

## DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption, on an emergency basis, of an amendment to repeal Chapter 51 (Medicaid Reimbursement for Services Provided by Home Health Aides) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR) and to create a new Chapter 99, entitled “Home Health Services,” of Title 29 (Public Welfare) of the DCMR.

Home Health services consist of a variety of services including skilled nursing, home health aide, physical therapy, occupational therapy, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and speech pathology and audiology services. All of these services are delivered in a beneficiary’s place of residence or a setting in which normal life activities take place with the goal of maintaining a beneficiary’s general health outcomes. Home Health services are provided to some of the most vulnerable Medicaid beneficiaries. Several factors have contributed to inconsistent quality of care and limited DHCF’s ability to effectively oversee and hold providers accountable for these services, including limited State Plan guidance, the absence of Skilled Nursing and therapy-related rules defining the services, and a lack of specificity in provider qualifications and billing requirements.

These emergency and proposed rules establish standards for Medicaid reimbursement of Home Health services that correlate to a proposed State Plan Amendment (SPA) that will update the amount, duration and scope of Home Health service delivery and implement new provider payment rates for Skilled Nursing services.

Skilled Nursing service rates have not kept pace with market rates in recent years, and have created access issues for some beneficiaries. DHCF is proposing this emergency rate increase and updated oversight standards to ensure that an adequate supply of qualified providers will be available to provide skilled nursing services to District Medicaid beneficiaries. Emergency adoption of this proposed rule is needed to protect the health and safety of District residents to ensure that Home Health service providers can hire and retain qualified staff, which will afford access to skilled nursing services authorized under the State Plan. Further, these rules include new federal standards that require face-to-face encounters between the ordering health practitioner and the beneficiary before Home Health services are delivered.

Emergency adoption is also required in order to ensure that providers of Home Health Aide services are compensated in accordance with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)). The provisions of these rules reflecting increased compensation for providers of Home Health Aide services in

accordance with the Living Wage Act are not contingent upon approval of the corresponding SPA.

The new federal standards have resulted in Chapter 51 (Medicaid Reimbursement for Services Provided by Home Health Aides) containing outdated information for providers and beneficiaries of Home Health Aide services. As the revised standards governing provider qualifications, eligibility requirements, service descriptions and delivery parameters, and reimbursement for Home Health Aide services have been incorporated into the new chapter created through these emergency and proposed rules, DHCF is repealing Chapter 51 in its entirety.

The corresponding SPA requires approval by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS). The State Plan Amendment was approved by the Council of the District of Columbia (Council) through the Fiscal Year 2016 Budget Support Act of 2015, enacted August 11, 2015 (D.C. Act 21-148; 62 DCR 10905). The Notice of Emergency and Proposed Rulemaking was adopted on February 7, 2017, and will become effective for dates of services rendered on or after March 1, 2017, if the corresponding State Plan Amendment has been approved by CMS with an effective date of March 1, 2017 or the effective date established by CMS, whichever is later. The emergency rules shall remain in effect not longer than one hundred and twenty days from the adoption date or until June 7, 2017, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The aggregate fiscal impact of the corresponding State Plan Amendment will be approximately \$1,083,000 in Fiscal Year 2017 and \$1,211,000 in Fiscal Year 2018.

The Director of DHCF also gives notice of the intent to take final rulemaking action to adopt these proposed rules in not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

**Title 29 DCMR, PUBLIC WELFARE, is amended as follows:**

**Chapter 51, MEDICAID REIMBURSEMENT FOR SERVICES PROVIDED BY HOME HEALTH AIDES, is deleted in its entirety.**

**A new Chapter 99, Home Health Services, is added to read as follows:**

**CHAPTER 99 HOME HEALTH SERVICES**

- 9900 GENERAL PROVISIONS**
- 9901 SKILLED NURSING SERVICES**
- 9902 HOME HEALTH AIDE SERVICES**
- 9903 PHYSICAL THERAPY SERVICES**
- 9904 OCCUPATIONAL THERAPY SERVICES**
- 9905 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES**
- 9906 AUDITS AND RECORD MAINTENANCE**
- 9999 DEFINITIONS**

**9900 GENERAL PROVISIONS**

9900.1 This chapter establishes general standards for conditions of participation for Medicaid providers and delineates specific standards governing Medicaid reimbursement for the following Home Health services:

- (a) Skilled Nursing services as described in Section 9901;
- (b) Home Health Aide services as described in Section 9902;
- (b) Physical Therapy services as described in Section 9903;
- (c) Occupational Therapy services as described in Section 9904; and
- (d) Speech Pathology and Audiology services as described in Section 9905.

