medicaid agency may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WAC.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 182-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) (~~CNP~~) Categorically needy - Emergency medical only; and

(ii) (~~LCP-MNP~~) Medically needy - Emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy (~~and/or~~) and home health aide visit per day.

(l) The medicaid agency does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar (~~procedure(s)~~) procedure or procedures.

(m) Home health visits made without a written (~~licensed practitioner's~~) physician's order, unless the verbal order is:

(i) Documented before the visit; and

(ii) The document is signed by the ordering (~~licensed practitioner~~) physician within forty-five days of the order being given.

(2) The medicaid agency does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) The medicaid agency evaluates a request for any service that is listed as noncovered under WAC 182-501-0160.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2200 (~~(Home health services)~~) Eligible providers.

The following may contract with the medicaid agency to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare)-certified;

(b) Is department of health (DOH) licensed as a home health agency;

(c) Submits a completed, signed core provider agreement to the medicaid agency; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by the medicaid agency to provide intermittent nursing services when no home health agency exists in the area (~~(a client resides)~~) where the client's normal life activities take place;

(b) Cannot contract with a medicare-certified home health agency;

(c) Submits a completed, signed core provider agreement to the medicaid agency; and

(d) Is assigned a provider number.

WAC 182-551-2210 (~~((Home health services))~~) **Provider requirements.** For any delivered home health service to be payable, the medicaid agency requires home health providers to develop and implement an individualized plan of care (POC) for the client.

(1) The POC must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

(c) Reflect the ordering (~~((licensed practitioner's))~~) physician's orders and client's current health status;

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by an ordering (~~((licensed practitioner))~~) physician at least every sixty calendar days, signed by the ordering (~~((licensed practitioner))~~) physician within forty-five days of the verbal order, and returned to the home health agency's file; and

(f) Be available to medicaid agency staff or its designated contractor(s) on request.

(2) The provider must include all the following in the POC:

(a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);

(b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;

(c) All secondary medical diagnoses, including (~~((date(s)))~~) date or dates of onset or exacerbation;

(d) The prognosis;

(e) The (~~((type(s)))~~) type or types of equipment required, including telemedicine as appropriate;

(f) A description of each planned service and goals related to the services provided;

(g) Specific procedures and modalities;

(h) A description of the client's mental status;

(i) A description of the client's rehabilitation potential;

(j) A list of permitted activities;

(k) A list of safety measures taken on behalf of the client; and

(l) A list of medications which indicates:

(i) Any new prescription; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the POC:

(a) A description of the client's functional limits and the effects;

(b) Documentation that justifies why the medical services should be provided in (~~((the client's residence))~~) a setting where the client's life activities take place instead of an ordering (~~((licensed practitioner's))~~) physician's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the department of social and health services (DSHS) case manager of admittance;

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge; and

(g) Order for the delivery of home health services through telemedicine, as appropriate.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 182-551-2120(3);

(c) All medications administered and treatments provided;

(d) All (~~licensed practitioner's~~) physician's orders, new orders, and change orders, with notation that the order was received before treatment;

(e) Signed (~~licensed practitioner's~~) physician's new orders and change orders;

(f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(g) Interdisciplinary and multidisciplinary team communications;

(h) Inter-agency and intra-agency referrals;

(i) Medical tests and results;

(j) Pertinent medical history; and

(k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the POC;

(b) Client response to the POC;

(c) Any clinical change in client status;

(d) Follow-up interventions specific to a change in status with significant clinical findings;

(e) Any communications with the attending ordering (~~licensed practitioner~~) physician; and

(f) Telemedicine findings, as appropriate.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, client compliance, and client response;

(b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;

(c) If a client's wound is not healing, the client's ordering (~~licensed practitioner~~) physician has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and

(d) The client's physical system assessment as identified in the POC.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2220 ((Home health services--))Provider payments.

(1) To be reimbursed, the home health provider must bill the medicaid

agency according to the conditions of payment under WAC 182-502-0150 and other issuances.

(2) Payment to home health providers is:

(a) A set rate per visit for each discipline provided to a client;

(b) Based on the county location of the providing home health agency; and

(c) Updated by general vendor rate changes.

(3) For clients eligible for both medicaid and medicare, the medicaid agency may pay for services described in this chapter only when medicare does not cover those services. The maximum payment for each service is medicaid's maximum payment.

(4) Providers must submit documentation to the medicaid agency during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 182-551-2210.

(5) After the medicaid agency receives the documentation, the medicaid agency's medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) The medicaid agency may take back or deny payment for any insufficiently documented home health care service when the (~~department's~~) medicaid agency's medical director or designee determines that:

(a) The service did not meet the conditions described in WAC 182-550-2030; or

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

WAC 182-500-0075 Medical assistance definitions—N. "National correct coding initiative (NCCI)" is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

"National provider indicator (NPI)" is a federal system for uniquely identifying all providers of health care services, supplies, and equipment.

"NCCI edit" is a software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency or the agency's designee's fee schedules, billing instructions, and other publications. The agency or the agency's designee has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards or agency or agency's designee policy.

"Nonapplying spouse" see "spouse" in WAC 182-500-0100.

"Nonbilling provider" is a health care professional enrolled with the agency only as an ordering, referring, prescribing provider for the Washington medicaid program and who is not otherwise enrolled as a medicaid provider with the agency.

"Noncovered service" see "covered service" in WAC 182-500-0020.

"Nonphysician practitioner" means a nurse practitioner or clinical nurse specialist, certified nurse midwife, or a physician assistant who works in collaboration with an ordering physician.

"Nursing facility" see "institution" in WAC 182-500-0050.

"Nursing facility long-term care services" are services in a nursing facility when a person does not meet the criteria for rehabilitation. Most long-term care assists people with support services. (Also called custodial care.)

"Nursing facility rehabilitative services" are the planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person's former functional and environmental status, or alternatively, to maintain or maximize remaining function.