



# RULE-MAKING ORDER

**CR-103P (May 2009)**  
(Implements RCW 34.05.360)

**Agency:** Health Care Authority, Washington Apple Health

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

- 31 days after filing.
- Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

- Yes
  - No
- If Yes, explain:

**Purpose:**

These amendments are housekeeping changes to update program names, agency names, and fix cross references.

**Citation of existing rules affected by this order:**

Repealed:  
 Amended: 182-551-1300, 182-551-1400, 182-551-1500, 182-551-1510, 182-551-1530, 182-551-1850, 182-551-2000,  
 182-551-2010, 182-551-2030, 182-551-2100, 182-551-2120, 182-551-2125, 182-551-2130, 182-551-2200,  
 182-551-2210, 182-551-2220  
 Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160

**Other authority:**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 15-23-071 on November 16, 2015.

Describe any changes other than editing from proposed to adopted version:

The agency struck the proposed changes in WAC 182-551-1500 (4)(b). The section reads:

(b) This benefit is limited to brief periods (~~brief periods~~) ~~six additional days of care in a thirty-day period~~ in medicaid agency-approved:

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: \_\_\_\_\_ phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_  
 e-mail \_\_\_\_\_

**Date adopted:** January 12, 2016

**NAME (TYPE OR PRINT)**

Wendy Barcus

**SIGNATURE**

**TITLE**

HCA Rules Coordinator

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: January 12, 2016**

**TIME: 2:26 PM**

**WSR 16-03-035**

(COMPLETE REVERSE SIDE)

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

**The number of sections adopted in the agency's own initiative:**

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	<u>16</u>	Repealed	_____
-----	-------	---------	-----------	----------	-------

**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	<u>16</u>	Repealed	_____

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

**WAC 182-551-1300 Requirements for a medicaid-approved hospice agency.** (1) To become a medicaid-approved hospice agency, the medicaid agency requires a hospice agency to provide documentation that it is medicare, Title XVIII-certified by the department of health (DOH) as a hospice agency.

(2) A medicaid-approved hospice agency must at all times meet the requirements in chapter 182-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) To ensure quality of care for ((~~medical assistance~~)) Washington apple health clients, the medicaid agency's clinical staff may conduct hospice agency site visits.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

**WAC 182-551-1400 Notification requirements for hospice agencies.**

(1) To be reimbursed for providing hospice services, the hospice agency must complete a medicaid hospice notification form (HCA 13-746) and forward the form to the medicaid agency's hospice program manager within five working days from when a ((~~medical assistance~~)) Washington apple health client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the medicaid hospice program of:

- (a) The name and address of the hospice agency;
- (b) The date of the client's first day of hospice care;
- (c) A change in the client's primary physician;
- (d) A client's revocation of the hospice benefit (home or institutional);
- (e) The date a client leaves hospice without notice;
- (f) A client's discharge from hospice care;
- (g) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);
- (h) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care((-)));
- (i) A client who is eligible for or becomes eligible for medicare or third-party liability (TPL) insurance;
- (j) A client who dies; or
- (k) A client who transfers to another hospice agency. Both the former hospice agency and current hospice agency must provide the medicaid agency with:

(i) The client's name, the name of the former hospice agency servicing the client, and the effective date of the client's discharge; and

(ii) The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

(2) The medicaid agency does not require a hospice agency to notify the hospice program manager when a hospice client is admitted to a hospital for palliative care.

(3) When a hospice agency does not notify the medicaid agency's hospice program within five working days of the date of the client's first day of hospice care as required in subsection (1)(c) of this section, the medicaid agency authorizes the hospice daily rate reimbursement effective the fifth working day (~~prior to~~) before the date of notification.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

**WAC 182-551-1500 Hospice daily rate—Four levels of hospice care.** All services, supplies and equipment related to the client's terminal illness and related conditions are included in the hospice daily rate. The medicaid agency pays for only one of the following four levels of hospice care per day (see WAC (~~388-551-1510~~) 182-551-1510 for payment methods):

(1) **Routine home care.** Routine home care includes daily care administered to the client at the client's residence. The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

(2) **Continuous home care.** Continuous home care includes acute skilled care provided to an unstable client during a brief period of medical crisis (~~in order~~) to maintain the client in the client's residence and is limited to:

(a) A minimum of eight hours of acute care provided during a twenty-four-hour day;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care;

(c) Homemaker, hospice aide, and attendant services that may be provided as supplements to the nursing care; and

(d) In home care only (not care in a nursing facility or a hospice care center).

(3) **Inpatient respite care.** Inpatient respite care includes room and board services provided to a client in a medicaid-approved hospice care center, nursing facility, or hospital. Respite care is intended to provide relief to the client's primary caregiver and is limited to:

(a) No more than six consecutive days; and

(b) A client not currently residing in a hospice care center, nursing facility, or hospital.

