

**WSR 23-24-026
PERMANENT RULES
HEALTH CARE AUTHORITY**

[Filed November 29, 2023, 8:24 a.m., effective January 1, 2024]

Effective Date of Rule: January 1, 2024.

Purpose: The health care authority (HCA) is reviewing these rules and amending them as needed to comply with the CURES Act of 2016; P.L. 114-255, which implements the electronic visit verification requirement for home health care service claims to be paid. In addition, HCA is amending chapter 182-551 WAC to update the rules to be consistent with the other rules for administration of the medicaid program.

Citation of Rules Affected by this Order: Repealing WAC 182-551-2140; and amending WAC 182-502-0002, 182-502-0100, 182-538-070, 182-551-2000, 182-551-2010, 182-551-2020, 182-551-2030, 182-551-2040, 182-551-2100, 182-551-2110, 182-551-2115, 182-551-2120, 182-551-2122, 182-551-2125, 182-551-2130, 182-551-2200, 182-551-2210, and 182-551-2220.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: P.L. 114-255.

Adopted under notice filed as WSR 23-19-051 on September 14, 2023.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-551-2000(4)		
Proposed	Home health skilled services are (provided) <u>authorized only</u> for acute, intermittent, short-term, and intensive courses of treatment.	As a result of stakeholder comment, removed the proposed addition of " <i>authorized only</i> " to avoid confusion.
Adopted	Home health skilled services are acute, intermittent, short-term, and intensive courses of treatment.	
WAC 182-551-2030(1)		
Proposed	The medicaid agency covers, <u>authorizes, and pays for</u> home health skilled services provided to eligible clients, subject to the provisions in this section and other applicable published WAC.	As a result of stakeholder comment, removed the proposed addition of " <i>authorizes and pays for</i> " to avoid confusion.
Adopted	The medicaid agency covers home health skilled services provided to eligible clients, subject to the provisions in this section and other applicable published WAC.	
WAC 182-551-2030(2)		
Proposed	Home health skilled services provided to eligible clients (must) <u>are authorized only when covered and medically necessary based on program rules and the following criteria:</u>	As a result of stakeholder comment, removed the proposed language " <i>are authorized only when covered and medically necessary based on program rules and the following criteria.</i> " All health care services provided to medicaid clients must be medically necessary and billed in accordance with agency program rules to be paid. See WAC 182-501-0050.
Adopted	Home health skilled services provided to eligible clients must:	
WAC 182-551-2030 (2)(c)		
Proposed	(Be medically necessary as defined in WAC 182-500-0070.)	As a result of stakeholder comment, HCA revised the sentence, keeping in the proposed struck out portion.
Adopted	Be medically necessary as defined in WAC 182-500-0070 and the process outlined in WAC 182-501-0165.	
WAC 182-551-2040(1)		

