Chapter 182-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

WAC

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SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

WAC 182-551-1000 Hospice program—General. (1) The medicaid agency's hospice program is a twenty-four hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care and a focus on quality of life. A hospice interdisciplinary team communicates with the client's nonhospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

(2) A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must certify the client as terminally ill and appropriate for hospice care.

(3) Hospice care is provided in a client's temporary or permanent place of residence.

(4) Hospice care ends when:

(a) The client or an authorized representative under RCW 7.70.065 revokes the hospice care;

(b) The hospice agency discharges the client;

(c) The client's physician determines hospice care is no longer appropriate; or

(d) The client dies.

(5) Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

(6) Medicaid agency-approved hospice agencies must meet the general requirements in chapter 182-502 WAC, Administration of medical programs—Providers.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1000, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1000, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1010 Hospice program—Definitions. The following definitions and abbreviations and those found in WAC 182-500-0005, Medical definitions, apply to this subchapter.

"Authorized representative" - An individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065.

"Biologicals" - Medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" - Six days or less within a thirty consecutive-day period.

"Community services office (CSO)" - An office of the department of social and health services (DSHS) that administers social and health services at the community level.

"Concurrent care" - Medically necessary services delivered at the same time as hospice services, providing a blend of curative and palliative services to clients twenty years of age and younger who are enrolled in hospice. See WAC 182-551-1860.

"Curative care" - Treatment aimed at achieving a disease-free state.

"Discharge" - A hospice agency ends hospice care for a client.

"Election period" - The time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care.

"Family" - An individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client.

"Home and community services (HCS) office" - A department of social and health services (DSHS) aging and disability services administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities.

"Hospice agency" - A person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer. (Note: For the purposes of this subchapter, requirements for hospice agencies also apply to hospice care centers.)

"Hospice aide" - An individual registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related activities, or both, to patients of a hospice agency, or hospice care center.

"Hospice aide services" - Services provided by hospice aides employed by an in-home services agency licensed to provide hospice or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, and personal care or homemaker services, and other nonmedical tasks, as defined in this section.

"Hospice care center" - A homelike noninstitutional facility where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280 and applicable rules.

"Hospice services" - Symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.

"Interdisciplinary team" - The group of individuals involved in client care providing hospice services or hospice care center services including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer.

"Palliative" - Medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care" - A written document based on assessment of client needs that identifies services to meet these needs.

"Related condition(s)" - Any health condition(s) that manifests secondary to or exacerbates symptoms associated with the progression of the condition and/or disease, the treatment being received, or the process of dying. (Examples of related conditions: Medication management of nausea and vomiting secondary to pain medication; skin breakdown prevention/treatment due to peripheral edema.)

"Residence" - A client's home or place of living.

"Revoke" or **"revocation" -** The choice to stop receiving hospice care.

"Terminally ill" - The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" - A day beginning and ending at midnight.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1010, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1010, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

Hospice—Coverage

WAC 182-551-1200 Client eligibility for hospice care. (1) A client who elects to receive hospice care must be eligible for one of the following medical assistance programs, subject to the restrictions and limitations in this chapter and other WAC:

(a) Categorically needy (CN);

(b) Children's health care as described in WAC 182-505-0210;

(c) Medically needy (MN); or

(d) Alien emergency medical (AEM) as described in WAC 182-507-0110, when the medical services are necessary to treat a qualifying emergency medical condition.

(2) A hospice agency is responsible to verify a client's eligibility with the client or the client's department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO).

(3) A client enrolled in one of the medicaid agency's managed care organizations (MCO) must receive all hospice services, including facility room and board, directly through that MCO. The MCO is responsible for arranging and providing all hospice services for an MCO client.

(4) A client who is also eligible for medicare hospice under part A is not eligible for hospice care through the medicaid agency's hospice program. The medicaid agency does pay hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center (HCC) and is not receiving general inpatient care or inpatient respite care. See also WAC 182-551-1530.

(5) A client who meets the requirements in this section is eligible to receive hospice care through the medicaid agency's hospice program when all of the following is met:

(a) The client's physician certifies the client has a life expectancy of six months or less.

(b) The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 182-551-1310.

(c) The hospice agency serving the client:

(i) Notifies the medicaid agency's hospice program within five working days of the admission of all clients, including:

(A) Medicaid-only clients;

(B) Medicaid-medicare dual eligible clients;

(C) Medicaid clients with third party insurance; and

(D) Medicaid-medicare dual eligible clients with third party insurance.

