Chapter 182-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

Last Update: 11/4/25

WAC

SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

182-551-1000 Hospice program—General.
182-551-1010 Hospice program—Definitions.

Hospice—Coverage

182-551-1200 Client eligibility for hospice care.
182-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate.

Hospice—Provider Requirements

182-551-1300 Requirements for a medicaid-approved hospice agency.
182-551-1305 Requirements for becoming a medicaid-approved hospice care center (HCC).
182-551-1310 Hospice election periods and election statements.
182-551-1315 Hospice certification process.
182-551-1320 Hospice plan of care.
182-551-1330 Hospice—Client care and responsibilities of hospice agencies.

Hospice—Discharges and Notification

182-551-1340 When a client leaves hospice without notice.
182-551-1350 Discharges from hospice care.
182-551-1360 Ending hospice care (revocations).
182-551-1370 When a hospice client dies.
182-551-1400 Notification requirements for hospice agencies.

Hospice—Payment

182-551-1500 Hospice daily rate—Four levels of hospice care.
182-551-1510 Rates methodology and payment method for hospice agencies.
182-551-1520 Payment method for nonhospice providers.
182-551-1530 Payment method for medicaid-medicare dual eligible clients.
182-551-1800 Pediatric palliative care (PPC) case management/coordination services—General.
182-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility.
182-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage.
182-551-1830 How to become a medicaid-approved pediatric palliative care (PPC) case management/coordination services provider.
182-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements.
182-551-1850 Pediatric palliative care (PPC) case management/coordination services—Rates methodology.
182-551-1860 Concurrent care for hospice clients age 20 and younger.

SUBCHAPTER II—HOME HEALTH SERVICES

182-551-2000 General.
182-551-2010 Definitions.
182-551-2020 Eligibility.
182-551-2030 Skilled services—Requirements.
182-551-2040 Face-to-face encounter requirements.
182-551-2100 Skilled nursing services.
182-551-2110 Specialized therapy.
182-551-2115 Medical social services.
182-551-2120 Aide services.
182-551-2122 Medical supplies, equipment, and appliances.
182-551-2125 Home health services delivered using telemedicine.
182-551-2130 Noncovered services.
182-551-2200 Eligible providers.
182-551-2210 Provider requirements.
182-551-2220 Provider payments.

SUBCHAPTER III—PRIVATE DUTY NURSING

182-551-3000 Private duty nursing for clients age seventeen and younger—General.
182-551-3050 Private duty nursing for clients age seventeen and younger—Definitions.
182-551-3100 Private duty nursing for clients age 17 and younger—Client eligibility.
182-551-3200 Private duty nursing for clients age 17 and younger—Provider requirements.
182-551-3300 Private duty nursing for clients age 17 and younger—Application requirements.
182-551-3400 Private duty nursing for clients age 17 and younger—Authorization.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-551-2140 Exceptions. [Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2140, filed 11/27/18, effective 1/1/19.] Repealed by WSR 23-24-026, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255.

SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

WAC 182-551-1000 Hospice program—General. (1) The medicaid agency's hospice program is a 24 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 health care representative may initiate 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 health care representative 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.

(7) A client enrolled in a medicaid agency-contracted managed care organization (MCO) must receive all hospice services, including facility room and board, directly through that MCO.

(8) The MCO is responsible for arranging and providing all hospice services for an MCO client consistent with the rules in this chapter.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1000, filed 7/25/25, effective 9/1/25. 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 chapter 182-500 WAC, Medical definitions, apply to this subchapter.

"Authorized health care representative" - A person who has authority under RCW 7.70.065 to provide informed consent to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who lacks capacity.

"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 30 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 20 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, 90 or 60 calendar days, that the client is certified as eligible for and chooses to receive hospice care.

"Family" - A person or people who are important to the client and need not be relatives.

"Home and community services (HCS) office" - A department of social and health services (DSHS) home and community living administration 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 people 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" - A person 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, 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 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 person, and emotional, spiritual, and bereavement support for the person and their family in a place of temporary or permanent residence.

"Interdisciplinary team" - The group of people 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 (POC)" - 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.

"24-hour day" - A day beginning and ending at midnight.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1010, filed 7/25/25, effective 9/1/25. 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) Subject to the requirements and limitations in this chapter and other medicaid agency rules, a person who elects to receive hospice care must be eligible for:

(a) One of the Washington apple health programs listed in the table in WAC 182-501-0060 with hospice as a covered benefit; or

(b) The alien emergency medical (AEM) program (see WAC 182-507-0110).