9900.2 In addition to the services identified in Subsection 9900.1, Medicaid reimbursable Home Health services include Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

9900.3 The standards of participation and specific requirements governing reimbursement for Home Care agencies enrolled in the Medicaid program providing DMEPOS services are set forth in Sections 996 and 997 of Chapter 9 of Title 29 DCMR.

9900.4 In order to qualify for Medicaid reimbursement, Home Health services listed in Section 9900.1 are services that are:

- (a) Ordered by a physician;
- (b) Provided at the beneficiary's residence or in a setting in which normal life activities take place, unless the exceptions referenced in Subsections 9900.5 and 9900.6 are met; and
- (c) Delivered in accordance with a plan of care developed by a Registered Nurse (R.N.) under a process that meets the requirements under Subsection 9900.11.

9900.5 Except as provided in Subsection 9900.6 and in accordance with 42 C.F.R. § 440.70(c)(1), Home Health services shall not be delivered in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for beneficiary services that include room and board.

- 9900.6 Home Health services may be provided in an ICF/IID if the home health service is not provided as part of the facility's services as required under 42 C.F.R. § 483.460.
- 9900.7 A beneficiary shall be eligible for the Medicaid reimbursable Home Health services referenced in Subsection 9900.1 if the following conditions are met:
- (a) DHCF or its designee receives an order for Home Health services from the beneficiary's physician establishing that the services are medically necessary in accordance with the requirements set forth in this chapter; and
  - (b) DHCF or its designee provides prior authorization in accordance with the service delivery requirements set forth in this chapter.
- 9900.8 In order for the services contained in the physician's order described in Subsection 9900.7(a) to be reimbursed by Medicaid, the order must be signed and dated by a physician knowledgeable about the beneficiary's needs and conditions and must state the amount, frequency, scope and duration of the service. The physician's signature on the order constitutes certification by the physician that the services ordered reflect the health status and needs of the beneficiary, and that the beneficiary is eligible for the service.
- 9900.9 For all Medicaid reimbursable Home Health services described in Subsection 9900.1, in order to be reimbursed the ordering physician shall:
- (a) Document that a face-to-face encounter, related to the primary reason the beneficiary requires Home Health services, occurred between the beneficiary and the health practitioner, as defined in Subsection 9900.10, within ninety (90) days before or within thirty (30) days after the start of services; and
  - (b) Indicate the name of the practitioner who conducted the face-to-face encounter and the date of the encounter on the order.
- 9900.10 In order for the services contained in the physician's order described in Subsection 9900.7(a) to be reimbursed by Medicaid, the face-to-face encounter described in Subsection 9900.9 shall be related to the primary reason the beneficiary requires Home Health services and shall be conducted by one of the following health practitioners:
- (a) The ordering physician;
  - (b) A nurse practitioner working in collaboration with the physician;
  - (c) A certified nurse mid-wife as authorized under District law;

- (d) A physician assistant acting under the supervision of the ordering physician; or
- (e) For beneficiaries receiving Home Health services immediately after an acute or post-acute stay, the attending acute or post-acute physician.

- 9900.11 In order for the services contained in the physicians' order described in Subsection 9900.7(a) to be reimbursed by Medicaid, the plan of care described in Subsection 9900.4 shall be developed and signed by an R.N. who is employed or under contract to the Home Health services provider. The signature of the R.N. on the plan of care constitutes a certification that the plan of care accurately reflects the assessed needs of the beneficiary and that the services identified in the plan of care are in accordance with the physician's order described in Subsections 9900.7 and 9900.8.
- 9900.12 The beneficiary's physician shall approve the initial plan of care by signing it within thirty (30) calendar days of the development of the plan of care, and noting his or her license number and National Provider Identification number on the plan of care.
- 9900.13 The plan of care for services described in Subsection 9900.1 shall be reviewed, updated and signed by the physician every sixty (60) calendar days.
- 9900.14 Home health services included in Subsection 9900.15 that are in the beneficiary's plan of care may not exceed thirty-six (36) visits per year for each beneficiary, except in cases where the beneficiary requests prior authorization and is approved by DHCF.
- 9900.15 The thirty six (36) visit home health service limitation includes any Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided during an annual period.
- 9900.16 Limitations on the delivery of Skilled Nursing services are described under Section 9901.
- 9900.17 Limitations on the delivery of DMEPOS are described under Section 9906.