Proposed/Adopted	WAC Subsection	Reason
Proposed	The ((face-to-face encounter requirements of this section may be met using telemedicine services. See WAC 182-551-2125)) <u>medicaid agency authorizes and pays for home health services provided under this chapter only when the face-to-face encounter requirements in this section are met.</u>	As a result of stakeholder comment, removed the proposed language " <i>authorizes and</i> " to avoid confusion.
Adopted	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.	
WAC 182-551-2100(1)		
Proposed	The medicaid agency covers ((the)) and pays for home health ((acute care)) skilled nursing services without prior authorization <u>up to service limitations.</u>	As a result of stakeholder comment, removed the proposed language " <i>and pays for.</i> "
Adopted	The medicaid agency covers home health skilled nursing services up to service limitations without prior authorization.	
WAC 182-551-2100(3)		
Proposed	The medicaid agency covers, <u>authorizes, and pays for the following home health</u> ((acute care)) skilled nursing services, subject to <u>program rules and</u> the provisions in this section:	As a result of stakeholder comment, removed the proposed language " <i>authorizes and</i> " to avoid confusion.
Adopted	The medicaid agency pays for the following home health skilled nursing services, subject to program rules and the provisions in this section:	
WAC 182-551-2100(4)		
Proposed	The medicaid agency limits <u>authorization of</u> skilled nursing visits provided to eligible clients to two per day.	As a result of stakeholder comment, removed the proposed language " <i>authorization of</i> " and revised the sentence to read " <i>pays for up to two.</i> "
Adopted	The medicaid agency pays for up to two skilled nursing visits, per client, per day.	
WAC 182-551-2110(1)		
Proposed	The medicaid agency covers, <u>authorizes, and pays for outpatient rehabilitation and habilitative services only when provided;</u>	As a result of stakeholder comment, removed the proposed language " <i>authorizes and pays for</i> " to avoid confusion.
Adopted	The medicaid agency covers outpatient rehabilitation and habilitative services only when provided;	
WAC 182-551-2110(3)		
Proposed	<u>The medicaid agency limits authorization of the same type of specialized therapy to one per day for eligible clients.</u>	As a result of stakeholder comment, removed proposed language " <i>authorization</i> " and replaced with " <i>payment</i> " to reflect meaning more accurately.
Adopted	The medicaid agency limits payment of the same type of specialized therapy to one per day for eligible clients.	
WAC 182-551-2110(4)		
Proposed	<u>The medicaid agency limits authorization of specialized therapy to once per day when there are two or more providers performing the same or similar procedure or procedures for the same client.</u>	As a result of stakeholder comment, removed proposed language " <i>authorization</i> " and replaced with " <i>payment</i> " to reflect meaning more accurately.
Adopted	The medicaid agency limits payment of specialized therapy to once per day when there are two or more providers performing the same or similar procedure or procedures for the same client.	
WAC 182-551-2115(1)		

Proposed/Adopted	WAC Subsection	Reason
Proposed	((Subject to funding appropriated by the legislature.)) <u>The medicaid agency covers, authorizes, and pays for medical social services, as defined in WAC 182-551-2010, provided by a home health agency in any setting where normal life activities take place under program rules, including the rules in this chapter.</u>	As a result of stakeholder comment, removed the proposed language " <i>authorizes and pays for</i> " to avoid confusion.
Adopted	The medicaid agency covers medical social services under program rules, including the rules in this chapter.	
WAC 182-551-2120 (1), (2), (3)		
Proposed	(1) The medicaid agency covers and 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)) services, one visit per client, per day under program rules, including the rules in this chapter. (2) The medicaid agency ((pays for home health aide services, as defined in WAC 182-551-2010, in any setting where normal life activities take place)) may authorize additional services on a case-by-case basis under WAC 182-501-0169.	As a result of stakeholder comments, HCA revised this language and split it into three subsections.
Adopted	(1) The medicaid agency covers home health aide services. (2) HCA pays for one visit, per client, per day under program rules, including the rules in this chapter. (3) The medicaid agency may authorize additional services on a case-by-case basis under WAC 182-501-0169.	
WAC 182-551-2122		
Proposed	The ((medical agency's home health program)) medicaid agency covers, authorizes, and pays for 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)).	As a result of stakeholder comment, removed the proposed language " <i>authorizes and pays for</i> " to avoid confusion.
Adopted	The medicaid agency covers medical supplies, equipment, and appliances, as defined and described in chapter 182-543 WAC.	
WAC 182-551-2125(1)		
Proposed	The medicaid agency ((covers)) <u>authorizes</u> the delivery of <u>one</u> home health service ((s)) through telemedicine ((for clients who have been)) , per eligible client, per day, under WAC 182-501-0300 and the requirements in this section.	As a result of stakeholder comment, removed the proposed language " <i>authorizes</i> " and replaced with " <i>pays for</i> " to avoid confusion.
Adopted	The medicaid agency pays for the delivery of one home health service through telemedicine, per eligible client, per day, under WAC 182-501-0300 and the requirements in this section.	
WAC 182-551-2210(1)		
Proposed	For any ((delivered)) home health services to be <u>authorized and payable</u> , the medicaid agency requires home health providers to develop and implement an individualized plan of care (POC) for the client.	As a result of stakeholder comment, removed the proposed language " <i>authorized and</i> " to avoid confusion.
Adopted	For any 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.	
WAC 182-551-2220(6)		

