WSR 22-19-092
PROPOSED RULES
HEALTH CARE AUTHORITY

[Filed September 21, 2022, 8:30 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-15-065.

Title of Rule and Other Identifying Information: WAC 182-501-0300 Telemedicine and store and forward technology, 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative, 182-531-1730 Telemedicine, 182-538-195 Telemedicine and store and forward technology, 182-551-2010 Definitions, 182-551-2040 Face-to-face encounter requirements, 182-551-2210 Provider requirements, 182-551-2125 Home health services delivered using telemedicine, and 182-537-0200 Definitions.

Hearing Location(s): On October 25, 2022, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the health care authority (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://us02web.zoom.us/webinar/register/WN__qei9CXvT4yA1EjxXzF7lw. If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: Not sooner than October 26, 2022.

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 25, 2022.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-1349, telecommunications relay service 711, email Johanna.Larson@hca.wa.gov, by October 14, 2022.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is developing and revising rules to provide for telemedicine and store and forward technology, in alignment with ESHB 1196. New WAC 182-501-0300 would replace WAC 182-531-1730 and provide more details regarding the authorized use of telemedicine and store and forward technology, including allowing audio-only telemedicine. WAC 182-501-0300 also sets out the agency's requirements for telemedicine and store and forward technology.

Although the agency planned to revise WAC 182-531A-1200 as part of this rule making, this revision will be done as part of a separate rule making, filed under WSR 22-19-087.

Reasons Supporting Proposal: See purpose above.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; ESHB 1196.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Josh Morse, P.O. Box 45502, Olympia, WA 98504-5502, 360-725-0839.

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.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Scope of exemption for rule proposal:

Is fully exempt.

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 a disproportionate cost on small businesses.

September 21, 2022
Wendy Barcus
Rules Coordinator

OTS-3973.2

NEW SECTION

WAC 182-501-0300 Telemedicine and store and forward technology. (1) **Purpose and scope.**

(a) This section identifies the requirements and limitations for coverage, authorization, and payment of health care services provided through telemedicine or store and forward technologies as defined in subsection (2) of this section.

(b) This section applies to health care services, including behavioral health services, provided to clients enrolled in:

(i) An agency-contracted managed care organization (MCO) and fee-for-service programs; and

(ii) Other agency-contracted programs, including grant-funded health care services and health care services administered by behavioral health administrative services organizations (BH-ASOs).

(2) **Definitions.** The following definitions and those found in RCW 71.24.335, 74.09.325, and chapter 182-500 WAC apply to this section.

(a) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the client at the originating site and the provider, for the purposes of diagnosis, consultation, or treatment.

(b) "Distant site" means the same as in RCW 71.24.335 or 74.09.325.

(c) "Established relationship" means the same as in RCW 71.24.335 or 74.09.325.

(d) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW.

(e) "In person" means the client and the provider are in the same location.

(f) "Originating site" means the same as in RCW 71.24.335 or 74.09.325.

(g) "Store and forward technology" see RCW 71.24.335 or 74.09.325.

(h) "Telemedicine" means the delivery of health care services using interactive audio and video technology, permitting real-time communication between the client at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only telemedicine, but does not include the following services:

(i) Email and facsimile transmissions;

(ii) Installation or maintenance of any telecommunication devices or systems;

(iii) Purchase, rental, or repair of telemedicine equipment; and

(iv) Incidental services or communications that are not billed separately, such as communicating laboratory results.

(3) **Requirements and authorized use of telemedicine and store and forward technology.**

(a) **Governing authority.** The medicaid agency determines the health care services that may be paid for when provided through telemedicine or store and forward technology as authorized by state law, including RCW 71.24.335, 74.09.325, and 74.09.327.

(b) **Coverage, authorization, and payment.** Health care services approved for delivery through telemedicine or store and forward technology must comply with the agency's program rules. The program rules include coverage, authorization, and payment by the agency or the agency's designee, including an agency-contracted managed care entity (managed care organization or behavioral health administrative services organization).

