WAC 182-551-2220 Provider payments. (1) To be reimbursed, the home health provider must bill the medicaid agency according to medicaid program rules, including chapter 182-502 WAC and agency published billing instructions.

(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 or pays less than the medicaid maximum payment. The maximum payment for each service is medicaid's maximum payment.

(4) The medicaid agency does not pay for services provided to clients at a hospital, adult day care, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is made under medicaid for inpatient services that include room and board.

(a) Residential facilities contracted with the state to provide services are not reimbursed separately for those same services under the medicaid agency's home health program.

(b) It is the responsibility of the home health agency to request coverage for a client when the services are not available to the client in the community or through long-term care.

(5) 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.

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

(7) The medicaid agency may take back or deny payment for any insufficiently documented home health care service when the medicaid agency or the agency's 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.

(8) For any in-home home health services to be payable, the medicaid agency requires claims to meet the electronic visit verification requirements. The claims must electronically verify the following data points:

(a) Type of service performed;

(b) Individual receiving the service;

(c) Date of the service;

(d) Location of service delivery;

(e) Individual providing the service; and

(f) Time services begin and the time services end.

(9) Covered home health services for clients enrolled in an agency-contracted managed care organization (MCO) are paid for by that MCO.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2220, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2220, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2220,

filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. WSR 10-10-087, § 388-551-2220, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]