**9901 SKILLED NURSING SERVICES**

- 9901.1 Medicaid reimbursable Skilled Nursing services are part-time or intermittent skilled nursing care services that are needed by a beneficiary due to an illness or injury, and are furnished by nurses in accordance with the beneficiary's plan of care described in Subsection 9900.4.

- 9901.2 In order to be eligible for Medicaid reimbursement, a Home Care agency providing Skilled Nursing services shall meet the following requirements:
- (a) Be enrolled as a Medicare Home Health Agency qualified to offer skilled nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R. Part 484;
  - (b) Have sufficient funds or “initial reserve operating funds” available for business expenses determined in accordance with federal special capitalization requirements for home care agencies participating in Medicare as set forth under 42 C.F.R. § 489.28;
  - (c) Meet the District of Columbia Department of Health licensure requirements in accordance with Chapter 39 (Home Care Agencies) of Title 22-B DCMR;
  - (d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under Chapter 94 (Medicaid Provider and Supplier, Screening, Enrollment, and Termination) of Title 29 DCMR; and
  - (e) Have a surety bond, in accordance with federal requirements for home care agencies participating in Medicaid as set forth under 42 C.F.R. § 441.16 and Subsection 9901.3.
- 9901.3 Except for government-operated Home Care Agencies, each Home Care Agency that is a Medicaid participating Home Care Agency or that seeks to become a Medicaid participating Home Care Agency shall:
- (a) Obtain a fifty thousand dollar (\$50,000) surety bond that meets the requirements as set forth under 42 C.F.R. § 441.16; and
  - (b) Furnish a copy of the surety bond to DHCF.
- 9901.4 Medicaid reimbursable Skilled Nursing services shall be provided by a R.N. or licensed practical nurse (L.P.N.) licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules.
- 9901.5 Medicaid-reimbursable Skilled Nursing services shall consist of the following duties:
- (a) Conducting initial assessments either prior to service provision or at the onset of care and reassessments every sixty (60) calendar days thereafter to develop and update a plan of care;

- (b) Coordinating the beneficiary's care and referrals among all Home Care agency providers;
- (c) Implementing preventive and rehabilitative nursing procedures;
- (d) Administering medications and treatments as prescribed by a licensed physician, pursuant to the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.*), as outlined under the plan of care;
- (e) Recording progress notes at each visit and summary notes at least once every sixty (60) calendar days;
- (f) Making necessary updates to the plan of care, and reporting any changes in the beneficiary's condition to his or her physician;
- (g) Instructing the beneficiary on treatment regimens identified under the plan of care;
- (h) Updating the physician on changes in the beneficiary's condition and obtaining orders to implement those changes; and
- (i) For R.N.s who supervise nursing services delivered by a skilled nurse (R.N. or L.P.N.), duties shall include, at minimum, the following:
  - (1) Supervising the beneficiary's skilled nurse on-site, at least once every sixty (60) calendar days;
  - (2) Ensuring that new or revised physician orders have been obtained initially from the treating physician and then at least every sixty (60) calendar days thereafter, to promote continuity of care;
  - (3) Reviewing the beneficiary's plan of care;
  - (4) Monitoring the beneficiary's general health outcomes, including taking vital signs, conducting a comprehensive physical examination, and determining mental status;
  - (5) Determining if the beneficiary has any unmet medical needs;
  - (6) Ensuring that all home health services are provided safely and in accordance with the plan of care;
  - (7) Ensuring that the beneficiary has received education on any needed services;