(c) **Billing requirements.** Providers must bill for health care services as required by the program rules and provider guides of the agency or the agency's designee, including a contracted managed care entity.

(d) **Criteria for health care services.**

(i) The agency determines the health care services that may be provided through telemedicine or store and forward technology based on whether the health care service is:

(A) A covered service when provided in person by the provider;

(B) Medically necessary;

(C) Determined to be safely and effectively provided through telemedicine or store and forward technology based on generally accepted health care practices and standards; and

(D) Provided through a technology that meets the standards required by state and federal laws governing the privacy and security of protected health information.

(ii) For health care services provided by audio-only telemedicine, the provider and client must have an established relationship.

(iii) For behavioral health services authorized for delivery through store and forward technology, there must be an associated visit between the referring provider and the client.

(4) **Health care services authorized for telemedicine and store and forward technology.**

(a) Health care services that are authorized to be provided through telemedicine or store and forward technology are identified in the agency's provider guides and fee schedules.

(b) For covered health care services approved for delivery through telemedicine or store and forward technology, the agency or the agency's designee, including an agency-contracted managed care entity (managed care organization (MCO) or behavioral health administrative services organization (BH-ASO)), may require:

(i) Utilization review;

(ii) Prior authorization; and

(iii) Deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable in-person health care service.

(5) **Payment of health care services delivered through telemedicine or store and forward technology.**

(a) The agency's designee, including an agency-contracted managed care entity (managed care organization (MCO) or behavioral health administrative services organization (BH-ASO)), pays providers for health care services delivered through telemedicine or store and forward technology in the same amount as when the health care services are provided in person, except as provided in these rules, RCW 71.24.335, and 74.09.325.

(b) The agency or the agency's designee, including an agency-contracted managed care entity (managed care organization or behavioral health administrative services organization) pays for encounter-eligible health care services authorized for delivery through telemedicine at the encounter rate when provided by:

(i) Rural health clinics;

(ii) Federally qualified health centers; or

(iii) Direct Indian health service clinics, tribal clinics, or tribal federally qualified health centers.

(6) **Client consent.**

(a) To receive payment for an audio-only telemedicine service, a provider must obtain client consent before delivering the service to the client.

(b) The client's consent to receive services must:

(i) Acknowledge the provider will bill the agency or the agency's designee, including an agency-contracted managed care entity (managed care organization or behavioral health administrative services organization) for the service; and

(ii) Be documented in the client's medical record.

(c) A provider may only bill a client for services if they comply with the requirements in WAC 182-502-0160.

(7) **Originating site and distant site.**

(a) Originating sites and distant sites must be located within the 50 United States, the District of Columbia, or United States territories.

(b) Originating sites may be paid facility fee for infrastructure and client preparation except as noted in (c) of this subsection.

(c) Originating sites facility fees are not paid when the:

(i) Service is provided by audio-only telemedicine;

(ii) Service is store and forward;

(iii) Originating site is:

(A) The client's home;

(B) A hospital, for inpatient services;

(C) A hospital or a hospital provider-based clinic that is an originating site for audio-only telemedicine;

(D) A skilled nursing facility;

(E) Any other location receiving payment for the client's room and board;

(F) Unable to qualify as a provider as defined in WAC 182-500-0085; or

(G) A provider employed by or affiliated with the same entity as the distant site.

(d) A facility fee payment may be subject to a negotiated agreement between the originating site and the managed care organization or the behavioral health administrative services organization.

(e) A distant site may not charge or be paid a facility fee for infrastructure and client preparation.

(8) **Recordkeeping.**

(a) Providers who furnish a health care service through telemedicine or store and forward technology must comply with the recordkeeping requirements in WAC 182-502-0020.