(ii) Meets the hospice agency requirements in WAC 182-551-1300 and 182-551-1305.

(d) The hospice agency provides additional information for a diagnosis when the medicaid agency requests and determines, on a case-by-case basis, the information that is needed for further review.

[Statutory Authority: RCW 41.05.021. WSR 13-04-094, § 182-551-1200, filed 2/6/13, effective 3/9/13. Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1200, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1200, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate. (1) The medicaid agency reimburses a hospice agency for providing covered services, including core services and supplies described in this section, through the medicaid agency's hospice daily rate, subject to the conditions and limitations described in this section and other WAC. See WAC 182-551-1860 for pediatric concurrent care.

(2) To qualify for reimbursement, covered services, including core services and supplies in the hospice daily rate, must be:

(a) Related to the client's hospice diagnosis;

(b) Identified by the client's hospice interdisciplinary team;

(c) Written in the client's plan of care (POC); and

(d) Made available to the client by the hospice agency on a twenty-four hour basis.

(3) The hospice daily rate includes the following core services that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

(a) Physician services related to the administration of POC.

(b) Nursing care provided by:

(i) A registered nurse (RN); or

(ii) A licensed practical nurse (LPN) under the supervision of an RN.

(c) Medical social services provided by a social worker under the direction of a physician.

(d) Counseling services provided to a client and the client's family members or caregivers.

(4) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

(a) Assure all contracted staff meets the regulatory qualification requirements;

(b) Have a written agreement with the service organization or individual providing the services and supplies; and

(c) Maintain professional, financial, and administrative responsibility.

(5) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC 182-551-1510(6), subject to the conditions and limitations described in this section and other WAC:

(a) Skilled nursing care;

(b) Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions;

(c) Communication with nonhospice providers about care not related to the client's terminal illness to ensure the client's plan of care needs are met and not compromised;

(d) Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges in accordance with WAC 182-543-9100 (6)(c). These services and equipment are paid by the hospice agency for the palliation and management of a client's terminal illness and related conditions and are included in the daily hospice rate;

(e) Hospice aide, homemaker, and/or personal care services that are ordered by a client's physician and documented in the POC. (Hospice aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified hospice aide and are an extension of skilled nursing or therapy services. See 42 C.F.R. 484.36);

(f) Physical therapy, occupational therapy, and speech-language therapy to manage symptoms or enable a client to safely perform ADLs (activities of daily living) and basic functional skills;

(g) Medical transportation services, including ambulance (see WAC 182-546-5550 (1)(d));

(h) A brief period of inpatient care, for general or respite care provided in a medicare-certified hospice care center, hospital, or nursing facility; and

(i) Other services or supplies that are documented as necessary for the palliation and management of a client's terminal illness and related conditions;

(6) A hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the hospice program. The medicaid agency does not pay separately for medical equipment or supplies that were previously authorized by the medicaid agency and delivered on or after the date the medicaid agency enrolls the client in the hospice program.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1210, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1210, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

Hospice—Provider Requirements

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

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

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

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1300, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1300, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1305 Requirements for becoming a medicaid-approved hospice care center (HCC). (1) To apply to become a medicaid-approved hospice care center, the medicaid agency requires a hospice agency to:

(a) Be enrolled with the medicaid agency as an approved hospice agency (see WAC 182-551-1300);

(b) Submit a letter of request to:

Hospice Program Manager
P.O. Box 45506
Olympia, WA 98504-5506; and

(c) Include documentation that confirms the approved hospice agency is medicare certified by department of health (DOH) as a hospice care center and provides one or more of the following levels of hospice care (levels of care are described in WAC 182-551-1500):

(i) Routine home care;

(ii) Inpatient respite care; and

(iii) General inpatient care.

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

(3) A hospice agency qualifies as a medicaid-approved hospice care center when:

(a) All the requirements in this section are met; and

(b) The medicaid agency provides the hospice agency with written notification.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1305, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1305, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1305, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1310 Hospice election periods, election statements, and the hospice certification process. (1) Hospice coverage is available for two ninety-day election periods followed by an unlimited number of sixty-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinitiate an election period for hospice care.

(2) The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

(a) Name and address of the hospice agency that will provide the care;

(b) Documentation that the client is fully informed and understands hospice care and waiver of other medicaid and/or medicare services;

(c) Effective date of the election; and

(d) Signature of the client or the client's authorized representative.