Proposed/Adopted	WAC Subsection	Reason
Proposed	After the medicaid agency receives the documentation, the medicaid ((agency's medical director)) <u>agency</u> or designee reviews the client's medical records for program compliance and quality of care.	To align with the definition of <i>agency's designee</i> found in WAC 182-500-0010, added the word "agency's" before the word "designee."
Adopted	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.	
WAC 182-551-2220(7)		
Proposed	The medicaid agency may take back or deny payment for any insufficiently documented home health care service when the medicaid ((agency's medical director)) <u>agency</u> or designee determines that:	To align with the definition of <i>agency's designee</i> found in WAC 182-500-0010, added the word "agency's" before the word "designee."
Adopted	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:	

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 5, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 18, Repealed 1.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 18, Repealed 1.

Date Adopted: November 29, 2023.

Wendy Barcus
Rules Coordinator

OTS-4793.2

AMENDATORY SECTION (Amending WSR 23-04-071, filed 1/30/23, effective 3/2/23)

WAC 182-502-0002 Eligible provider types. The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include treatment, equipment, related supplies, and drugs.

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesiologists;

(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531A-0800:

(i) Licensed behavior analyst;

- (ii) Licensed assistant behavior analyst; and
- (iii) Certified behavior technician.
- (d) Audiologists;
- (e) ~~((Substance use disorder professionals:~~
 - ~~(i) Mental health providers; and~~
 - ~~(ii) Peer counselors.~~
 - ~~(f))~~ Chiropractors;
 - ~~((g))~~ (f) Dentists;
 - ~~((h))~~ (g) Dental health aide therapists, as provided in chapter 70.350 RCW;
 - ~~((i))~~ (h) Dental hygienists;
 - ~~((j))~~ (i) Denturists;
 - ~~((k))~~ (j) Dietitians or nutritionists;
 - ~~((l))~~ (k) Hearing aid fitters/dispensers;
 - (l) Home health aide credentialed with DOH as nursing assistant certified or nursing assistant registered;
 - (m) Licensed practical nurse;
 - (n) Marriage and family therapists;
 - ~~((n))~~ (o) Mental health counselors;
 - ~~((o))~~ (p) Mental health care providers;
 - ~~((p))~~ (q) Midwives;
 - ~~((q))~~ (r) Naturopathic physicians;
 - ~~((r))~~ (s) Nurse anesthetist;
 - ~~((s))~~ (t) Ocularists;
 - ~~((t))~~ (u) Occupational therapists;
 - ~~((u))~~ (v) Ophthalmologists;
 - ~~((v))~~ (w) Opticians;
 - ~~((w))~~ (x) Optometrists;
 - ~~((x))~~ (y) Orthodontists;
 - ~~((y))~~ (z) Orthotist;
 - ~~((z))~~ (aa) Osteopathic physicians;
 - ~~((aa))~~ (bb) Osteopathic physician assistants;
 - ~~((bb))~~ (cc) Peer counselors;
 - ~~((cc))~~ (dd) Podiatric physicians;
 - ~~((dd))~~ (ee) Pharmacists;
 - ~~((ee))~~ (ff) Physicians;
 - ~~((ff))~~ (gg) Physician assistants;
 - ~~((gg))~~ (hh) Physical therapists;
 - ~~((hh))~~ (ii) Prosthetist;
 - ~~((ii))~~ (jj) Psychiatrists;
 - ~~((jj))~~ (kk) Psychologists;
 - ~~((kk))~~ (ll) Radiologists;
 - ~~((ll))~~ (mm) Registered nurse;
 - (nn) Registered nurse delegators;
 - ~~((mm))~~ (oo) Registered nurse first assistants;
 - ~~((nn))~~ (pp) Respiratory therapists;
 - ~~((oo))~~ (qq) Social workers; and
 - ~~((pp))~~ (rr) Speech/language pathologists;
 - (ss) Substance use disorder professionals:
 - (i) Mental health providers; and
 - (ii) Peer counselors.
 - (2) Agencies, centers and facilities:
 - (a) Adult day health centers;
 - (b) Ambulance services (ground and air);
 - (c) Ambulatory surgery centers (medicare-certified);
 - (d) Birthing centers (licensed by the department of health);
 - (e) Cardiac diagnostic centers;