(2) A client who is eligible for hospice under medicare part A is not eligible for hospice care through the medicaid agency's hospice program.

(3) The medicaid agency pays hospice nursing facility room and board if the client is:

(a) Admitted to a nursing facility or hospice care center (HCC); and

(b) Not receiving general inpatient care or inpatient respite care. See also WAC 182-551-1530.

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

(a) The client's physician certifies the client has a life expectancy of six months or less, which is supported by medical records, including documentation that the person's condition is declining;

(b) The client or an authorized health care representative on the client's behalf elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 182-551-1310;

(c) The client's hospice agency must:

(i) Notify the medicaid agency's hospice program within five business days of the client's admission. The hospice agency must give notice for clients with the following types of eligibility:

(A) Medicaid-only;

(B) Medicaid-medicare dual eligible;

(C) Medicaid with third-party insurance; and

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

(ii) Meet 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 and 41.05.160. WSR 25-16-015, s 182-551-1200, filed 7/25/25, effective 9/1/25. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-551-1200, filed 3/12/14, effective 4/12/14. 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 through the medicaid agency's hospice daily rate.

(2) Covered services include core services and supplies described in this section, subject to the requirements and limitations described in this section and other WAC. See WAC 182-551-1860 for pediatric concurrent care.

(3) 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 24-hour basis.

(4) The hospice daily rate includes the following core services:

(a) Physician services related to POC administration.

(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.

(5) Core services must be provided by hospice agency staff. If necessary, a contracted hospice agency may provide core services to supplement services provided by hospice staff to meet client needs:

(a) During a period of peak patient loads; or

(b) Under extraordinary circumstances.

(6) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency.

(7) To be reimbursed the hospice daily rate, a hospice agency must:

(a) Ensure all contracted staff meet the regulatory qualification requirements;

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

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

(8) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC 182-551-1510, subject to the requirements 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. See chapter 182-543 WAC. 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 services that meet the following criteria:

(i) Ordered by a client's physician and documented in the POC;

(ii) Provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness; and

(iii) Provided by a qualified hospice aide and are an extension of skilled nursing or therapy services. See 42 C.F.R. Part 484;

(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)(e));

(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;

(9) 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.

(10) 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 and 41.05.160. WSR 25-16-015, s 182-551-1210, filed 7/25/25, effective 9/1/25. 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 medicaid-approved, a hospice agency must be 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 Washington apple health clients, the medicaid agency's clinical staff conducts hospice agency site visits.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1300, filed 7/25/25, effective 9/1/25; WSR 16-03-035, § 182-551-1300, filed 1/12/16, effective 2/12/16. 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 and 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 become a medicaid-approved hospice care center, the hospice agency must be medicare-certified by the 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):

(a) Routine home care;

(b) Inpatient respite care; and

(c) 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 and 41.05.160. WSR 25-16-015, s 182-551-1305, filed 7/25/25, effective 9/1/25. 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 and election statements. (1) Hospice coverage is available for two 90-day election periods followed by an unlimited number of 60-day election periods.

(2) A client or a client's authorized health care representative must sign an election statement to initiate or reinitiate an election period for hospice care.

(3) 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 or the client's authorized health care representative 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 health care representative.

(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.

(5) The client or the client's authorized health care representative 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 and 41.05.160. WSR 25-16-015, s 182-551-1310, filed 7/25/25, effective 9/1/25. 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 182-551-1315 Hospice certification process. (1) The following describes the hospice certification process:

(a) When a client or the client's authorized health care representative 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 the hospice agency obtained verbal certification, followed up 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 60 calendar days following the day the hospice care begins; and

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

(b) For a subsequent election period, the medicaid agency requires a hospice physician or hospice nurse practitioner to:

(i) Have a face-to-face encounter with every hospice client:

(A) Within 30 calendar days prior to the 180th-day recertification; and

(B) Prior to each subsequent recertification to determine continued eligibility of the client for hospice care; and

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

(c) The hospice agency must:

(i) Document in the client's medical file that it obtained a verbal certification, followed up with a written certification signed by:

(A) The medical director of the hospice agency; or

(B) A physician staff member of the hospice agency;

(ii) 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

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

(2) The medicaid agency does not pay for face-to-face encounters to recertify a hospice client.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1315, filed 7/25/25, effective 9/1/25.]

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 246-335-640, 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 business 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:

(a) A registered nurse;
(b) A social worker; and
(c) One other hospice interdisciplinary team member.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1320, filed 7/25/25, effective 9/1/25. 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 rescinds the approval. See WAC 182-543-9000(17).

(b) Communicating with other medicaid programs and documenting the services a client receives 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 (DSHS) home and community living administration.