(3) The following describes the hospice certification process:

(a) When a client elects to receive hospice care, the medicaid agency requires a hospice agency to:

(i) Obtain a signed written certification from a physician of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:

(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and

(B) The client's attending physician (if the client has one).

(iii) Place the signed written certification of the client's terminal illness in the client's medical file:

(A) Within sixty days following the day the hospice care begins; and

(B) Before billing the medicaid agency for the hospice services.

(b) For subsequent election periods, the medicaid agency requires:

(i) A hospice physician or hospice nurse practitioner to:

(A) Have a face-to-face encounter with every hospice client within thirty days prior to the one hundred eightieth-day recertification and prior to each subsequent recertification to determine continued eligibility of the client for hospice care. The medicaid agency does not pay for face-to-face encounters to recertify a hospice client; and

(B) Attest that the face-to-face encounter took place.

(ii) The hospice agency to:

(A) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency;

(B) Place the written certification of the client's terminal illness in the client's medical file before billing the medicaid agency for the hospice services; and

(C) Submit the written certification to the medicaid agency with the hospice claim related to the recertification.

(4) When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1310, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1310, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1310, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1320 Hospice plan of care. (1) A hospice agency must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with department of health (DOH) requirements as described in WAC 246-335-085, and meet the requirements in this section.

(2) A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

(3) At least two other hospice interdisciplinary team members must review the POC no later than two working days after it is developed.

(4) The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes at least:

(a) A registered nurse;

(b) A social worker; and

(c) One other hospice interdisciplinary team member.

[WSR 11-14-075, recodified as § 182-551-1320, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1320, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1330 Hospice—Client care and responsibilities of hospice agencies. (1) A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

(a) Determining if the medicaid agency has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, the medicaid agency will rescind the approval. See WAC 182-543-9100(7).

(b) Communicating with other medicaid programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other medicaid programs include, but are not limited to, programs administered by the department of social and health services aging and disability services administration (ADSA).

(c) Documenting each contact with nonhospice providers.

(2) When a client resides in a nursing facility, the hospice agency must:

(a) Coordinate the client's care with all providers, including pharmacies and medical vendors; and

(b) Provide the same level of hospice care the hospice agency provides to a client residing in their home.

(3) Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

(a) By choosing hospice care from a hospice agency, the client gives up the right to:

(i) Covered medicaid hospice service and supplies received at the same time from another hospice agency; and

(ii) Any covered medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

(b) Services and supplies are not paid through the hospice daily rate if they are:

(i) Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions (see WAC 182-551-1210(3));

(ii) Not covered by the hospice daily rate;

(iii) Provided under a Title XIX medicaid program when the services are similar or duplicate the hospice care services; or

(iv) Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

(4) A hospice agency must have written agreements with all contracted providers.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1330, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1330, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1330, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

Hospice—Discharges and Notification

WAC 182-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 182-551-1360, the hospice agency must do all of the following:

(1) Within five working days of becoming aware of the client's decision, inform and notify in writing the medicaid hospice program manager (see WAC 182-551-1400 for further requirements);

(2) Complete a medicaid hospice notification form (HCA 13-746) and forward a copy to the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) to notify that the client is discharging from the program;

(3) Notify the client, or the client's authorized representative, that the client's discharge has been reported to the medicaid agency; and

(4) Document the effective date and details of the discharge in the client's hospice record.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1340, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1340, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1340, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1350 Discharges from hospice care. (1) A hospice agency may discharge a client from hospice care when the client:

(a) Is no longer certified for hospice care;

(b) Is no longer appropriate for hospice care; or

(c) The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five working days, complete a medicaid hospice notification form (HCA 13-746) and forward the form to the medicaid hospice program manager (see WAC 182-551-1400 for additional requirements), and a copy to the appropriate DSHS home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current services card when obtaining medicaid covered health care services or supplies, or both; and

(ii) Used until the medicaid agency removes the hospice restriction from the client's information available online at https://www.waproviderone.org.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1350, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-551-1350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1350, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1360 Ending hospice care (revocations). (1) A client or a client's authorized representative may choose to stop hospice care at any time by signing a revocation statement.

(2) The revocation statement documents the client's choice to stop medicaid hospice care. The revocation statement must include all of the following:

(a) Client's signature (or the client's authorized representative's signature if the client is unable to sign);

(b) Date the revocation was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and revocation dates in the client's hospice records.