(4) **General inpatient hospice care.** General inpatient hospice care includes services administered to a client for pain control or management of acute symptoms. In addition:

(a) The services must conform to the client's written plan of care (POC).

(b) This benefit is limited to brief periods of care in medicaid agency-approved:

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice care centers.

(c) There must be documentation in the client's medical record to support the need for general inpatient level of hospice care.

**WAC 182-551-1510 Rates methodology and payment method for hospice agencies.** This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC (~~(388-551-1500)~~) 182-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

- (a) Wage component;
- (b) Wage index; and
- (c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the (~~(department)~~) medicaid agency bases payment rates on the metropolitan statistical area (MSA) county location. MSAs are identified in the (~~(department's current published billing instructions)~~) medicaid agency's provider guides.

(4) Payment rates for:

(a) Routine and continuous home care services are based on the county location of the client's residence.

(b) Inpatient respite and general inpatient care services are based on the MSA county location of the providing hospice agency.

(5) The medicaid agency pays hospice agencies for services (not room and board) at a daily rate calculated as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(6) The medicaid agency:

(a) Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(7) Hospice agencies must bill the medicaid agency for their services using hospice-specific revenue codes.

(8) For hospice clients in a nursing facility:

(a) The medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no (~~(greater)~~) more than the nursing facility's current medicaid daily rate.

(9) The medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(10) The daily rate for authorized out-of-state hospice services is the same as for in-state non-MSA hospice services.

(11) The client's notice of action (award) letter states the amount of participation the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount of the client's participation if the client has any; and

(b) Must show the client's monthly participation on the hospice claim. (Hospice providers may refer to the medicaid agency's (~~current published billing instructions~~) provider guides for how to bill a hospice claim.) If a client has a participation amount that is not reflected on the claim and the medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the medicaid agency.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

**WAC 182-551-1530 Payment method for medicaid-medicare dual eligible clients.** (1) The medicaid agency will not pay the portion of hospice care for a client that is covered under medicare part A. Nursing home room and board charges described in WAC 182-551-1510 that are not covered under medicare part A may be covered by the medicaid agency.

(2) The medicaid agency may pay for hospice care provided to a client:

(a) Covered by medicaid part B (medical insurance); and

(b) Not covered by medicare part A.

(3) For hospice care provided to a medicaid-medicare dual eligible client, hospice agencies are responsible to bill:

(a) Medicare before billing the medicaid agency;

(b) The medicaid agency for hospice nursing facility room and board;

(c) The medicaid agency for hospice care center room and board; and

(d) Medicare for general inpatient care or inpatient respite care.

(4) All the limitations and requirements related to hospice care described in (~~this~~) subchapter I apply to the payments described in this section.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-1850 Pediatric palliative care (PPC) case management/coordination services—Rates methodology.** (1) The (~~department~~) medicaid agency determines the reimbursement rate for a pediatric palliative care (PPC) contact described in WAC (~~388-551-1820~~)

182-551-1820 using the average of statewide metropolitan statistical area (MSA) home health care rates for skilled nursing, physical therapy, speech-language therapy and occupational therapy.

(2) The (~~department~~) medicaid agency makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a (~~vendor~~) vendor rate change. New rates become effective as directed by the legislature and are effective until the next rate change.

(3) The reimbursement rate for authorized out-of-state PPC services is the same as the in-state non-MSA rate.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2000 Home health services—General.** The purpose of the (~~department's~~) 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, subject to the restrictions and limitations in (~~this~~) subchapter II.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters (~~388-515~~) 182-514 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2010 Home health services—Definitions.** The following definitions and abbreviations and those found in chapter 182-500 WAC (~~388-500-0005~~) apply to (~~this~~) 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:

- (~~(1)~~) (a) An injection;
- (~~(2)~~) (b) Blood draw; or
- (~~(3)~~) (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:

- (~~(1)~~) (a) Observation;
- (~~(2)~~) (b) Assessment;
- (~~(3)~~) (c) Treatment;
- (~~(4)~~) (d) Teaching;
- (~~(5)~~) (e) Training;

((+6+)) (f) Management; and

((+7+)) (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 the patient's place of residence.

**"Home health aide"** means ~~((an individual))~~ 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. ~~((Such))~~ 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. See also WAC ~~((388-551-2000))~~ 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's))~~ department of social and health services' (DSHS) division of developmental disabilities (DDD) or aging and ((disability services)) long-term support administration ((+ADSA+)) (ALISA) through home and community services (HCS) ~~((or the division of developmental disabilities (DDD)))~~.

**"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 and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC ~~((388-551-2210))~~ 182-551-2210.

**"Residence"** means a client's home or place of living. (See WAC ~~((388-551-2030))~~ 182-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through ~~((department's))~~ the medicaid agency's home health program.)