(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 and 41.05.160. WSR 25-16-015, s 182-551-1330, filed 7/25/25, effective 9/1/25. 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 the client's authorized health care representative removes the client from hospice care and 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 business days of becoming aware of the client's or the authorized health care representative's decision, inform and notify the medicaid hospice program manager in writing (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 health care 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 and 41.05.160. WSR 25-16-015, s 182-551-1340, filed 7/25/25, effective 9/1/25. 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:

(a) Client is no longer certified for hospice care;

(b) Client is no longer appropriate for hospice care; or

(c) 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 business 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 through the ProviderOne system.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1350, filed 7/25/25, effective 9/1/25. 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 health care representative may decide to stop hospice care at any time by signing a revocation statement.

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

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

(b) Date the revocation was signed; and

(c) Actual date that the client decided 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) Notify in writing the medicaid agency's hospice program, within five business days of becoming aware of the client's decision (see WAC 182-551-1400 for additional requirements) by completing the Medicaid Hospice Notification form (HCA 13-746);

(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 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 and 41.05.160. WSR 25-16-015, s 182-551-1360, filed 7/25/25, effective 9/1/25. 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 business days, notify the medicaid agency by completing the Medicaid Hospice Notification form (HCA 13-746) to the medicaid agency; 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 and 41.05.160. WSR 25-16-015, s 182-551-1370, filed 7/25/25, effective 9/1/25. 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:

(a) Complete a Medicaid Hospice Notification form (HCA 13-746); and

(b) Forward the form to the medicaid agency's hospice program within five business days from the date a Washington apple health client begins hospice care, or has a change in hospice status.

(c) Notify the medicaid hospice program of:

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

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

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

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

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

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

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

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

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

(x) A client who dies; or

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

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

(B) 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 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 business days of the date of the client's first day of hospice care as required in subsection (1) of this section, the medicaid agency authorizes the hospice daily rate reimbursement effective the fifth business day before the date of notification.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1400, filed 7/25/25, effective 9/1/25; WSR 16-03-035, § 182-551-1400, filed 1/12/16, effective 2/12/16. 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 182-551-1510 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 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 24-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 and 41.05.160. WSR 25-16-015, s 182-551-1500, filed 7/25/25, effective 9/1/25; WSR 16-03-035, § 182-551-1500, filed 1/12/16, effective 2/12/16. 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 182-551-1500.

(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 medicaid agency bases payment rates on the core-based statistical area (CBSA) county location. CBSAs are identified in the medicaid agency's provider guides.

(4) The medicaid agency pays hospice agencies for services,not room and board, at a daily rate methodology 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.

(b) Payments for routine home care are based on a two-tiered payment methodology.

(i) Days one through 60 are paid at the base routine home care rate.

(ii) Days 61 and after are paid at a lower routine home care rate.

(iii) If a client discharges and readmits to a hospice agency's program within 60 calendar days of that discharge, the prior hospice days continue to follow the client and count towards the client's eligible days in determining whether the hospice agency may bill at the base or lower routine home care rate.

(iv) If a client discharges from a hospice agency's program for more than 60 calendar days, a readmit to the hospice agency's program resets the client's hospice days.

(c) Hospice services are eligible for an end-of-life service intensity add-on payment when the following criteria are met:

(i) The day on which the services are provided is a routine home care level of care;

(ii) The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;

(iii) The service is provided by a registered nurse or social worker that day for at least 15 minutes and up to four hours total; and

(iv) The service is not provided by the social worker via telephone.

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

(5) The medicaid agency:

(a) Pays for routine home 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.

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

(7) 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 95 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 more than the nursing facility's current medicaid daily rate.

(8) 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.

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

(10) The medicaid agency reduces hospice payments by two percent for providers who did not comply with the annual medicare quality data reporting program as required under 42 U.S.C. Sec. 1395f (i)(5)(A)(i). The payment reduction is effective for the fiscal reporting year in which the provider failed to submit data required for the annual medicare quality reporting program.

(a) The two percent payment reduction applies to routine home care, including the service intensity add-on, continuous home care, inpatient respite care, and general inpatient care.

(b) The two percent payment reduction does not apply to pediatric palliative care, the hospice care center daily rate, and the nursing facility room and board rate.

(c) Any provider affected by the two percent payment reduction receives written notification.

(d) Any provider affected by the two percent payment reduction may appeal the rate reduction per WAC 182-502-0220.

