PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: September 19, 2018
TIME: 9:39 AM

WSR 18-19-102

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 18-05-068 and 18-05-066 **; 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); or**

☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) WAC 182-551-2000 General; 182-551-2010 Definitions; 182-551-2020 Eligibility; 182-551-2030 Skilled services-Requirements; 182-551-2040 Face-to-face encounter requirements; 182-551-2100 Covered skilled nursing services; 182-551-2110 Covered specialized therapy; 182-551-2120 Covered aide services; 182-551-2122 Medical supplies, equipment, and appliances; 182-551-2125 Delivered through telemedicine; 182-551-2130 Noncovered services; 182-551-2140 Exceptions; 182-551-2200 Eligible providers; 182-551-2210 Provider requirements; 182-551-2220 Provider payments; 182-500-0075 Medical definitions – N.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
October 23, 2018	10:00 AM	Health Care Authority Cherry Street Plaza **Pear Conference Room (107)** 626 8th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than October 24, 2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: (360) 586-9727
Other:
By (date) October 23, 2018

Assistance for persons with disabilities:

Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: (800) 848-5429 or 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) October 19, 2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is amending these rules as a result of federal regulations published in February 2016 under 42 C.F.R. 440.70, 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.

Non-physician practitioners, including advanced registered nurse practitioners (ARNPs), may perform the face-to-face encounter to determine the need for home health services, which must be documented by a physician. Only physicians may sign orders for home health services. Non-physicians, including ARNPs, may no longer sign orders for these services.

The agency is also aligning these rules with the federal regulations to clarify that home health services are not restricted to clients who are homebound or to services furnished solely in the home. Services may be provided in any setting where normal life activities take place.

Reasons supporting proposal: See Purpose above

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: 42 C.F.R. Section 440.70)

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

Name of proponent: (person or organization) 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

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

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:

TTY:
Email:
Other:

☒ 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.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☒ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.
Citation and description: 42 C.F.R Section 440.70 provides that only physicians may sign orders for home health services and does not restrict these services to clients who are homebound or to services provided solely in the home.

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☐ No Briefly summarize the agency's analysis showing how costs were calculated.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: September 19, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

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 the following professionals who work in collaboration with an ordering physician: A nurse practitioner, clinical nurse specialist, certified nurse midwife, or a physician assistant.

"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.

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

WAC 182-551-2000 ((~~Home health services —~~))General. (1) 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~~)) any setting where normal life activities take place, subject to the restrictions and limitations in subchapter II.

(2) A client does not have to be homebound or need nursing or therapy services to receive services under this chapter.

(3) 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.

(4) Home health services include the following services and items:

(a) Nursing service, see WAC 182-551-2100;

(b) Home health aide service, see WAC 182-551-2120;

(c) Medical supplies, equipment, and appliances suitable for use in any setting where normal life activities take place, see chapter 182-543 WAC; and

(d) Physical therapy, occupational therapy, or speech therapy, see WAC 182-551-2110, and audiology services, see WAC 182-531-0375.

(5) The agency evaluates medical equipment requests for medical necessity according to WAC 182-501-0165.

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 any 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 any 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 (ALTSA) 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 any 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.~~)) Eligibility. (1) ((~~Persons~~)) Clients 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~~)) provisions in this chapter. ((~~Persons~~)) Clients enrolled in an agency-contracted managed care organization (MCO) receive all home health services through their designated plan.

(2) The agency ((~~does not~~)) covers home health services ((~~under the home health program~~)) for ((~~persons~~)) clients in the ((~~CNP-emergency~~)) alien emergency medical ((~~only and LCP-MNP-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~~)) program under WAC 182-507-0120.

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~~)) covers 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) Meet face-to-face requirements described in WAC 182-551-2040.

(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 the client's residence~~)) and why instructing the client would be most effectively done in any setting where the client's 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 ((~~the client's residence~~)) any setting where normal life activities take place.

(i) The medicaid agency does not ((~~reimburse~~)) pay 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~~)) setting in which payment is or could be made under medicaid for inpatient services that include 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 where a client resides; or

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

NEW SECTION

WAC 182-551-2040 Face-to-face encounter requirements. (1) The medicaid agency pays for home health services provided under this chapter only when the face-to-face encounter requirements in this section are met.

(2) For initiation of home health services, with the exception of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires home health services and must occur within ninety days before or within the thirty days after the start of the services.

(3) For the initiation of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires medical equipment and must occur no later than six months prior to the start of services.

(4) The face-to-face encounter may be conducted by the ordering physician, a nonphysician practitioner as described in WAC

182-500-0075, or the attending acute, or post-acute physician, for beneficiaries admitted to home health immediately after an acute or post-acute stay.

(5) If a nonphysician practitioner as described in WAC 182-500-0075 (or the attending physician when a client is discharged from an acute hospital stay) performs the face-to-face encounter, the nonphysician practitioner (or attending physician) must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the client's medical record.

(6) For all home health services except medical equipment under WAC 182-551-2122, the physician responsible for ordering the services must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (2) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

(7) For medical equipment under WAC 182-551-2122, except as provided in (b) of this subsection, an ordering physician, a nonphysician practitioner as described in WAC 182-500-0075, except for certified nurse midwives, or the attending physician when a client is discharged from an acute hospital stay, must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (3) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

(8) The face-to-face encounter may occur through telemedicine. See WAC 182-551-2125.

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 the home health acute care skilled nursing services ((~~listed~~)) subject to the limitations in this section ((~~when~~)). The agency evaluates a request for covered home health acute care skilled nursing services that are:

(a) In excess of the home health care program's limitations or restrictions, according to WAC 182-501-0169; and

(b) Listed as noncovered, according to WAC 182-501-0160.

(2) The home health acute care skilled nursing services must be furnished by a qualified provider((~~. The medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves the services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165~~)) in any setting where normal life activities take place.

((~~(2)~~)) (3) The medicaid agency covers the following home health acute care skilled nursing services, subject to the ((~~limitations~~)) provisions 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~~)) enrolled 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)~~)) referred to a first steps maternity support services (MSS) provider. The visits are provided by a registered nurse who has either:

((~~(I)~~)) (A) National perinatal certification; or

((~~(II)~~)) (B) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

((~~(3)~~)) (4) 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 habilitative services ((~~in an in-home setting~~)) provided by a home

health agency in any setting where 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. Additional services require prior authorization and are granted if medically necessary, as defined in WAC 182-500-0070.

(2) The medicaid agency ((~~reimburses~~)) pays 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 any setting where normal life activities take place.

NEW SECTION

WAC 182-551-2122 Medical supplies, equipment, and appliances. The medical agency's home health program covers medical supplies, equipment, and appliances, as defined and described in chapter 182-543 WAC, that are suitable for use in any setting in which 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)~~)) (ALTSA).

(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~~)) ALTSA 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 that are covered under the AEM categorically needy and medically needy programs and are 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~~)) pay 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.

NEW SECTION

WAC 182-551-2140 Exceptions. The following services are not included in the home health benefit:

(1) More than one of the same type of specialized therapy and home health aide visit per day.

(2) Duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure or procedures.

(3) Home health visits made without a written physician's order, unless the verbal order is:

(a) Documented before the visit; and

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

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.

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

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~~)) any 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~~)) an agency-contracted managed care ((~~plan~~)) organization (MCO) are paid for by that ((~~plan~~)) MCO.