(b) Providers using telemedicine or store and forward technology must document in the client's medical record the:

(i) Technology used to deliver the health care service by telemedicine or store and forward technology (audio, visual, or other means) and any assistive technologies used;

(ii) Client's location for telemedicine only. This information is not required when a provider uses store and forward technology;

(iii) People attending the appointment with the client (e.g., family, friends, or caregivers) during the delivery of the health care service;

(iv) Provider's location;

(v) Names and credentials (MD, ARNP, RN, PA, CNA, LMHP, etc.) of all originating and distant site providers involved in the delivery of the health care service;

(vi) Start and end time or duration of service when billing is based on time;

(vii) Client's consent for the telemedicine technology used to deliver the health care service. In extenuating circumstances when consent cannot be obtained, the provider must document the reason.

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OTS-3974.1

AMENDATORY SECTION (Amending WSR 19-22-017, filed 10/25/19, effective 11/25/19)

WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1) The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's Washington apple health program. Refer to WAC 182-501-0060 and 182-501-0065; and

(b) Medically necessary as defined in WAC 182-500-0070.

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC 182-501-0165.

(3) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

(4) The agency covers the following physician-related services and health care professional services, subject to the conditions in subsections (1), (2), and (3) of this section:

(a) Alcohol and substance misuse counseling (refer to WAC 182-531-1710);

(b) Allergen immunotherapy services;
(c) Anesthesia services;
(d) Dialysis and end stage renal disease services (refer to chapter 182-540 WAC);
(e) Emergency physician services;
(f) ENT (ear, nose, and throat) related services;
(g) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 182-534-0100);
(h) Habilitative services (refer to WAC 182-545-400);
(i) Reproductive health services (refer to chapter 182-532 WAC);
(j) Hospital inpatient services (refer to chapter 182-550 WAC);
(k) Maternity care, delivery, and newborn care services (refer to chapter 182-533 WAC);
(l) Office visits;
(m) Vision-related services (refer to chapter 182-544 WAC for vision hardware for clients ((~~twenty~~)) 20 years of age and younger);
(n) Osteopathic treatment services;
(o) Pathology and laboratory services;
(p) Physiatry and other rehabilitation services (refer to chapter 182-550 WAC);
(q) Foot care and podiatry services (refer to WAC 182-531-1300);
(r) Primary care services;
(s) Psychiatric services;
(t) Psychotherapy services (refer to WAC 182-531-1400);
(u) Pulmonary and respiratory services;
(v) Radiology services;
(w) Surgical services;
(x) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects (e.g., congenital or as a result of illness or physical trauma), or for mastectomy reconstruction for post cancer treatment;
(y) Telemedicine (refer to WAC ((~~182-531-1730~~)) 182-501-0300);
(z) Tobacco/nicotine cessation counseling (refer to WAC 182-531-1720);
(aa) Vaccines for adults, adolescents, and children in the United States administered according to the current advisory committee on immunization practices (ACIP) recommended immunization schedule published by the Centers for Disease Control and Prevention (CDC). Vaccines outside the regular schedule may be covered if determined to be medically necessary;
(bb) Other outpatient physician services.
(5) The agency covers physical examinations for Washington apple health clients only when the physical examination is for one or more of the following:
(a) A screening exam covered by the EPSDT program (see WAC 182-534-0100);
(b) An annual exam for clients of the division of developmental disabilities; or
(c) A screening pap smear, mammogram, or prostate exam.
(6) By providing covered services to a client eligible for Washington apple health, a provider who meets the requirements in WAC 182-502-0005(3) accepts the agency's rules and fees which includes federal and state law and regulations, billing instructions, and provider notices.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-22-017, § 182-531-0100, filed 10/25/19, effective 11/25/19; WSR 18-21-058, §