(4) When a client revokes hospice care, the hospice agency must:

(a) Inform and notify in writing the medicaid agency's hospice program manager, within five working days of becoming aware of the client's decision (see WAC 182-551-1400 for additional requirements);

(b) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) of the revocation by completing and forwarding a copy of the medicaid hospice notification form (HCA 13-746) to the appropriate DSHS home and community services (HCS) office or community services office (CSO);

(c) Keep the revocation statement in the client's hospice record;

(d) Provide the client with a copy of the revocation statement; and

(e) Inform the client that the revocation statement must be:

(i) Presented with the client's current services card when obtaining medicaid covered health care services or supplies, or both; and

(ii) Used until the medicaid agency issues a new services card that identifies that the client is no longer a hospice client.

(5) After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1360, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1360, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1360, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1370 When a hospice client dies. When a client dies, the hospice agency must:

(1) Within five working days, inform and notify in writing the medicaid agency's hospice program manager; and

(2) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) of the client's date of death by completing and forwarding a copy of the medicaid hospice notification form (HCA 13-746) to the appropriate DSHS HCS office or CSO.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1370, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1370, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1370, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1400 Notification requirements for hospice agencies. (1) To be reimbursed for providing hospice services, the hospice agency must complete a medicaid hospice notification form (HCA 13-746) and forward the form to the medicaid agency's hospice program manager

within five working days from when a medical assistance client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the medicaid hospice program of:

(a) The name and address of the hospice agency;

(b) The date of the client's first day of hospice care;

(c) A change in the client's primary physician;

(d) A client's revocation of the hospice benefit (home or institutional);

(e) The date a client leaves hospice without notice;

(f) A client's discharge from hospice care;

(g) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);

(h) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care.);

(i) A client who is eligible for or becomes eligible for medicare or third party liability (TPL) insurance;

(j) A client who dies; or

(k) A client who transfers to another hospice agency. Both the former agency and current agency must provide the medicaid agency with:

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

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

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

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

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1400, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1400, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

Hospice—Payment

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

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

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

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

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

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

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

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

(a) No more than six consecutive days; and

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

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

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

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

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice care centers.

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

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1500, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1500, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

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

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

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

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

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

(4) Payment rates for:

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

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

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

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

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

(6) The medicaid agency:

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

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

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

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

(8) For hospice clients in a nursing facility:

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

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

(9) The medicaid agency:

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

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

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

(ii) The day of death.

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

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

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

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

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1510, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1510, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1510, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1520 Payment method for nonhospice providers. (1) The medicaid agency pays for hospitals that provide inpatient care to clients in the hospice program for medical conditions not related to their terminal illness according to chapter 182-550 WAC, Hospital services.

(2) The medicaid agency pays providers who are attending physicians and not employed by the hospice agency, the usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the terminal illness; and

(c) When the client's providers, including the hospice agency, coordinate the health care provided.

(3) The department of social and health services (DSHS) aging and disability services administration (ADSA) pays for services provided to a client eligible under the community options program entry system (COPES) directly to the COPES provider.

(a) The client's monthly participation amount, if there is one, for services provided under COPES is paid separately to the COPES provider; and

(b) Hospice agencies must bill the medicaid agency's hospice program directly for hospice services, not the COPES program.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1520, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1520, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1520, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

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

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

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

(b) Not covered by medicare part A.

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

(a) Medicare before billing the medicaid agency;

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

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

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

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

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814

(a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1530, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1530, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1530, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24. WSR 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

WAC 182-551-1800 Pediatric palliative care (PPC) case management/coordination services—General. Through a hospice agency, the medicaid agency's pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1800, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1800, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility. To receive pediatric palliative care (PPC) case management/coordination services, a person must:

(1) Be twenty years of age or younger;

(2) Be a current recipient of the:

(a) Categorically needy program (CNP);

(b) Limited casualty program - Medically needy program (LCP-MNP);

(c) CNP - Alien emergency medical;

(d) LCP-MNP - Alien emergency medical;

(e) Children's health insurance program (SCHIP); and

(3) Have a life-limiting medical condition that requires case management and coordination of medical services due to at least three of the following circumstances:

(a) An immediate medical need during a time of crisis;

(b) Coordination with family member(s) and providers required in more than one setting (i.e., school, home, and multiple medical offices or clinics);

(c) A life-limiting medical condition that impacts cognitive, social, and physical development;

(d) A medical condition with which the family is unable to cope;

(e) A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and

(f) Therapeutic goals focused on quality of life, comfort, and family stability.