- (8) Ensuring the safe discharge or transfer of the beneficiary;
  - (9) Ensuring that the physician receives progress notes when the beneficiary's health condition changes, or when there are deviations from the plan of care;
  - (10) Ensuring that a summary report of the visit is sent to the physician every sixty (60) calendar days; and
  - (11) Reporting any instances of abuse, neglect, exploitation or fraud to DHCF and other appropriate District government agencies, including the Department of Health, to promote a safe and therapeutic environment in accordance with 17 DCMR § 5414.
- 9901.6 For Medicaid reimbursable services, the initial assessment to develop the plan of care and reassessments to update the plan of care shall only be conducted by an R.N. The R.N. conducting an initial assessment or periodic reassessment in accordance with this Chapter shall certify in writing that the statements made in the assessment are true and accurate.
- 9901.7 Consistent with the Department of Health regulations at 22-B DCMR § 3917, Medicaid reimbursable Skilled Nursing services provided by an L.P.N. shall be supervised by an R.N.
- 9901.8 When an L.P.N. provides Skilled Nursing services, the duties of the L.P.N. shall not include supervisory duties.
- 9901.9 When an R.N. is supervising a skilled nurse (L.P.N. or R.N.) providing Medicaid reimbursable services, the R.N. shall monitor and supervise the services provided by the L.P.N. or R.N., including conducting a site visit at least once every sixty (60) calendar days, or more frequently, if specified in the beneficiary's plan of care.
- 9901.10 The skilled nurse shall record progress notes during each visit which shall comply with the standards of nursing care established under 17 DCMR §§ 5414 and 5514, and which shall include the following information:
- (a) Notations regarding any unusual health or behavioral events or changes in status;
  - (b) Notations regarding any matter requiring follow-up on the part of the service provider or DHCF; and
  - (c) A concise written statement of the beneficiary's progress or lack of progress, medical conditions, functional losses, and treatment goals as



outlined in the plan of care that demonstrates that the beneficiary's services continue to be reasonable and necessary.

- 9901.11 The skilled nurse shall prepare summary notes every sixty calendar (60) days summarizing the progress notes recorded at each visit and bringing attention to any matter requiring follow-up on the part of the Home Care Agency or DHCF.
- 9901.12 Skilled Nursing services shall be reimbursed by Medicaid for up to six (6) hours a day with prior authorization by DHCF, in accordance with the requirements set forth under Subsection 9901.13. Beneficiaries may also qualify for additional reimbursable hours if they meet the requirements referenced under Subsection 9901.16. The need for continuing Skilled Nursing services shall be reassessed and certified by the physician every sixty (60) calendar days.
- 9901.13 For Medicaid reimbursable services, a beneficiary or his/her physician shall obtain prior authorization for the initiation of Skilled Nursing services by submitting a physician's order as described in Section 9900 to DHCF or its agent to support the beneficiary's need for Skilled Nursing services which aligns with the beneficiary's assessed needs.
- 9901.14 A Home Care agency shall obtain prior authorization for continuing Medicaid reimbursable Skilled Nursing services every sixty (60) calendar days by submitting an updated physician's order and any supporting documentation to DHCF or its agent to support the beneficiary's need for ongoing Skilled Nursing services which align with the beneficiary's assessed needs, as outlined in the updated plan of care.
- 9901.15 Medicaid reimbursable Skilled Nursing services may be provided without a prior authorization for up to six (6) hours a day for a period not to exceed five (5) calendar days only when the beneficiary's need for Skilled Nursing services is immediate, such as an emergency situation or to ensure the safe and orderly discharge of the beneficiary from a hospital or nursing home to the beneficiary's home.
- 9901.16 Beneficiaries in need of more hours of Medicaid reimbursable Skilled Nursing services beyond the six (6) hour per day cap may request a health and safety review by DHCF or its designated agent to determine whether additional hours are medically necessary and that the beneficiary's needs can be safely met in the home. The Home Care agency shall submit documentation supporting the beneficiary's additional need for Skilled Nursing services which aligns with the physician's order and the health status and needs as outlined in the plan of care to DHCF's Long Term Care Administration.
- 9901.17 Beneficiaries enrolled in the § 1915(c) Individuals with Intellectual and Developmental Disabilities (IDD) Home and Community-Based Services Waiver in need of additional hours of Skilled Nursing services beyond those provided

under the State Plan may be eligible to receive Skilled Nursing services under the ID/DD Waiver to the extent the individual has first exhausted the State Plan benefit; qualifies for Skilled Nursing services or extended Skilled Nursing services under 29 DCMR §§ 1931 *et seq.*; and such services are consistent with the individual's plan of care.