182-531-0100, filed 10/9/18, effective 11/9/18; WSR 15-03-041, § 182-531-0100, filed 1/12/15, effective 2/12/15. Statutory Authority: RCW 41.05.021. WSR 13-18-035, § 182-531-0100, filed 8/28/13, effective 9/28/13. Statutory Authority: RCW 41.05.021 and 42 C.F.R. 455.410. WSR 13-04-095, § 182-531-0100, filed 2/6/13, effective 3/9/13. Statutory Authority: RCW 41.05.021 and section 1927 of the Social Security Act. WSR 12-18-062, § 182-531-0100, filed 8/31/12, effective 10/1/12. WSR 11-14-075, recodified as § 182-531-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-14-055, § 388-531-0100, filed 6/29/11, effective 7/30/11. Statutory Authority: RCW 74.09.521. WSR 08-12-030, § 388-531-0100, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-531-0100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

OTS-3983.1

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-531-1730 Telemedicine.

OTS-3984.1

AMENDATORY SECTION (Amending WSR 20-14-062, filed 6/26/20, effective 7/27/20)

WAC 182-537-0200 Definitions. The following definitions and those found in chapter 182-500 WAC apply to this chapter:

"Agency" - See WAC 182-500-0010.

"Assessment" - For the purposes of this chapter, an assessment is made-up of medically necessary tests given to an individual child by a licensed health care provider to evaluate whether a child with a disability is in need of early intervention services or special education and related services. Assessments are a part of the individualized education program (IEP) and individualized family service plan (IFSP) evaluation and reevaluation processes.

"Charter school" - A public school governed by a charter school board and operated according to the terms of the charter school contract. Charter schools are open to all students, do not charge tuition, and do not have special entrance requirements.

"Child with a disability" - For purposes of this chapter, a child with a disability is a child evaluated and determined to need early intervention services or special education and related services because of a disability in one or more of the following eligibility categories:

- Autism;
- Deaf-blindness;
- Developmental delay for children ages three through nine, with an adverse educational impact, the results of which require special education and related direct services;
- Hearing loss (including deafness);
- Intellectual disability;
- Multiple disabilities;
- Orthopedic impairment;
- Other health impairment;
- Serious emotional disturbance (emotional behavioral disturbance);
- Specific learning disability;
- Speech or language impairment;
- Traumatic brain injury; and
- Visual impairment (including blindness).

"Core provider agreement" – See WAC 182-500-0020.

"Early intervention services" - Means developmental services provided to children ages birth through two. For the purposes of this chapter, early intervention services include:

- Audiology services;
- Health services;
- Nursing services;
- Occupational therapy;
- Physical therapy;
- Psychological services; and
- Speech-language pathology.

"Educational service district" - A regional agency which provides cooperative and informal services to local school districts within defined regions of the state.

"Electronic signature" - See WAC 182-500-0030.

"Evaluation" - Procedures used to determine whether a child has a disability, and the nature and extent of the early intervention or special education and related services needed. (See WAC 392-172A-01070 and 34 C.F.R. Sec. 303.321.)

"Fee-for-service" - See WAC 182-500-0035.

"Handwritten signature" - A scripted name or legal mark of an individual on a document to signify knowledge, approval, acceptance, or responsibility of the document.

"Health care-related services" - For the purposes of this chapter, means developmental, corrective, and other supportive services required to assist a student ages three through twenty eligible for special education and include:

- Audiology;
- Counseling;
- School health services and school nurse services;
- Occupational therapy;
- Physical therapy;
- Psychological assessments and services; and
- Speech-language therapy.

"Individualized education program (IEP)" - A written educational program for a child who is age three through twenty-one and eligible for special education. An IEP is developed, reviewed and revised according to WAC 392-172A-03090 through 392-172A-03115.

"Individualized family service plan (IFSP)" - A plan for providing early intervention services to a child birth through age two, with a disability or developmental delay and the child's family. The IFSP:

• Is based on the evaluation and assessment described in 34 C.F.R. Sec. 303.321;

• Includes the content specified in 34 C.F.R. Sec. 303.344; and

• Is developed under the IFSP procedures in 34 C.F.R. Secs. 303.342, 303.343, and 303.345.