(4) See WAC 182-551-1860 for concurrent palliative and curative care for hospice clients twenty years of age and younger.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1810, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1810, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1810, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage. (1) The medicaid agency's pediatric palliative care (PPC) case management/coordination services cover up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC.

(2) One pediatric palliative care contact consists of:

(a) One visit with a registered nurse, social worker, or therapist (for the purpose of this section, the medicaid agency defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

(i) Pain and symptom management;

(ii) Psychosocial counseling; or

(iii) Education/training.

(b) Two hours or more per month of case management or coordination services to include any combination of the following:

(i) Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);

(ii) Establishing or implementing care conferences;

(iii) Arranging, planning, coordinating, and evaluating community resources to meet the client's needs;

(iv) Visits lasting twenty minutes or less (for example, visits to give injections, drop off supplies, or make appointments for other PPC-related services.); and

(v) Visits not provided in the client's home.

(3) The medicaid agency does not pay for a pediatric palliative care contact described in subsection (2) of this section when a client is receiving services from any of the following:

(a) Home health program;

(b) Hospice program;

(c) Private duty nursing (private duty nursing can subcontract with PPC to provide services)/medical intensive care;

(d) Disease case management program; or

(e) Any other medicaid program that provides similar services.

(4) The medicaid agency does not pay for a pediatric palliative care contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1820, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1820, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1820, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1830 How to become a medicaid-approved pediatric palliative care (PPC) case management/coordination services provider. This section applies to medicaid-approved providers who currently do not provide pediatric palliative care (PPC) services to medical assistance clients.

(1) To apply to become a medicaid-approved provider of PPC services, a provider must:

(a) Be a medicaid-approved hospice agency (see WAC 182-551-1300 and 182-551-1305); and

(b) Submit a letter to the medicaid agency's hospice/PPC program manager requesting to become a medicaid-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

(2) A hospice agency qualifies to provide PPC services when:

(a) All the requirements in this section are met; and

(b) The medicaid agency provides the hospice agency with written notification.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1830, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1830, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1830, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements. (1) An eligible provider of pediatric palliative care (PPC) case management/coordination services must do all of the following:

(a) Meet the conditions in WAC 182-551-1300;

(b) Confirm that a client meets the eligibility criteria in WAC 182-551-1810 prior to providing the pediatric palliative care services;

(c) Place in the client's medical record a written order for PPC from the client's physician;

(d) Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of pediatric palliative care services;

(e) Document in the client's medical record:

(i) A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs).

(ii) The medical necessity for those services to be provided in the client's residence; and

(iii) Discharge planning.

(f) Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members;

(g) Assign and make available a PPC case manager (nurse, social worker or therapist) to implement care coordination with community-based providers to assure clarity, effectiveness, and safety of the client's POC;

(h) Complete and fax the pediatric palliative care (PPC) referral and 5-day notification form (HCA 13-752) to the medicaid agency's PPC program manager within five working days from date of occurrence of the client's:

(i) Date of enrollment in PPC.

(ii) Discharge from the hospice agency or PPC program when the client:

(A) No longer meets PPC criteria;

(B) Is able to receive all care in the community;

(C) Does not require any services for sixty days; or

(D) Discharges from the PPC program and enrolls in the medicaid hospice program.

(iii) Transfer to another hospice agency for pediatric palliative care services.

(iv) Death.

(i) Maintain the client's file which includes the POC, visit notes, and all of the following:

(i) The client's start of care date and dates of service;

(ii) Discipline and services provided (in-home or place of service);

(iii) Case management activity and documentation of hours of work; and

(iv) Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g., the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

(j) Provide when requested by the medicaid agency's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified in subsection (1)(i) of this section.

(2) If the medicaid agency determines the POC, visit notes, and/or other required information do not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by the medicaid agency.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1840, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-551-1840, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.-520. WSR 05-18-033, § 388-551-1840, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1850 Pediatric palliative care (PPC) case management/coordination services—Rates methodology. (1) The department determines the reimbursement rate for a pediatric palliative care (PPC) contact described in WAC 388-551-1820 using the average of statewide metropolitan statistical area (MSA) home health care rates for skilled nursing, physical therapy, speech-language therapy and occupational therapy.