(11) The client's notice of action (award) letter states the amount 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 that the client is required to pay, if any; and

(b) Must show the client's monthly required payment on the hospice claim. (Hospice providers may refer to the medicaid agency's provider guides for how to bill a hospice claim.) If a client has a required payment 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 and 41.05.160. WSR 25-16-015, s 182-551-1510, filed 7/25/25, effective 9/1/25. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 U.S.C. Sec. 1395f (i)(5)(A)(i). WSR 17-03-073, § 182-551-1510, filed 1/11/17, effective 2/11/17. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. 418 Subpart G. WSR 16-14-009, § 182-551-1510, filed 6/23/16, effective 7/24/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-1510, filed 1/12/16, effective 2/12/16. 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 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 physician-related services 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) home and community living administration 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 for services provided under COPES, if there is one, 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 and 41.05.160. WSR 25-16-015, s 182-551-1520, filed 7/25/25, effective 9/1/25. 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 does not pay the portion of hospice care for a client who is covered under medicare part A. Nursing home room and board charges described in WAC 182-551-1510 that are not covered under medicare part 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 subchapter I apply to the payments described in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1530, filed 7/25/25, effective 9/1/25; WSR 16-03-035, § 182-551-1530, filed 1/12/16, effective 2/12/16. 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 20 years of age or younger;

(2) Be a current recipient of the:

(a) Alternative benefit plan (ABP);

(b) Categorically needy program (CNP);

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

(d) CNP - Alien emergency medical;

(e) LCP-MNP - Alien emergency medical; or

(f) Children's health insurance program (CHIP); 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; or

(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 age 20 and younger.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-16-015, s 182-551-1810, filed 7/25/25, effective 9/1/25. 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 allows, without prior authorization, up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC. See WAC 182-501-0169 for limitation extension requests.

(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, including 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 20 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 and 41.05.160. WSR 25-16-015, s 182-551-1820, filed 7/25/25, effective 9/1/25. 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 medicaid 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 and 41.05.160. WSR 25-16-015, s 182-551-1830, filed 7/25/25, effective 9/1/25. 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:

(a) Meet the requirements 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);

(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 business 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 60 calendar 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 and/or the client's family's response to the palliative care and its effectiveness. For example, the client might have required acute care or hospital emergency room visits without the pediatric palliative care services; and

(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 and 41.05.160. WSR 25-16-015, s 182-551-1840, filed 7/25/25, effective 9/1/25. 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 medicaid agency determines the reimbursement rate for a pediatric palliative care (PPC) contact described in WAC 182-551-1820 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 medicaid agency makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a vendor 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-1850, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-1850, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 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 age 20 and younger. (1) In accordance with 42 U.S.C. 1396d (o)(1)(C), a client age 20 and younger may voluntarily elect hospice care without waiving any rights to services that the client is entitled to under Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) that are related to the treatment of the client's condition for which a diagnosis of terminal illness has been made.

(2) The related services in subsection (1) of this section and medications requested for clients age 20 and younger are subject to the medicaid agency's specific program rules governing those services or medications.

(3) When a noncovered service is recommended based on the early periodic screening, diagnosis, and treatment (EPSDT) program for a child age 20 and younger, providers must follow the rules in chapter 182-534 WAC.

(4) 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 and 41.05.160. WSR 25-16-015, s 182-551-1860, filed 7/25/25, effective 9/1/25; WSR 18-24-008, § 182-551-1860, filed 11/26/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, section 2302 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. 1396d (o)(1)(C). WSR 17-12-082, § 182-551-1860, filed 6/5/17, effective 7/6/17. 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 General. (1) The purpose of the medicaid agency's home health services program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in any setting where normal life activities take place, subject to the restrictions and limitations in subchapter II. See also 42 C.F.R. 440.70.

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

(a) Nursing services, see WAC 182-551-2100;

(b) Home health aide service, see WAC 182-551-2120;

(c) Medical supplies, equipment, and appliances suitable for use in any setting where normal life activities take place, see chapter 182-543 WAC;

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

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

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

(4) Home health skilled services are acute, intermittent, short-term, and intensive courses of treatment. See chapters 182-514 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

(5) Home health visits require a written order from an authorized practitioner, unless there is a verbal order that is:

(a) Documented before the visit; and

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2000, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-05-048, § 182-551-2000, filed 2/9/22, effective 3/12/22. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2000, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-03-035, § 182-551-2000, filed 1/12/16, effective 2/12/16. 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 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to subchapter II:

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

"Authorized practitioner" means:

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

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

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

(a) An injection;
(b) Blood draw; or
(c) Placement of medications in containers.