- (f) Case management agencies;
 - (g) Substance use disorder treatment facilities certified by the department of health (DOH);
 - (h) Withdrawal management treatment facilities certified by DOH;
 - (i) Community AIDS services alternative agencies;
 - (j) Community mental health centers;
 - (k) Diagnostic centers;
 - (l) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;
 - (m) Family planning clinics;
 - (n) Federally qualified health centers (designated by the federal department of health and human services);
 - (o) Genetic counseling agencies;
 - (p) Health departments;
 - (q) Health maintenance organization (HMO)/managed care organization (MCO);
 - (r) HIV/AIDS case management;
 - (s) Home health agencies;
 - (t) Hospice agencies;
 - (u) Hospitals;
 - (v) Indian health service facilities/tribal 638 facilities;
 - (w) Tribal or urban Indian clinics;
 - (x) Inpatient psychiatric facilities;
 - (y) Intermediate care facilities for individuals with intellectual disabilities (ICF-IID);
 - (z) Kidney centers;
 - (aa) Laboratories (CLIA certified);
 - (bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;
 - (cc) Neuromuscular and neurodevelopmental centers;
 - (dd) Nurse services/delegation;
 - (ee) Nursing facilities (approved by the DSHS aging and long-term support administration);
 - (ff) Pathology laboratories;
 - (gg) Pharmacies;
 - (hh) Private duty nursing agencies;
 - (ii) Radiology - Stand-alone clinics;
 - (jj) Rural health clinics (medicare-certified);
 - (kk) School districts and educational service districts;
 - (ll) Sleep study centers; and
 - (mm) Washington state school districts and educational service districts.
- (3) Suppliers of:
 - (a) Blood, blood products, and related services;
 - (b) Durable and nondurable medical equipment and supplies;
 - (c) Complex rehabilitation technologies;
 - (d) Infusion therapy equipment and supplies;
 - (e) Prosthetics/orthotics;
 - (f) Hearing aids; and
 - (g) Respiratory care, equipment, and supplies.
 - (4) Contractors:
 - (a) Transportation brokers;
 - (b) Spoken language interpreter services agencies;
 - (c) Independent sign language interpreters; and
 - (d) Eyeglass and contact lens providers.

AMENDATORY SECTION (Amending WSR 15-14-039, filed 6/24/15, effective 7/25/15)

- WAC 182-502-0100 General conditions of payment.** (1) The medic-aid agency reimburses for medical services furnished to an eligible client when all the following apply:
- (a) The service is within the scope of care of the client's Washington apple health program;
 - (b) The service is medically (~~or dentally~~) necessary;
 - (c) The service is properly authorized;
 - (d) The provider bills within the time frame set in WAC 182-502-0150;
 - (e) The provider bills according to agency rules and billing instructions; and
 - (f) The provider follows third-party payment procedures.
- (2) The agency is the payer of last resort, unless the other payer is:
- (a) An Indian health service;
 - (b) A crime victims program through the department of labor and industries; or
 - (c) A school district for health services provided under the Individuals with Disabilities Education Act.
- (3) The agency does not reimburse providers for medical services identified by the agency as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:
- (a) Copayments (copays) (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met);
 - (b) Deductibles (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met); and
 - (c) Spenddown (see WAC 182-519-0110).
- (4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and Washington apple health before the agency makes any payment.
- (5) The provider is responsible for verifying whether a client has Washington apple health coverage for the dates of service.
- (6) The agency may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service when it was provided if:
- (a) The agency considered the person eligible at the time of service;
 - (b) The service was not otherwise paid for; and
 - (c) The provider submits a request for payment to the agency.
- (7) The agency does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the agency.
- (8) Information about medical care for jail inmates is found in RCW 70.48.130.
- (9) The agency pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the agency, whichever is lower.