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

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

[WSR 11-14-075, recodified as § 182-551-1850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-18-033, § 388-551-1850, filed 8/30/05, effective 10/1/05.]

WAC 182-551-1860 Concurrent care for hospice clients twenty years of age and younger. (1) In accordance with Section 2302 of the Patient Protection and Affordable Care Act of 2010 and Section 1814(a)(7) of the Social Security Act, hospice palliative services are available to clients twenty years of age and younger without forgoing curative services which the client is entitled to under Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) for treatment of the terminal condition.

(2) Unless otherwise specified within this section, curative treatment including related services and medications requested for clients twenty years of age and younger are subject to the medicaid agency's specific program rules governing those services or medications.

(3) The following services aimed at achieving a disease-free state are included under the curative care benefit:

(a) Radiation;
(b) Chemotherapy;
(c) Diagnostics, including laboratory and imaging;
(d) Licensed health care professional services;
(e) Inpatient and outpatient hospital care;
(f) Surgery;
(g) Medication;
(h) Equipment and related supplies; and
(i) Ancillary services, such as medical transportation.

(4) The following are not included under the curative care benefit:

(a) Hospice covered services as described in WAC 182-551-1210;

(b) Services related to symptom management such as:

(I) Radiation;
(II) Chemotherapy;
(III) Surgery;
(IV) Medication; and
(V) Equipment and related supplies; and

(c) Ancillary services, such as medical transportation.

(5) Health care professionals must request prior authorization from the agency in accordance with WAC 182-501-0163 for enrollment in a concurrent care plan. Prior authorization requests are subject to medical necessity review under WAC 182-501-0165.

(6) If the curative treatment includes noncovered services in accordance with WAC 182-501-0070, the provider must request an exception to rule in accordance with WAC 182-501-0160.

(7) If the medicaid agency denies a request for a covered service, refer to WAC 182-502-0160, Billing a client, for when a client may be responsible to pay for a covered service.

[Statutory Authority: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act. WSR 12-09-079, § 182-551-1860, filed 4/17/12, effective 5/18/12.]

SUBCHAPTER II—HOME HEALTH SERVICES

WAC 182-551-2000 Home health services—General. The purpose of the department's home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence, subject to the restrictions and limitations in this subchapter.

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

[WSR 11-14-075, recodified as § 182-551-2000, 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, § 388-551-2000, 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, § 388-551-2000, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

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

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

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

(1) An injection;
(2) Blood draw; or
(3) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

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

(1) Observation;
(2) Assessment;
(3) Treatment;
(4) Teaching;
(5) Training;
(6) Management; and
(7) Evaluation.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

"Home health aide" means an individual registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a medicare-certified home health agency with a current provider number. See also WAC 388-551-2000.

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

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an order-

ing licensed practitioner and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC 388-551-2210.

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

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

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

(1) Physical;

(2) Occupational; or

(3) Speech/audiology services.

(See WAC 388-551-2110.)

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

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

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

[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.]

WAC 182-551-2020 Home health services—Eligible clients. (1) Clients in the following fee-for-service programs are eligible to receive home health services subject to the limitations described in this chapter. Clients enrolled in a department-contracted managed care organization (MCO) receive all home health services through their designated plan.

(a) Categorically needy program (CNP);

(b) Limited casualty program - Medically needy program (LCP-MNP); and

(c) Medical care services (MCS) under the following programs:

(i) General assistance - Unemployable (GA-U); and

(ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).

(2) The department does not cover home health services under the home health program for clients in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. The department evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 388-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

(a) The client requires hospital care due to an emergent medical condition as described in WAC 388-500-0005; and

(b) The department authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

[WSR 11-14-075, recodified as § 182-551-2020, 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, § 388-551-2020, 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, § 388-551-2020, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 182-551-2030 Home health skilled services—Requirements. (1) The department reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

(a) Meet the definition of "acute care" in WAC 388-551-2010.

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

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

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

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

(f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of an ordering licensed practitioner's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.

(g) Be provided in the client's residence.

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

(ii) Clients in residential facilities contracted with the state and paid by other programs such as home and community programs to provide limited skilled nursing services, are not eligible for department-funded limited skilled nursing services unless the services are prior authorized under the provisions of WAC 388-501-0165.