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

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

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

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

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

"Home health agency" means an agency or organization that attests to the satisfaction of the medicaid agency that it meets the requirements for participation in medicare or is certified under the medicare program to provide comprehensive health care on an intermittent or part-time basis to a patient in any setting where the patient's normal life activities take place.

"Home health aide" means a person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and

supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

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

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided on an intermittent or part-time basis by a home health agency. See also WAC 182-551-2000.

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

"Medical social services" are services delivered by a medical social worker that are intended to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the client's medical condition or rate of recovery.

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

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an authorized practitioner and a home health agency provider. The plan describes the home health care to be provided in any setting where the client's normal life activities take place. See WAC 182-551-2210.

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

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

(a) Physical;

(b) Occupational; or

(c) Speech/audiology services.

(See WAC 182-551-2110.)

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2010, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 2021 c 157. WSR 23-04-048, § 182-551-2010, filed 1/26/23, effective 2/26/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-05-048, § 182-551-2010, filed 2/9/22, effective 3/12/22; WSR 21-23-044, § 182-551-2010, filed 11/9/21, effective 12/10/21. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2010, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-03-035, § 182-551-2010, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, chapter 74.09

RCW, and 2009 c 326. WSR 10-10-087, § 388-551-2010, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2020, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2020, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-551-2020, filed 3/12/14, effective 4/12/14. 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 Skilled services—Requirements. (1) The medicaid agency covers home health skilled services provided to eligible clients, subject to the provisions in this section and other applicable published WAC.

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

(a) Meet the definition of "acute care" in WAC 182-551-2010;

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

(c) Be medically necessary as defined in WAC 182-500-0070 and the process outlined in WAC 182-501-0165;

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

(e) Meet face-to-face requirements described in WAC 182-551-2040;

(f) Be provided under a plan of care (POC), as defined in WAC 182-551-2010 and described in WAC 182-551-2210. Any statement in the POC must be supported by documentation in the client's medical records;

(g) Be used to prevent placement in a more restrictive setting;

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

(i) The client's medical records must justify the medical reason or reasons that the services should be provided where the client's normal life activities take place instead of at an ordering physician's office, clinic, or other outpatient setting.

(3) Clients in residential facilities contracted with the state and paid by other programs, such as home and community programs to provide skilled nursing services, are eligible for skilled nursing services

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2030, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2030, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2030, filed 1/12/16, effective 2/12/16. 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. Statutory 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 182-551-2040 Face-to-face encounter requirements. (1) The medicaid agency pays for home health services provided under this chapter only when the face-to-face encounter requirements in this section are met.

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

(3) For initiation of home health services, with the exception of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires home health services and must occur within 90 calendar days before or within the 30 calendar days after the start of the home health services.

(4) For the initiation of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires medical equipment and must occur no more than six months before the start of services.

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

(a) A physician;

(b) A nurse practitioner;

(c) A clinical nurse specialist;

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

(e) A physician assistant; or

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

(6) Services may be ordered by:

(a) Physicians;

(b) Nurse practitioners;

(c) Clinical nurse specialists; or

(d) Physician assistants.

(7) For all home health services except medical equipment under WAC 182-551-2122, the physician, nurse practitioner, clinical nurse specialist, or physician assistant responsible for ordering the services must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (3) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

(8) For medical equipment under WAC 182-551-2122, an ordering physician, nurse practitioner, clinical nurse specialist, physician assistant, or the attending physician when a client is discharged from an acute hospital stay, must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (4) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2040, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 2021 c 157. WSR 23-04-048, § 182-551-2040, filed 1/26/23, effective 2/26/23. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. § 440.70. WSR 21-12-051, § 182-551-2040, filed 5/26/21, effective 6/26/21; WSR 18-24-023, § 182-551-2040, filed 11/27/18, effective 1/1/19.]

WAC 182-551-2100 Skilled nursing services. (1) The medicaid agency covers home health skilled nursing services up to service limitations without prior authorization. See WAC 182-501-0169 for information on limitation extension.

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

(3) The medicaid agency pays for the following home health skilled nursing services, subject to program rules and the provisions in this section:

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

(i) Observation;

(ii) Assessment;

(iii) Treatment;

(iv) Teaching;

(v) Training;

(vi) Management; and

(vii) Evaluation.

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

(i) An injection;

(ii) Blood draw; or

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

(c) Home infusion therapy only if the client:

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

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

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

(i) When provided by a medicaid agency-approved home health agency with an infant phototherapy provider; and

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

(e) Limited high-risk obstetrical services:

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

(ii) For up to three home health visits per pregnancy if enrolled in or referred to a first steps maternity support services (MSS) provider. The visits are provided by a registered nurse who has either:

(A) National perinatal certification; or

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

(4) The medicaid agency pays for up to two skilled nursing visits, per client, per day.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2100, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2100, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2100, filed 1/12/16, effective 2/12/16. 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 Specialized therapy. (1) The medicaid agency covers outpatient rehabilitation and habilitative services only when provided:

(a) By a home health agency; and

(b) In any setting where normal life activities take place.