OTS-4794.2

AMENDATORY SECTION (Amending WSR 23-03-063, filed 1/12/23, effective 2/12/23)

WAC 182-538-070 Payments, corrective action, and sanctions for managed care organizations (MCOs). (1) The medicaid agency pays apple health managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been developed using generally accepted actuarial principles and practices;

(b) Are appropriate for the populations to be covered and the services to be furnished under the MCO contract;

(c) Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;

(d) Are based on analysis of historical cost, rate information, or both; and

(e) Are paid based on legislative allocations.

(2) The MCO is solely responsible for payment of MCO-contracted health care services. The agency will not pay for a service that is the MCO's responsibility, even if the MCO has not paid the provider for the service.

(3) Home health services delivered through MCOs involving an in-home visit by a provider require the provider to comply with electronic visit verification requirements. See WAC 182-551-2220.

(4) The agency pays MCOs a service-based enhancement rate for wraparound with intensive services (WISe) administered by a certified WISe provider who holds a current behavioral health agency license issued by the department of health under chapter 246-341 WAC.

~~((4))~~ (5) For crisis services, the MCO must determine whether the person receiving the services is eligible for Washington apple health or if the person has other insurance coverage.

~~((5))~~ (6) The agency may require corrective action for:

(a) Substandard rates of clinical performance measures;

(b) Deficiencies found in audits and on-site visits; or

(c) Findings of noncompliance with any contractual, state, or federal requirements.

~~((6))~~ (7) The agency may:

(a) Impose sanctions for an MCO's noncompliance with any contractual, state, or federal requirements including, but not limited to, intermediate sanctions as described in 42 C.F.R. Sec. 438.700 and 42 C.F.R. Sec. 438.702; and

(b) Apply a monthly penalty assessment associated with poor performance on selected behavioral health performance measures.

~~((7))~~ (8) As authorized by 42 C.F.R. Sec. 438.702(b), if an MCO fails to meet any material obligation under the MCO contract including, but not limited to, the items listed in 42 C.F.R. Sec. 438.700

(b), (c), or (d), the agency may impose the maximum allowable sanction on a per-occurrence, per-day basis until the agency determines the MCO has:

(a) Corrected the violation; and

(b) Remedied any harm caused by the noncompliance.

~~((8))~~ (9) The agency pays an enhancement rate for each MCO enrollee assigned to a federally qualified health center or rural health clinic, as authorized under chapters 182-548 and 182-549 WAC.

~~((9))~~ (10) The agency pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child or children and the MCO pays for any part of labor and delivery.

OTS-4795.5

AMENDATORY SECTION (Amending WSR 22-05-048, filed 2/9/22, effective 3/12/22)

WAC 182-551-2000 General. (1) The purpose of the medicaid agency's home health services program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in any setting where normal life activities take place, subject to the restrictions and limitations in subchapter II. See also 42 C.F.R. 440.70.

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

(a) Nursing services, 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;

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

(e) Medical social services, see WAC 182-551-2115.

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

~~((3))~~ (4) 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;~~

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

~~(e) Medical social services, see WAC 182-551-2115.~~

~~(5) The agency evaluates medical equipment requests for medical necessity according to WAC 182-501-0165.)~~ (5) Home health visits require a written order from an authorized practitioner, unless there is a verbal order that is:

(a) Documented before the visit; and

(b) Signed by the ordering authorized practitioner within 45 calendar days of the order being given.

(6) The medicaid agency evaluates requests for home health services based on medical necessity and other program rules related to medicaid funded services including those found in this chapter, chapters 182-501 and 182-502 WAC.

(7) Home health services, delivered through fee-for-service or managed care, involving an in-home visit by a provider, require the provider to comply with electronic visit verification requirements. See WAC 182-551-2220.

(8) The medicaid agency does not pay for administrative costs billed above the visit rate.

AMENDATORY SECTION (Amending WSR 23-04-048, filed 1/26/23, effective 2/26/23)

WAC 182-551-2010 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.

"Authorized practitioner" means:

(a) A physician, nurse practitioner, clinical nurse specialist, or physician assistant who may order and conduct home health services, including face-to-face encounter services; or

(b) A certified nurse midwife under 42 C.F.R. 440.70 when furnished by a home health agency that meets the conditions of participation for medicare who may conduct home health services, including face-to-face encounter services.