(h) Be provided by:

(i) A home health agency that is Title XVIII (medicare) certified;

(ii) A registered nurse (RN) prior authorized by the department when no home health agency exists in the area a client resides; or

(iii) An RN authorized by the department when the RN is unable to contract with a medicare-certified home health agency.

[WSR 11-14-075, recodified as § 182-551-2030, 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, § 388-551-2030, filed 5/3/10, effective 6/3/10. Stat-

utory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2030, filed 7/15/02, effective 8/15/02.]

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

(2) The department covers the following home health acute care skilled nursing services, subject to the limitations in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, if the services involve one or more of the following:

(i) Observation;

(ii) Assessment;

(iii) Treatment;

(iv) Teaching;

(v) Training;

(vi) Management; and

(vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

(i) An injection;

(ii) Blood draw; or

(iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

(i) Is willing and capable of learning and managing the client's infusion care; or

(ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

(i) When provided by a department-approved infant phototherapy agency; and

(ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

(i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(ii) For up to three home health visits per pregnancy if:

(A) Enrollment in or referral to the following providers of first steps has been verified:

(I) Maternity support services (MSS); or

(II) Maternity case management (MCM); and

(B) The visits are provided by a registered nurse who has either:

(I) National perinatal certification; or

(II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

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

[WSR 11-14-075, recodified as § 182-551-2100, 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, § 388-551-2100, 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, § 388-551-2100, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 182-551-2110 Home health services—Covered specialized therapy. The agency covers specialized therapy (also known as outpatient rehabilitation) in an in-home setting by a home health agency. See chapter 182-545 WAC outpatient rehabilitation for coverage and limitations. Specialized therapy is defined in WAC 182-551-2010.

[Statutory Authority: RCW 41.05.021. WSR 11-21-066, § 182-551-2110, filed 10/17/11, effective 11/17/11. WSR 11-14-075, recodified as § 182-551-2110, 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, § 388-551-2110, 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, § 388-551-2110, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 182-551-2120 Home health services—Covered aide services. (1) The department pays for one home health aide visit, per client per day.

(2) The department reimburses for home health aide services, as defined in WAC 388-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

(a) Skilled nursing services; or

(b) Specialized therapy services.

(3) The department covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[WSR 11-14-075, recodified as § 182-551-2120, 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, § 388-551-2120, 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, § 388-551-2120, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 182-551-2125 Home health services—Delivered through telemedicine. (1) The department covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis(es) where there is a high risk of sudden change in clinical status which could compromise health outcomes.

(2) The department pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner's home health plan of care.

(3) To receive payment for the delivery of home health services through telemedicine, the services must involve:

(a) An assessment, problem identification, and evaluation which includes:

(i) Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering licensed practitioner regarding telemedicine findings;

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

(vi) Referral to the emergency room as needed.

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

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

[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.]

WAC 182-551-2130 Home health services—Noncovered services. (1) The department does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and disability services administration (ADSA).

(i) The department considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, the department may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) CNP - Emergency medical only; and

(ii) LCP-MNP - Emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) HRSA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

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

(i) Documented prior to the visit; and

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

(2) HRSA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) HRSA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0160.

[WSR 11-14-075, recodified as § 182-551-2130, 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, § 388-551-2130, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-551-2130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2130, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 182-551-2200 Home health services—Eligible providers. The following may contract with the department to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare) certified;

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

(c) Submits a completed, signed core provider agreement to the department; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

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

(b) Is unable to contract with a medicare-certified home health agency;

(c) Submits a completed, signed core provider agreement to the department; and

(d) Is assigned a provider number.

[WSR 11-14-075, recodified as § 182-551-2200, 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, § 388-551-2200, 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, § 388-551-2200, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

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

(1) The POC must:

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

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

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

(d) Contain specific goals and treatment plans;

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

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

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

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

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

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

(d) The prognosis;

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

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

(g) Specific procedures and modalities;

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

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

(j) A list of permitted activities;

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

(l) A list of medications which indicates:

(i) Any new prescription; and

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

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

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

(b) Documentation that justifies why the medical services should be provided in the client's residence instead of an ordering licensed practitioner's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the DSHS case manager of admittance;

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge; and

(g) Order for the delivery of home health services through telemedicine, as appropriate.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 388-551-2120(3);

(c) All medications administered and treatments provided;

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

(e) Signed licensed practitioner's new orders and change orders;

(f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(g) Interdisciplinary and multidisciplinary team communications;

(h) Inter-agency and intra-agency referrals;

(i) Medical tests and results;

(j) Pertinent medical history; and

(k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the POC;

(b) Client response to the POC:

(c) Any clinical change in client status;

(d) Follow-up interventions specific to a change in status with significant clinical findings;

(e) Any communications with the attending ordering licensed practitioner; and

(f) Telemedicine findings, as appropriate.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, client compliance, and client response;

(b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;

(c) If a client's wound is not healing, the client's ordering licensed practitioner has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and

(d) The client's physical system assessment as identified in the POC.