9901.18 The Medicaid reimbursement rate for Skilled Nursing services shall be fifteen dollars (\$15.00) for each fifteen (15) minute unit of service for services provided by a R.N., and twelve dollars and fifty cents (\$12.50) for each fifteen (15) minute unit of service provided by a L.P.N.

9901.19 The Medicaid reimbursement rate for an initial assessment by a R.N. shall be a flat rate of one hundred and twenty dollars (\$120). The reimbursement rate for reassessments and supervisory visits shall be the R.N. rate for each fifteen (15) minute unit of service not to exceed a total of eight (8) units of service per reassessment or supervisory visit.

9901.20 A provider seeking Medicaid reimbursement shall provide and document at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to be able to bill a unit of service.

9901.21 Medicaid reimbursable Skilled Nursing services shall comply with the following service limitations:

- (a) Assessments, reassessments or supervisory visits of a skilled nurse or aide shall not be included in the calculation of the daily Skilled Nursing cap;
- (b) When a skilled nurse performs the duties described under Subsections 9901.5(b)-(h) during an initial assessment or reassessment, these services shall be included as part of the rate paid for an initial assessment or reassessment and shall not be billed separately; and
- (c) When a skilled nurse provides assistance with activities of daily living during an assessment, supervisory, or Skilled Nursing visit, the Home Care agency shall ensure that activities performed during the assessment, supervisory, or Skilled Nursing visit are only billed as Skilled Nursing services and may not also be billed as personal care aide services.

9901.22 Beneficiaries who receive Medicaid-reimbursed Skilled Nursing services may not concurrently receive Medicaid-reimbursed Private Duty Nursing services under the State Plan.

## 9902 HOME HEALTH AIDE SERVICES

9902.1 Medicaid reimbursable Home Health Aide services are services that are required by a beneficiary due to an illness or injury, and include assistance with activities

of daily living, assistance with self-administered medications, or other clinical tasks to assist with the provision of nursing or skilled services such as cleaning around a feeding tube and assistance with oxygen therapy, on a part-time or intermittent basis.

9902.2 In order to be eligible for Medicaid reimbursement, a Home Care agency providing Home Health Aide services shall meet all requirements of Subsection 9901.2.

9902.3 Medicaid reimbursable Home Health Aide services shall be provided by a home health aide certified in accordance with Chapter 93 (Home Health Aides) of Title 17 DCMR who is supervised in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules.

9902.4 Medicaid reimbursable Home Health Aide services shall consist of the following duties:

- (a) Performing personal care including assistance with activities of daily living such as bathing, personal hygiene, toileting, transferring from the wheelchair, and instrumental activities such as meal preparation, laundry, grocery shopping, and telephone use;
- (b) Changing urinary drainage bags;
- (c) Assisting the beneficiary with transfer, ambulation, and exercise as prescribed;
- (d) Assisting the beneficiary with self-administration of medication;
- (e) Measuring and recording temperature, pulse, respiration, and blood pressure;
- (f) Measuring and recording height and weight;
- (g) Observing, recording, and reporting the beneficiary's physical condition, behavior, or appearance;
- (h) Preparing meals in accordance with dietary guidelines;
- (i) Assisting with skills necessary for food consumption;
- (j) Implementing universal precautions to ensure infection control;
- (k) Performing tasks related to keeping the beneficiary's living area in a condition that promotes the beneficiary's health and comfort;

- (l) Changing simple dressings that do not require the skills of a licensed nurse;
- (m) Assisting the beneficiary with activities that are directly supportive of skilled therapy services;
- (n) Assisting with routine care of prosthetic and orthotic devices
- (o) Emptying and changing colostomy bags and performing care of the stoma;
- (p) Cleaning around a gastrostomy tube site;
- (q) Administering an enema; and
- (r) Assisting with oxygen therapy.