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2110, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2110, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-04-026, § 182-551-2110, filed 1/25/16, effective 3/1/16. 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 182-551-2115 Medical social services. (1) The medicaid agency covers medical social services under program rules, including the rules in this chapter.

(2) Medical social services include the following:

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

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

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

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

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

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

(4) The medicaid agency may authorize additional services on a case-by-case basis under WAC 182-501-0169.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2115, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-05-048, § 182-551-2115, filed 2/9/22, effective 3/12/22.]

WAC 182-551-2120 Aide services. (1) The medicaid agency covers home health aide services.

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

(3) The medicaid agency may authorize additional services on a case-by-case basis under WAC 182-501-0169.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2120, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2120, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2120, filed 1/12/16, effective 2/12/16. 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 182-551-2122 Medical supplies, equipment, and appliances. The medicaid agency covers medical supplies, equipment, and appliances, as defined and described in chapter 182-543 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2122, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2122, filed 11/27/18, effective 1/1/19.]

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

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

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

(b) Have a diagnosis or diagnoses where there is a high risk of sudden change in clinical status which could compromise health outcomes.

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

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

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

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

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

(i) Teaching regarding medication management, as appropriate;

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

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

(iv) Coordination of care with the ordering physician regarding findings;

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

(vi) Referral to the emergency room as needed.

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2125, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 2021 c 157. WSR 23-04-048, § 182-551-2125, filed 1/26/23, effective 2/26/23. Statutory Authority:

RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2125, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2125, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2125, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. WSR 10-10-087, § 388-551-2125, filed 5/3/10, effective 6/3/10.]

WAC 182-551-2130 Noncovered services. (1) The medicaid agency does not cover the following home health services under the home health program:

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

(i) Prior to ALTSA implementing a long-term care skilled nursing plan or specialized therapy plan, the medicaid agency may consider a short-term authorization of these services as an exception to rule (ETR); and

(ii) Any services authorized are subject to the provisions in this section and other applicable WAC.

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

(c) Psychiatric skilled nursing services.

(d) Prenatal and postpartum skilled nursing services, except as listed under WAC 182-551-2100.

(e) Well-baby follow-up care.

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

(g) Health care for a medically stable client.

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

(i) Categorically needy - Emergency medical only; and

(ii) Medically needy - Emergency medical only.

(2) The medicaid agency evaluates a request for home health services that are listed as noncovered:

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2130, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-05-048, § 182-551-2130, filed 2/9/22, effective 3/12/22. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2130, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-03-035, § 182-551-2130, filed 1/12/16, effective 2/12/16. 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, ef-

fective 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 Eligible providers. The following may contract with the medicaid agency to provide home health services through the home health program, subject to the requirements and limitations in this section and other applicable published WAC:

(1) A home health agency that:

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

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

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

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

(2) A registered nurse (RN) who:

(a) Is prior authorized by the medicaid agency to provide intermittent nursing services when no home health agency exists in the area where the client's normal life activities take place;

(b) Cannot contract with a medicare-certified home health agency;

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2200, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2200, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2200, filed 1/12/16, effective 2/12/16. 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 Provider requirements. (1) For any home health services to be payable, the medicaid agency requires home health providers to develop and implement an individualized plan of care (POC) for the client that must:

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

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

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

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by an authorized practitioner at least every 60 calendar days;

(f) Be signed by the authorized practitioner within 45 days if a verbal order is given; and

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

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

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

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

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

(d) The prognosis;

(e) The type or types of equipment required;

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

(g) Specific procedures and modalities;

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

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

(j) A list of permitted activities;

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

(l) A list of medications which indicates:

(i) Any new prescription; and

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

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

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

(b) Documentation that justifies why the medical services should be provided in any setting where the client's life activities take place instead of an authorized practitioner's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the department of social and health services (DSHS) case manager of admittance;

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

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

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

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 182-551-2120;

(c) All medications administered and treatments provided;

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

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

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

(g) Interdisciplinary and multidisciplinary team communications;

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

(i) Medical tests and results;

(j) Pertinent medical history; and

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

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

(a) Skilled interventions per the POC;

(b) Client response to the POC;

(c) Any clinical change in client status;

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

(e) Any communications with the attending authorized practitioner; and

(f) Telemedicine findings, as appropriate.