"Medically necessary" - See WAC 182-500-0070.

"National provider identifier (NPI)" - See WAC 182-500-0075.

"Reevaluation" - Procedures used to determine whether a child continues to need early intervention services or special education and related services. (See WAC 392-172A-03015 and 34 C.F.R. Secs. 303.342 and 303.343.)

"Related services" – See WAC 392-172A-01155.

"School-based health care services contract" - A contract that describes and defines the relationship between the agency, the school-based health care services program, and the school district, ESD, charter, or tribal school.

"School-based health care services program" or **"SBHS"** - Is an agency-administered program that pays contracted school districts, educational service districts (ESDs), charter schools, and tribal schools for providing early intervention services or special education health-related services to children ages birth through twenty who have an IEP or IFSP.

"School district" - A group of schools administered by a particular authority within defined geographical division.

"Signature log" - A typed list that verifies a licensed provider's identity by associating each provider's signature with their name, handwritten initials, credentials, license and national provider identifier (NPI).

"Special education" - See WAC 392-172A-01175.

"Supervision" - Means supervision provided by a licensed health care provider either directly or indirectly to assist the supervisee in the administration of early intervention or health care-related services outlined in the IEP or IFSP.

"Telemedicine" - See WAC ((~~182-531-1730~~)) 182-501-0300.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-14-062, § 182-537-0200, filed 6/26/20, effective 7/27/20; WSR 19-04-095, § 182-537-0200, filed 2/5/19, effective 3/8/19; WSR 16-07-141, § 182-537-0200, filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 41.05.021, 34 C.F.R. 300.154(d), and chapter 182-502 WAC. WSR 13-21-079, § 182-537-0200, filed 10/17/13, effective 11/17/13. Statutory Authority: RCW 41.05.021. WSR 13-05-017, § 182-537-0200, filed 2/7/13, effective 3/10/13. WSR 11-14-075, recodified as § 182-537-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. WSR 09-07-004, § 388-537-0200, filed 3/4/09, effective 4/4/09.]

OTS-3976.1

NEW SECTION

WAC 182-538-195 Telemedicine and store and forward technology. The medicaid agency's rules related to the authorized use of telemedi-

cine and store and forward technology are found in WAC 182-501-0300 and are applicable to the benefits (including behavioral health services) administered by agency-contracted managed care entities (managed care organizations and behavioral health administrative service organizations) and fee-for-service programs.

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OTS-3977.1

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

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.

"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).

"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" - ((~~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~~)) See WAC 182-501-0300.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-05-048, § 182-551-2010, filed 2/9/22, effective 3/12/22; WSR 21-23-044, § 182-551-2010, filed 11/9/21, effective 12/10/21. 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 182-551-2125 Home health services delivered ((~~through~~)) using telemedicine. (1) The medicaid agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis 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 ((~~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 physician regarding ((~~telemedicine~~)) findings;

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

(vi) Referral to the emergency room as needed.

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2125, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2125, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2125, 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, § 388-551-2125, filed 5/3/10, effective 6/3/10.]

OTS-3982.1

AMENDATORY SECTION (Amending WSR 21-12-051, filed 5/26/21, effective 6/26/21)

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

(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.

(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 ((~~ninety~~)) 90 days before or within the ((~~thirty~~)) 30 days after the start of the 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.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. § 440.70. WSR 21-12-051, § 182-551-2040, filed 5/26/21, effective 6/26/21; WSR 18-24-023, § 182-551-2040, filed 11/27/18, effective 1/1/19.]

AMENDATORY SECTION (Amending WSR 21-23-044, filed 11/9/21, effective 12/10/21)

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 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, signed by the authorized practitioner within 45 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 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;

(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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-23-044, § 182-551-2210, filed 11/9/21, effective 12/10/21. 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 and 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.]