9902.5 Home Health Aide services shall be reimbursed by Medicaid for up to four (4) hours per day with prior authorization by DHCF, in accordance with the requirements set forth under Subsection 9902.6. The need for continuing Home Health Aide services shall be reassessed and certified by the physician every sixty (60) days.

9902.6 A beneficiary and his/her physician shall obtain prior authorization for the initiation of Medicaid reimbursable Home Health Aide services by submitting a physician's order as described in Section 9900 to DHCF or its agent to support the beneficiary's need for Home Health Aide services which aligns with the beneficiary's assessed needs.

9902.7 The Home Care agency shall obtain prior authorization for continuing Medicaid reimbursable Home Health Aide services every sixty (60) calendar days by submitting an updated physician's order and any supporting documentation to DHCF or its agent to support the beneficiary's need for ongoing Home Health Aide services which aligns with the beneficiary's assessed needs, as outlined in the updated plan of care.

9902.8 Beneficiaries in need of additional hours of Medicaid reimbursable Home Health Aide services may request a health and safety review by DHCF or its designated agent to determine the need for additional hours beyond the four (4) hour per day cap on Home Health Aide services. The Home Care agency shall submit documentation supporting the beneficiary's additional need for Home Health Aide services which aligns with the physician's order and the beneficiary's health status and needs as outlined in the plan of care to DHCF's Long Term Care Administration.

- 9902.9 For dates of service prior to January 1, 2017, providers shall be reimbursed five dollars and two cents (\$5.02) per unit of service for allowable Home Health Aide services as authorized in the approved plan of care, of which no less than three dollars and forty six cents (\$3.46) per fifteen (15) minutes for services rendered by a home health aide shall be paid to the home health aide to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)).
- 9902.10 For dates of service beginning January 1, 2017, providers shall be reimbursed five dollars and five cents (\$5.05) per unit of service for allowable Home Health Aide services as authorized in the approved plan of care, of which no less than three dollars and forty-nine cents (\$3.49) per fifteen (15) minutes for services rendered by a home health aide shall be paid to the home health aide to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)).
- 9902.11 Subsequent changes to the reimbursement rate(s) shall be posted on the Medicaid fee schedule at [www.dc-medicaid.com](http://www.dc-medicaid.com) and DHCF shall also publish a notice in the *D.C. Register* which reflects the change in the reimbursement rate(s).
- 9902.12 If a beneficiary is receiving Adult Day Health Program (ADHP) services under Chapter 97 of Title 29 DCMR on the same day that Home Health Aide services are delivered, the combination of Medicaid reimbursable ADHP and Home Health Aide services shall not exceed a total of twelve (12) hours per day.
- 9902.13 A beneficiary shall not receive Personal Care Aide (PCA) services under Chapter 42 or Chapter 50 of Title 29 DCMR and Home Health Aide services concurrently. Medicaid claims for PCA services submitted by a provider for any hour in which the beneficiary was receiving Medicaid reimbursable Home Health Aide services shall be denied.

**9903 PHYSICAL THERAPY SERVICES**

- 9903.1 Medicaid reimbursable Physical Therapy services are skilled services designed to treat a beneficiary's identified physical dysfunction or reduce the degree of pain associated with movement, injury or long term disability. Physical Therapy services should also maximize independence and prevent further disability, maintain health, and promote mobility.
- 9903.2 Medicaid reimbursable Physical Therapy services shall be provided in accordance with the beneficiary's plan of care described in Subsection 9900.4.
- 9903.3 In accordance with the District's Medicaid State Plan, Physical Therapy is provided as part of a plan of care in a hospital, skilled care facility, intermediate care facility or through a Home Care agency.

- 9903.4 In order to be eligible for Medicaid reimbursement for Physical Therapy services, a Home Care agency shall meet the requirements under Subsection 9901.2.
- 9903.5 Medicaid-reimbursable Physical Therapy services shall be provided by a physical therapist with at least two (2) years of experience and licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules.
- 9903.6 Medicaid-reimbursable Physical Therapy services shall consist of the following duties:
- (a) Conducting an initial evaluation and assessment that summarizes the physician's order and documents the beneficiary's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions;
  - (b) Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;
  - (c) Maintaining ongoing involvement and consulting with other service providers and caregivers;
  - (d) Consulting and instructing the beneficiary, family, or other caregivers on the therapy plan;
  - (e) Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
  - (f) Assessing the beneficiary's need for the use of adaptive equipment;
  - (g) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the beneficiary's needs;
  - (h) Accurately completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines; and
  - (i) Conducting periodic examinations and modifying treatments for the beneficiary receiving services and ensuring that Physical Therapy recommendations are incorporated into the plan of care.