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2210, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 2021 c 157. WSR 23-04-048, § 182-551-2210, filed 1/26/23, effective 2/26/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-23-044, § 182-551-2210, filed 11/9/21, effective 12/10/21. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2210, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2210, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2210, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. WSR 10-10-087, § 388-551-2210, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

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

(2) Payment to home health providers is:

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

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

(c) Updated by general vendor rate changes.

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

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

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

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

(5) Providers must submit documentation to the medicaid agency during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 182-551-2210.

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

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

(a) The service did not meet the conditions described in WAC 182-550-2030; or

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

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

(a) Type of service performed;

(b) Individual receiving the service;

(c) Date of the service;

(d) Location of service delivery;

(e) Individual providing the service; and

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-551-2220, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. Section 440.70. WSR 18-24-023, § 182-551-2220, filed 11/27/18, effective 1/1/19. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-035, § 182-551-2220, filed 1/12/16, effective 2/12/16. WSR 11-14-075, recodified as § 182-551-2220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. WSR 10-10-087, § 388-551-2220, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. WSR 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. WSR 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

SUBCHAPTER III—PRIVATE DUTY NURSING

WAC 182-551-3000 Private duty nursing for clients age seventeen and younger—General. (1) The medically intensive children's program (MICP) provides private duty nursing to clients, either through fee-for-service or an agency-contracted managed care organization (MCO).

(2) The MICP is available to clients age seventeen and younger, whose complex medical needs cannot be managed within the scope of intermittent home health services.

(3) Managed care clients receive private duty nursing services through their agency-contracted MCO. (See chapter 182-538 WAC). Providers must follow the policies and procedures of the client's MCO, including the authorization of services.

(4) For clients with third-party liability (TPL) coverage (see WAC 182-500-0105) that includes private duty nursing, the procedures and policies in subchapter III, titled Private Duty Nursing, apply when determining coverage of additional hours under MICP.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-15-010, § 182-551-3000, filed 7/6/18, effective 9/1/18. 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.]

WAC 182-551-3050 Private duty nursing for clients age seventeen and younger—Definitions. The following definitions and those found in chapter 182-500 WAC apply to this subchapter.

"Nursing care consultant" means a registered nurse employed by the department of social and health services (DSHS) to evaluate clinical eligibility for the medically intensive children's program (MICP) and provide a written assessment summary.

"Private duty nursing" means skilled nursing care and services provided in the home for clients with complex medical needs that cannot be managed within the scope of intermittent home health services.

"Skilled nursing care" means the medical care provided by a licensed nurse or delegate working under the direction of a physician as described in RCW 18.79.260.

"Skilled nursing services" means the management and administration of skilled nursing care requiring the specialized judgment, knowledge, and skills of a registered nurse or licensed practical nurse as described in RCW 18.79.040 and 18.79.060.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-15-010, § 182-551-3050, filed 7/6/18, effective 9/1/18.]

WAC 182-551-3100 Private duty nursing for clients age 17 and younger—Client eligibility. (1) To be eligible for private duty nursing under the medically intensive children's program (MICP), clients must:

(a) Be age 17 or younger;

(b) Meet financial eligibility under subsection (2) of this section;

(c) Meet medical eligibility under subsection (3) of this section;

(d) Have informal support by a person who has been trained to provide designated skilled nursing care and is able to perform the care as required;

(e) Have prior authorization from the department of social and health services/developmental disabilities community services (DSHS/DDCS); and

(f) Have exhausted all other funding sources for private duty nursing, according to RCW 74.09.185, prior to accessing these services through the medically intensive children's program (MICP).

(2) To be financially eligible for private duty nursing, clients must meet medicaid eligibility requirements under the categorically needy program, the medically needy program, or alternative benefits plan program (see WAC 182-501-0060).

(3) To be medically eligible for private duty nursing under fee-for-service, clients must be assessed by a DSHS/DDCS nursing care consultant and determined medically eligible for MICP.

(4) Clients must meet the following criteria to be medically eligible for MICP:

(a) Require four or more continuous hours of active skilled nursing care with consecutive tasks at a level that:

(i) Cannot be delegated at the time of the initial assessment; and

(ii) Can be provided safely outside of a hospital in a less restrictive setting.