"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.

"Electronic visit verification (EVV)" means, with respect to home health services, a system under which in-home visits conducted as part of delivery of such services are electronically verified with respect to:

- (a) The type of service performed;
- (b) The individual receiving the service;
- (c) The date of the service;
- (d) The location of service delivery;
- (e) The individual providing the service; and
- (f) The time the service begins and ends.

"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 that attests to the satisfaction of the medicaid agency that it meets the requirements for participation in medicare or is certified under the medicare program 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.

"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 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))~~ home health agency. 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).

"Medical social services" are services delivered by a medical social worker that are intended to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the client's medical condition or rate of recovery. ~~((Medical social services include assessment of the social and emotional factors related to the client's illness, need for care, response to treatment, and adjustment to care; evaluation of the client's home situation, financial resources, and availability of community resources; assistance in obtaining available community resources and financial resources; and counseling the client and family to address emotional issues related to the illness.))~~

"Medical social worker" has the same meaning given for "social worker" in WAC 246-335-510.

"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 authorized practitioner and a home health agency provider. The plan describes the home health care to be provided in any setting where the client's normal life activities take place. See WAC 182-551-2210.

"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" - See WAC 182-501-0300 and 182-551-2125.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2020 Eligibility. (1) ~~((Clients in the Washington apple health programs listed in the table in WAC 182-501-0060 are eligible to receive home health services))~~ Washington apple health clients are eligible for home health services as identified in the table in WAC 182-501-0060 and subject to the provisions in this chapter.

(2) Clients enrolled in an agency-contracted managed care organization (MCO) receive all home health services through their designated plan. EVV requirements are applicable to the in-home delivery of home health services for clients enrolled in a managed care organization.

~~((2))~~ (3) The agency covers home health services for clients in the alien emergency medical program under WAC 182-507-0120.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2030 Skilled services—Requirements. (1) The medic-aid agency covers home health skilled services provided to eligible clients, subject to the provisions 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 ~~((-))~~ and the process outlined in WAC 182-501-0165;

(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 ~~((-))~~;

(g) Be used to prevent placement in a more restrictive setting ~~((- In addition,))~~;

(h) Be provided in any setting where normal life activities take place; and

(i) The client's medical records must justify the medical reason or reasons that the services should be provided ((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 physician's office, clinic, or other outpatient setting.

~~((h) Be provided in any setting where normal life activities take place.~~

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

~~(ii)) (3) 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.~~

~~(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)) only on a short-term, temporary basis while authorization of these services is pending with the other state programs. Prior authorization is required.~~

AMENDATORY SECTION (Amending WSR 23-04-048, filed 1/26/23, effective 2/26/23)

WAC 182-551-2040 Face-to-face encounter requirements. (1) The ~~((face-to-face encounter requirements of this section may be met using telemedicine services. See WAC 182-551-2125))~~ 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) 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))~~ face-to-face encounter requirements of this section may be met using telemedicine services. See WAC 182-551-2125.

(3) 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 90 calendar days before or within the 30 calendar days after the start of the home health services.

(4) 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 more than six months before the start of services.

(5) The face-to-face encounter may be conducted by:

- (a) A physician;
- (b) A nurse practitioner;
- (c) A clinical nurse specialist;

(d) A certified nurse midwife under 42 C.F.R. 440.70 when furnished by a home health agency that meets the conditions of participation for medicare;

(e) A physician assistant; or

(f) The attending acute, or post-acute physician, for beneficiaries admitted to home health immediately after an acute or post-acute stay.

(6) Services may be ordered by:

- (a) Physicians;
- (b) Nurse practitioners;
- (c) Clinical nurse specialists; or
- (d) Physician assistants.