9903.7 Subject to the limitation set forth in Subsection 9900.15, Physical Therapy services may be reimbursed by Medicaid for up to thirty-six (36) visits per year without prior authorization and approval by DHCF.

9903.8 Requests for additional Physical Therapy visits may be approved by DHCF when the beneficiary requests prior authorization and a physician's order documents the need for additional Physical Therapy services.

9903.9 Physical Therapy services shall be reimbursed pursuant to the District of Columbia's Medicaid fee schedule, available at [www.dc-medicaid.com](http://www.dc-medicaid.com).

#### **9904 OCCUPATIONAL THERAPY SERVICES**

9904.1 Medicaid reimbursable Occupational Therapy services are skilled services designed to maximize independence, gain skills, prevent further disability, and develop, restore, or maintain a beneficiary's daily living and work skills.

9904.2 Medicaid reimbursable Occupational Therapy services shall be provided in accordance with the beneficiary's plan of care as described in Subsection 9900.4.

9904.3 In accordance with the District's Medicaid State Plan, Occupational Therapy is provided as part of a plan of care in a hospital, skilled care facility, intermediate care facility or through a Home Care agency.

9904.4 In order to be eligible for Medicaid reimbursement, a Home Care agency providing Occupational Therapy services shall meet the requirements under Subsection 9901.2.

9904.5 Medicaid reimbursable Occupational Therapy services shall be provided by an occupational therapist with at least two (2) years of experience and licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules.

9904.6 Medicaid-reimbursable Occupational Therapy services shall consist of the following duties:

- (a) Conducting an initial evaluation and assessment that:
  - (1) Summarizes the physician's order;
  - (2) Documents the beneficiary's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions; and
  - (3) Reflects the beneficiary's employment and living goals;

- (b) Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;
- (c) Consulting and instructing the beneficiary, family, or other caregivers on the therapy plan;
- (d) Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
- (e) Assessing the beneficiary's need for the use of adaptive equipment;
- (f) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the beneficiary's needs;
- (g) Completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines;
- (h) Conducting and documenting quarterly assessments to verify the condition of the adaptive equipment; and
- (i) Conducting periodic examinations to modify treatments for the beneficiary, when necessary, and ensure that Occupational Therapy recommendations are incorporated into the plan of care.

9904.7 Subject to the limitation set forth in § 9900.15, Occupational Therapy services may be reimbursed by Medicaid for up to thirty-six (36) visits per year without a prior authorization and approval by DHCF.

9904.8 Requests for Medicaid reimbursement of additional Occupational Therapy visits may be approved by DHCF when a beneficiary requests prior authorization and a physician's order documents the need for additional Occupational Therapy services.

9904.9 Occupational Therapy services shall be reimbursed pursuant to the District of Columbia's Medicaid fee schedule, available at [www.dc-medicaid.com](http://www.dc-medicaid.com).

## **9905 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES**

9905.1 Medicaid reimbursable Speech Pathology and Audiology services are skilled therapeutic interventions to address communicative and speech disorders to maximize a beneficiary's expressive and receptive communication skills and are



intended to treat the beneficiary's medical or non-medical communicative disorder.