(b) Require two or more tasks of complex skilled nursing care such as:

(i) System assessments, including multistep approaches of systems (e.g., respiratory assessment, airway assessment, vital signs, nutritional and hydration assessment, complex gastrointestinal assessment and management, seizure management requiring intervention, or level of consciousness);

(ii) Administration of treatment for complex respiratory issues related to technological dependence requiring multistep approaches on a day-to-day basis (e.g., ventilator tracheostomy);

(iii) Assessment of complex respiratory issues and interventions with use of oximetry, titration of oxygen, ventilator settings, humidification systems, fluid balance, or any other cardiopulmonary critical indicators based on medical necessity;

(iv) Skilled nursing interventions of intravenous/parenteral administration of multiple medications and nutritional substances on a continuing or intermittent basis with frequent interventions; or

(v) Skilled nursing interventions of enteral nutrition and medications requiring multistep approaches daily.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-22-083, s 182-551-3100, filed 11/4/25, effective 12/5/25; WSR 18-15-010, § 182-551-3100, filed 7/6/18, effective 9/1/18.]

WAC 182-551-3200 Private duty nursing for clients age 17 and younger—Provider requirements. Providers qualified to deliver pri-

vate duty nursing under the medically intensive children's program must have the following:

(1) An in-home services license with the state of Washington to provide private duty nursing;

(2) A contract with the department of social and health services/developmental disabilities community services (DSHS/DDCS) to provide private duty nursing; and

(3) A signed core provider agreement with the medicaid agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-22-083, s 182-551-3200, filed 11/4/25, effective 12/5/25; WSR 18-15-010, § 182-551-3200, filed 7/6/18, effective 9/1/18.]

WAC 182-551-3300 Private duty nursing for clients age 17 and younger—Application requirements. Clients requesting private duty nursing through fee-for-service must submit a complete signed medically intensive children's program (MICP) application (DSHS form 15-398). The MICP application must include the following:

(1) DSHS 14-012 consent form;

(2) DSHS 14-151 request for DDCS eligibility determination form for clients not already determined DDCS eligible;

(3) DSHS 03-387 notice of practices for client medical information;

(4) Appropriate and current medical documentation including medical plan of treatment or plan of care (WAC 246-335-080) with the client's age, medical history, diagnoses, and the parent/guardian contact information including address and phone number;

(5) A list of current treatments or treatment records;

(6) Information about ventilator, bilevel positive airway pressure (BiPAP), or continuous positive airway pressure (CPAP) hours per day or frequency of use;

(7) History and physical from current hospital admission, recent discharge summary, or recent primary physician exam;

(8) A recent interim summary, discharge summary, or clinical summary;

(9) Recent nursing charting within the past five to seven days of hospitalization or in-home nursing documentation;

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

(11) An emergency medical plan that includes strategies to address loss of power and environmental disasters such as methods to maintain life-saving medical equipment supporting the client. The plan may include notification of electric and gas companies and the local fire department;

(12) A psycho-social history/summary with the following information, as available:

(a) Family arrangement and current situation;

(b) Available personal support systems; and

(c) Presence of other stresses within and upon the family.

(13) Statement that the home care plan is safe for the child and is agreed to by the child's parent or legal guardian;

(14) Information about other family supports such as medicaid, school hours, or hours paid by a third-party insurance or trust; and

(15) For a client with third-party insurance or a managed care organization (MCO), a denial letter from the third-party insurance or MCO that states the private duty nursing will not be covered.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-22-083, s 182-551-3300, filed 11/4/25, effective 12/5/25; WSR 18-15-010, § 182-551-3300, filed 7/6/18, effective 9/1/18.]

WAC 182-551-3400 Private duty nursing for clients age 17 and younger—Authorization. (1) Private duty nursing when provided through fee-for-service requires prior authorization from the department of social and health services/developmental disabilities community services (DSHS/DDCS).

(2) DSHS/DDCS authorizes requests for private duty nursing on a case-by-case basis when:

(a) The application requirements under WAC 182-551-3300 are met; and

(b) The nursing care consultant determines the services to be medically necessary, as defined in WAC 182-500-0070 and according to the process in WAC 182-501-0165.

(3) DSHS/DDCS authorizes only the number of private duty nursing hours that are medically necessary.

(a) Services are limited to 16 hours of private duty nursing per day.

(b) DSHS/DDCS may adjust the number of authorized hours when the client's condition or situation changes.

(c) Additional hours beyond 16 per day are subject to review as a limitation extension under WAC 182-501-0169.

(4) Private duty nursing provided to the client in excess of the authorized hours may be the financial responsibility of the client, the client's family, or the client's guardian. Providers must follow the provisions of WAC 182-502-0160.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-22-083, s 182-551-3400, filed 11/4/25, effective 12/5/25; WSR 18-15-010, § 182-551-3400, filed 7/6/18, effective 9/1/18.]