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

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

((+1+)) (a) Physical;

((+2+)) (b) Occupational; or

((+3+)) (c) Speech/audiology services.

(See WAC ~~((388-551-2110))~~ 182-551-2110.)

**"Telemedicine"** - For the purposes of WAC ~~((388-551-2000 through 388-551-2220))~~ 182-551-2000 through 182-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through:

~~((1))~~ (a) The collection and transmission of clinical data ~~((and the transmission of such 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

~~((2))~~ (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 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2030 Home health skilled services—Requirements.**

(1) The ~~((department))~~ 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 ~~((388-551-2010))~~ 182-551-2010.

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

(c) Be medically necessary as defined in WAC ~~((388-500-0005))~~ 182-500-0070.

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

(e) Be provided under a plan of care (POC), as defined in WAC ~~((388-551-2010))~~ 182-551-2010 and described in WAC ~~((388-551-2210))~~ 182-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.

(f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of an ordering licensed practitioner'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) Be provided in the client's residence.

(i) The ~~((department))~~ medicaid agency does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

(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 ~~((department))~~ medicaid agency-funded limited skilled nursing services unless the services are prior authorized under ~~((the provisions of))~~ WAC ~~((388-501-0165))~~ 182-501-0165.

(h) Be provided by:

- (i) A home health agency that is Title XVIII (medicare)-certified;
- (ii) A registered nurse (RN) prior authorized by the ((department)) medicaid agency when no home health agency exists in the area a client resides; or
- (iii) An RN authorized by the ((department)) medicaid agency when the RN ((is unable to)) cannot contract with a medicare-certified home health agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2100 Home health services—Covered skilled nursing services.** (1) The ((department)) medicaid agency covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. The ((department)) medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves ((such)) the services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC ((388-501-0165)) 182-501-0165.

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2120 Home health services—Covered aide services.**

- (1) The ((department)) medicaid agency pays for one home health aide visit, per client per day.
- (2) The ((department)) medicaid agency reimburses for home health aide services, as defined in WAC ((388-551-2010)) 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 ((department)) medicaid agency covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2125 Home health services—Delivered through telemedicine.** (1) The ((department)) 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) where there is a high risk of sudden change in clinical status which could compromise health outcomes.

(2) The ((department)) medicaid agency pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner'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 regarding telemedicine findings;

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

(vi) Referral to the emergency room as needed.

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

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2130 Home health services—Noncovered services.** (1)

The ((~~department~~)) 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 administration (ADSA).

(i) The ((~~department~~)) 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 to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, the ((~~department~~)) 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((~~s~~)).

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC ((~~388-551-2100~~)) 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 - Emergency medical only; and

(ii) LCP-MNP - 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 home health aide visit per day.

(1) ((HRSA)) 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).

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

(i) Documented ((~~prior to~~)) before the visit; and

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

(2) ((HRSA)) 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) ((HRSA)) The medicaid agency evaluates a request for any service that is listed as noncovered under ((~~the provisions of~~)) WAC ((~~388-501-0160~~)) 182-501-0160.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2200 Home health services—Eligible providers.** The following may contract with the ((~~department~~)) 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 ((~~department~~)) medicaid agency; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by the ((~~department~~)) medicaid agency to provide intermittent nursing services when no home health agency exists in the area a client resides;

- (b) ~~((Is unable to))~~ Cannot contract with a medicare-certified home health agency;
- (c) Submits a completed, signed core provider agreement to the ~~((department))~~ medicaid agency; and
- (d) Is assigned a provider number.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-551-2210 Home health services—Provider requirements.**

For any delivered home health service to be payable, the ~~((department))~~ 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 orders and client's current health status;
  - (d) Contain specific goals and treatment plans;
  - (e) Be reviewed and revised by an ordering licensed practitioner at least every sixty calendar days, signed by the ordering licensed practitioner within forty-five days of the verbal order, and returned to the home health agency's file; and
  - (f) Be available to ~~((department))~~ medicaid agency staff or its designated contractor(s) on request.
- (2) The provider must include all the following in the POC ~~((all of the following))~~:
  - (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) of onset or exacerbation;
  - (d) The prognosis;
  - (e) The type(s) 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 instead of an ordering licensed practitioner'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 (~~(388-551-2120)~~) 182-551-2120(3);

(c) All medications administered and treatments provided;

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

(e) Signed licensed practitioner'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; 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 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.

**WAC 182-551-2220 Home health services—Provider payments.** (1)

~~((In order))~~ To be reimbursed, the home health provider must bill the ~~((department))~~ medicaid agency according to the conditions of payment under WAC ~~((388-502-0150))~~ 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 ~~((department))~~ 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 ~~((department))~~ medicaid agency during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC ~~((388-551-2210))~~ 182-551-2210.

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

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

(a) The service did not meet the conditions described in WAC ~~((388-550-2030))~~ 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.