(7) For all home health services except medical equipment under WAC 182-551-2122, the physician, nurse practitioner, clinical nurse specialist, or physician assistant 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 (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) For medical equipment under WAC 182-551-2122, (~~except as provided in (b) of this subsection,~~) an ordering physician, nurse practitioner, clinical nurse specialist, physician assistant, 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 (4) 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.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2100 ((Covered)) Skilled nursing services. (1) The medicaid agency covers ((the)) home health ((acute care)) skilled nursing services up to service limitations without prior authorization ((subject to the provisions in this section. Additional services require prior authorization and are granted if medically necessary, as defined in WAC 182-500-0070. The agency evaluates a request for home health acute care skilled nursing services that are listed as noncovered:

~~(a) For a person age 21 and older, according to WAC 182-501-0160;~~

~~(b) For a person age 20 and younger, under the early and periodic screening diagnosis and treatment (EPSDT) provisions in chapter 182-543 WAC; and~~

~~(c) For a person age 19 or older that is under emergency related services only, according to WAC 182-507-0120)). See WAC 182-501-0169 for information on limitation extension.~~

(2) The home health ((acute care)) skilled nursing services must be furnished by a qualified provider in any setting where normal life activities take place.

(3) The medicaid agency ((covers)) pays for the following home health ((acute care)) skilled nursing services, subject to program rules and the 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 home health agency with an infant phototherapy ((agency)) provider; 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~~) birth parent, unborn, or newborn;
 - (ii) For up to three home health visits per pregnancy if enrolled in or referred to a first steps maternity support services (MSS) provider. The visits are provided by a registered nurse who has either:
 - (A) National perinatal certification; or
 - (B) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.
- (4) The medicaid agency (~~limits~~) pays for up to two skilled nursing visits ((provided to eligible clients to two)), per client, per day.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2110 ((Covered)) Specialized therapy. (1) The medicaid agency covers outpatient rehabilitation and habilitative services only when provided:

- (a) By a home health agency; and
- (b) In any setting where normal life activities take place.

(2) Outpatient rehabilitation and habilitative services are described in chapter 182-545 WAC. Specialized therapy is defined in WAC 182-551-2010.

(3) The medicaid agency limits payment of the same type of specialized therapy to one per day for eligible clients.

(4) The medicaid agency limits payment of specialized therapy to once per day when there are two or more providers performing the same or similar procedure or procedures for the same client.

AMENDATORY SECTION (Amending WSR 22-05-048, filed 2/9/22, effective 3/12/22)

WAC 182-551-2115 ((Covered)) Medical social services. (1)

~~((Subject to funding appropriated by the legislature,))~~ The medicaid agency covers medical social services ~~((, as defined in WAC 182-551-2010, provided by a home health agency in any setting where normal life activities take place))~~ under program rules, including the rules in this chapter.

(2) Medical social services include the following:

(a) Assessment of the social and emotional factors related to the client's illness;

(b) Need for care, response to treatment, and adjustment to care;

(c) Evaluation of the client's home situation, financial resources, and availability of community resources;

(d) Assistance in obtaining available community resources and financial resources; and

(e) Counseling the client and family to address emotional issues related to the illness.

(3) The medicaid agency pays for up to eight 15-minute units per 365-day period without prior authorization.

(4) The medicaid agency ~~((pays for))~~ may authorize additional services ~~((with prior authorization))~~ on a case-by-case basis ~~((when medically necessary))~~ under WAC 182-501-0169.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2120 ((Covered)) Aide services. (1) The medicaid agency ~~((pays for one))~~ covers 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))~~ services.

(2) The agency pays for one visit per client, per day under program rules, including the rules in this chapter.

(3) The medicaid agency ~~((pays for home health aide services, as defined in WAC 182-551-2010, in any setting where normal life activities take place))~~ may authorize additional services on a case-by-case basis under WAC 182-501-0169.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2122 Medical supplies, equipment, and appliances.

The ~~((medical agency's home health program))~~ medicaid agency 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 23-04-048, filed 1/26/23, effective 2/26/23)

WAC 182-551-2125 Home health services delivered using telemedicine. (1) The medicaid agency (~~(eovers)~~) pays for the delivery of one home health service((s)) through telemedicine ((for clients who have been)), per eligible client, per day, under WAC 182-501-0300 and the requirements in this section.

(2) For clients to be eligible to receive home health services through telemedicine, the medicaid agency requires the client to:

(a) Be diagnosed with an unstable condition ((who may)) causing the client to be at risk for hospitalization or a more costly level of care (. The client must); and

(b) Have a 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 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;

(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 physician regarding 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.