[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.]

WAC 182-551-2220 Home health services—Provider payments. (1) In order to be reimbursed, the home health provider must bill the department according to the conditions of payment under WAC 388-502-0150 and other issuances.

(2) Payment to home health providers is:

(a) A set rate per visit for each discipline provided to a client;

(b) Based on the county location of the providing home health agency; and

(c) Updated by general vendor rate changes.

(3) For clients eligible for both medicaid and medicare, the department may pay for services described in this chapter only when medicare does not cover those services. The maximum payment for each service is medicaid's maximum payment.

(4) Providers must submit documentation to the department during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

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

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

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

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

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

WAC 182-551-3000 Private duty nursing services for clients seventeen years of age and younger. This section applies to private duty nursing services for eligible clients on fee-for-service programs. Managed care clients receive private duty nursing services through their plans (see chapter 388-538 WAC).

(1) **"Private duty nursing"** means four hours or more of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services. Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

(a) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);

(b) Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bilevel positive airway pressure, intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);

(c) Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO_2s, ventilator settings, humidification systems, fluid balance, etc.); and

(d) Interventions (e.g., medications, suctioning, IV's, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

(2) To be eligible for private duty nursing services, a client must meet all the following:

(a) Be seventeen years of age or younger (see chapter 388-71 WAC for information about private duty nursing services for clients eighteen years of age and older);

(b) Be eligible for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-501-0060 and 388-501-0065);

(c) Need continuous skilled nursing care that can be provided safely outside an institution; and

(d) Have prior authorization from the department.

(3) The department contracts only with home health agencies licensed by Washington state to provide private duty nursing services and pays a rate established by the department according to current funding levels.

(4) A provider must coordinate with a division of developmental disabilities case manager and request prior authorization by submitting a complete referral to the department, which includes all of the following:

(a) The client's age, medical history, diagnosis, and current prescribed treatment plan, as developed by the individual's physician;

(b) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;

(c) An emergency medical plan which includes notification of electric, gas and telephone companies as well as local fire department;

(d) Psycho-social history/summary which provides the following information:

(i) Family constellation and current situation;

(ii) Available personal support systems;

(iii) Presence of other stresses within and upon the family; and

(iv) Projected number of nursing hours needed in the home, after discussion with the family or guardian.

(e) A written request from the client or the client's legally authorized representative for home care.

(5) The department approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

(a) The information submitted by the provider is complete;

(b) The care provided will be based in the client's home;

(c) Private duty nursing will be provided in the most cost-effective setting;

(d) An adult family member, guardian, or other designated adult has been trained and is capable of providing the skilled nursing care;

(e) A registered or licensed practical nurse will provide the care under the direction of a physician; and

(f) Based on the referral submitted by the provider, the department determines:

(i) The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;

(ii) The client requires more nursing care than is available through the home health services program; and

(iii) The home care plan is safe for the client.

(6) Upon approval, the department will authorize private duty nursing services up to a maximum of sixteen hours per day except as provided in subsection (7) of this section, restricted to the least costly equally effective amount of care.

(7) The department may authorize additional hours:

(a) For a maximum of thirty days if any of the following apply:

(i) The family or guardian is being trained in care and procedures;

(ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that noninstitutionalized care is still safe for the client;

(iii) The family or guardian caregiver is ill or temporarily unable to provide care;

(iv) There is a family emergency; or

(v) The department determines it is medically necessary.

(b) After the department evaluates the request according to the provisions of WAC 388-501-0165 and 388-501-0169.

(8) The department adjusts the number of authorized hours when the client's condition or situation changes.

(9) Any hours of nursing care in excess of those authorized by the department are the responsibility of the client, family or guardian.

[WSR 11-14-075, recodified as § 182-551-3000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-551-3000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 01-05-040, § 388-551-3000, filed 2/14/01, effective 3/17/01.]