WSR 21-19-156
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 22, 2021, 11:42 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-14-007.

Title of Rule and Other Identifying Information: WAC 182-543-2000 Eligible providers and provider requirements, 182-551-2010 Definitions, and 182-551-2210 Provider requirements.

Hearing Location(s): On October 26, 2021, at 10:00 a.m. The health care authority (HCA) remains closed in response to the coronavirus disease (COVID-19) public health emergency. Until further notice, HCA continues to hold public hearings virtually without a physical meeting place. This promotes social distancing and the safety of the residents of Washington state. To attend the virtual public hearing, you must register in advance https://zoom.us/webinar/register/WN_Ig_1_lBzQ0Oa2h_0Y6Ak0w. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: Not sooner than October 27, 2021.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by October 26, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by October 8, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending these rules to change occurrences of "ordering physician" to "authorized practitioner" to align with amendments in chapters 182-543 and 182-551 WAC recently made in WSR 21-12-051.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, 18.79.256.

Statute Being Implemented: RCW 41.05.021, 41.05.160, 18.79.256

Rule is not necessitated by federal law, federal or state court decision.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Cynde Rivers, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-5282.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule does not impose more-than-minor costs on businesses.

September 22, 2021
Wendy Barcus

Rules Coordinator

OTS-3266.1

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

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 physician, nurse practitioner, clinical nurse specialist, or physician assistant who may order 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.

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

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

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

"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. See also WAC 182-551-2000.

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

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an ((~~ordering physician~~)) 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" - For the purposes of WAC 182-551-2000 through 182-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through:

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2010, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-03-035, § 182-551-2010, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2010, 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, § 388-551-2010, 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, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

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

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

(1) The POC must:

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

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

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

(d) Contain specific goals and treatment plans;

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

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

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

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

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

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

(d) The prognosis;

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

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

(g) Specific procedures and modalities;

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

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

(j) A list of permitted activities;

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

(l) A list of medications which indicates:

(i) Any new prescription; and

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

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

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

(b) Documentation that justifies why the medical services should be provided in any setting where the client's life activities take place instead of an ((~~ordering physician's~~)) 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, 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 ((~~physician's~~)) authorized practitioner's orders, new orders, and change orders, with notation that the order was received before treatment;

(e) Signed ((~~physician's~~)) 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 ((~~ordering physician~~)) 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;

(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 physician~~)) 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.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2210, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-03-035, § 182-551-2210, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2210, 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, § 388-551-2210, 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, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory

Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

OTS-3267.1

AMENDATORY SECTION (Amending WSR 18-24-021, filed 11/27/18, effective 1/1/19)

WAC 182-543-2000 Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for medical equipment and repairs on a fee-for-service basis as follows:

(a) Providers who are enrolled with medicare for medical equipment and related repair services;

(b) Qualified complex rehabilitation technology (CRT) suppliers who are enrolled with medicare;

(c) Medical equipment dealers and pharmacies who are enrolled with medicare, and have a national provider identifier (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy;

(f) Physicians who provide medical equipment in the office; and

(g) Out-of-state prosthetics and orthotics providers who meet their state regulations.

(2) Providers and suppliers of medical equipment must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Have the proper business license and be certified, licensed and bonded if required, to perform the services billed to the agency;

(c) Have a valid prescription for the medical equipment.

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at https://www.hca.wa.gov/billers-providers/forms-and-publications;

(B) Be written by ((~~a physician~~)) an authorized practitioner as defined in WAC ((~~182-500-0085~~)) 182-551-2010 and meet the face-to-face encounter requirements described in WAC 182-551-2040;

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the medical equipment. Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual-eligible clients when medicare is the primary payer and the agency is being billed for only the copay, only the deductible, or both, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Provide only new equipment to clients, which include full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Provide documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

(g) Bill the agency using only the allowed procedure codes listed in the agency's published medical equipment billing guide.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Part 440.70; 42 U.S.C. section 1396 (b)(i)(27). WSR 18-24-021, § 182-543-2000, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-15-073, § 182-543-2000, filed 7/14/17, effective 8/14/17. Statutory Authority: RCW 41.05.021 and 2013 c 178. WSR 14-08-035, § 182-543-2000, filed 3/25/14, effective 4/25/14. Statutory Authority: RCW 41.05.021 and Affordable Care Act (ACA) - 76 Fed. Reg. 5862, 42 C.F.R. Parts 405, 424, 447, 455, 457, and 498. WSR 12-15-015, § 182-543-2000, filed 7/10/12, effective 9/1/12. WSR 11-14-075, recodified as § 182-543-2000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.04.050. WSR 11-14-052, § 388-543-2000, filed 6/29/11, effective 8/1/11; WSR 07-17-062, § 388-543-2000, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. WSR 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]