(6) Electronic visit verification requirements are not applicable to home health services delivered through telemedicine. Other program rules may apply similar or the same record requirements to providers of home health services.

AMENDATORY SECTION (Amending WSR 22-05-048, filed 2/9/22, effective 3/12/22)

WAC 182-551-2130 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 long-term support administration (AL TSA).

(i) Prior to AL TSA implementing a long-term care skilled nursing plan or specialized therapy plan, the medicaid agency may consider (~~requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for AL TSA to implement a long-term care skilled nursing plan or specialized therapy plan~~) a short-term authorization of these services as an exception to rule (ETR); 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 provisions in this section and other applicable (~~published~~) WAC.

(b) Social work services that are not "medical social services" as defined in WAC 182-551-2010 or listed as covered in WAC 182-551-2115.

(c) Psychiatric skilled nursing services.

(d) (~~Pre- and postnatal~~) Prenatal and postpartum 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) Health care for a medically stable client (~~(e.g., one who does not have an acute episode, a disease exacerbation, or treatment change)~~).

(h) Home health specialized therapies and home health aide visits for AEM clients (~~that are covered under the AEM categorically needy and medically needy programs and are~~) in the following programs:

(i) Categorically needy - Emergency medical only; and

(ii) Medically needy - Emergency medical only.

(~~(i) 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).~~

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

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

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

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

(~~ii) The document is signed by the ordering physician within 45 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))~~ (2) The medicaid agency evaluates a request for ((any)) home health services that ((is)) are listed as noncovered ((under WAC 182-501-0160)):

(a) For a person age 21 and older, under WAC 182-501-0160;

(b) For a person age 20 and younger, under the early and periodic screening diagnosis and treatment (EPSDT) provisions in chapter 182-534 WAC; and

(c) For a person age 19 or older that is under emergency related services only, under WAC 182-507-0120.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2200 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))~~ requirements and limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare)-certified, or if the services being provided are not covered by medicare, the provider may attest to the medicaid agency it meets the requirements for participation in medi-care;

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

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

(d) ((Is assigned a provider number)) Has a home health taxonomy on their provider file in the medicaid agency's claim payment system.

(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 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 is enrolled; and

(d) ((Is assigned a provider number)) Has an RN home health taxonomy on their provider file in the medicaid agency's claim payment system.

AMENDATORY SECTION (Amending WSR 23-04-048, filed 1/26/23, effective 2/26/23)

WAC 182-551-2210 Provider requirements. (1) For any ((delivered)) home health services 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)) that 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 authorized practitioner's orders and client's current health status;
 - (d) Contain specific goals and treatment plans;
 - (e) Be reviewed and revised by an authorized practitioner at least every 60 calendar days ~~((7))~~;
 - ~~(f) Be signed by the authorized practitioner within 45 days ((of the)) if a verbal order ((, and returned to the home health agency's file)) is given;~~ and
 - ~~((f))~~ (g) 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 or dates of onset or exacerbation;
 - (d) The prognosis;
 - (e) The type or types of equipment required;
 - (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 any setting where the client's life activities take place instead of an authorized 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 ~~((or telemonitoring))~~, 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 authorized practitioner's orders, new orders, and change orders, with notation that the order was received before treatment;

- (e) Signed authorized 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 authorized 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; and
- (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 authorized 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.
- (7) For any in-home delivered home health services to be payable, the medicaid agency requires home health providers to meet the electronic visit verification requirements.

AMENDATORY SECTION (Amending WSR 18-24-023, filed 11/27/18, effective 1/1/19)

WAC 182-551-2220 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))~~ 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.

~~((5))~~ (6) After the medicaid agency receives the documentation, the medicaid ((agency's medical director)) agency or the agency's designee reviews the client's medical records for program compliance and quality of care.

~~((6))~~ (7) The medicaid agency may take back or deny payment for any insufficiently documented home health care service when the medicaid ((agency's medical director)) 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.

~~((7))~~ (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.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-551-2140 Exceptions.