- 9905.2 Medicaid reimbursable Speech Pathology and Audiology services shall be provided in accordance with the beneficiary's plan of care as described in Subsection 9900.4.
- 9905.3 In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall be limited to beneficiaries eligible through the Early Periodic Screening Diagnostic Treatment (EPSDT) benefit.
- 9905.4 In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall only be provided by a facility licensed to provide medical rehabilitation services or a Home Care agency.
- 9905.5 In order to be eligible for Medicaid reimbursement, a Home Care agency providing Speech Pathology and Audiology services shall meet the requirements under Subsection 9901.2.
- 9905.6 Medicaid reimbursable Speech Pathology and Audiology services shall be provided by a speech language pathologist or audiologist with at least two (2) years of experience that is licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules.
- 9905.7 Medicaid-reimbursable Speech Pathology and Audiology services shall consist of the following duties:
- (a) Conducting a comprehensive assessment, which shall include the following:
    - (1) A background review and current functional review of communication capabilities in different environments, including employment, residence, and other settings in which normal life activities take place;
    - (2) An evaluation of the beneficiary's potential for using augmentative or alternative speech devices, methods, or strategies;
    - (3) An evaluation of the beneficiary's potential for using sign language or other expressive communication methods; and
    - (4) A needs assessment for the use of adaptive eating equipment.

- (b) Developing and implementing the treatment plan that describes treatment strategies including, direct therapy, training caregivers, monitoring requirements, monitoring instructions, and anticipated outcomes;
- (c) Assisting beneficiaries with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;
- (d) Conducting aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss, if applicable;
- (e) Recording daily progress notes and summary notes at least quarterly, or more frequently as needed;
- (f) Conducting periodic examinations, modifying treatments for the beneficiary receiving services and ensuring that the recommendations are incorporated into the Plan of Care; when necessary; and
- (g) Conducting discharge planning.

9905.8 Subject to the limitations set forth in Subsection 9900.15, Medicaid reimbursable Speech Pathology and Audiology services may be provided for up to thirty-six (36) visits per year without a prior authorization.

9905.9 Requests for Medicaid reimbursement for additional Speech Pathology and Audiology visits may be approved by DHCF when a beneficiary requests prior authorization and a physician's order documents the need for additional Speech Pathology and Audiology services.

9905.10 Speech Pathology and Audiology services shall be reimbursed pursuant to the District of Columbia's Medicaid fee schedule, available at [www.dc-medicaid.com](http://www.dc-medicaid.com).

## **9906 AUDITS AND RECORD MAINTENANCE**

9906.1 All Medicaid reimbursable Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology services shall adhere to the audit and record maintenance requirements set forth in this section.

9906.2 Record maintenance requirements related to DMEPOS shall be governed under Subsection 996 of Chapter 9 (Medicaid Program) of Title 29 DCMR.

9906.3 DHCF shall perform audits to ensure that Medicaid payments are consistent with efficiency, economy and quality of care and made in accordance with federal and District rules governing the Medicaid program.

- 9906.4 DHCF shall routinely conduct the audit process to determine, by statistically valid scientific sampling, the appropriateness of services rendered and billed to Medicaid. These audits shall be conducted on-site or through an off-site desk review.
- 9906.5 Each Home Care Agency shall allow access to relevant records and program documentation upon request and during an on-site audit or review by DHCF, other District of Columbia government officials and representatives of the United States Department of Health and Human Services (HHS).
- 9906.6 Each Home Care agency shall maintain complete and accurate records reflecting the specific Home Health services provided to each beneficiary for each unit of service billed. Such records shall be maintained for a period of ten (10) years or when all audits have been completed, whichever is longer.

**9999 DEFINITIONS**

- 9999.1 When used in this chapter, the following terms shall have the following meanings:

**Adaptive Equipment** - Medical devices used to assist the beneficiary in performing activities of daily living

**Order** - A formal, written instruction signed by the physician regarding a beneficiary's medical care, treatment or management which specifically requests the provision of a specific service.

**Plan of Care** - A written document developed by the R.N. hired by the Home Health services provider that delineates the various treatments of the beneficiary.

**Skilled Nurse** - An R.N. or L.P.N. licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules or appropriately licensed in the jurisdiction where services are rendered.

**Surety Bond** - One or more bonds issued by one or more surety companies under 31 U.S.C. §§ 9304 to 9308 and 31 C.F.R. Parts 223, 224, and 225.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Senior Deputy Director/Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4<sup>th</sup> Street, NW, Suite 900 South, Washington DC 20001, via telephone on (202) 442-8742, via email at [DHCFPublicComments@dc.gov](mailto:DHCFPublicComments@dc.gov), or online at [www.dcregs.dc.gov](http://www.dcregs.dc.gov), within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.

