

**Washington Apple Health (Medicaid)**

# Private Duty Nursing for Children Billing Guide

**July 1, 2018**

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

## About this guide

This publication takes effect July 1, 2018, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

## What has changed?

Subject	Change	Reason for Change
All	Contact information for the Medically Intensive Home Care Program Manager updated throughout the billing guide.	Correction
<a href="#">Definitions</a>	Definition of Developmental Disabilities Administration (DDA) updated.	Clarification
<a href="#">Behavioral Health Organization (BHO)</a>	Language changed to reflect that as of July 1, 2018, the Health Care Authority is managing the contracts for the BHOs. There is no change in billing with this transfer.	Complies with <a href="#">House Bill 1388</a> , which transfers the Behavioral Health Authority from the Department of Social and Health Services to the Health Care Authority

## How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) web page.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

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# Resources

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Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	<p style="text-align: center;">See the agency's <a href="#">Billers and Providers</a> web page</p>
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Who do I call for pharmacy authorization?	
Where do I send backup documentation?	
Who do I call for prior authorization?	<p>Developmental Disabilities Administration (DDA)                      Medically Intensive Home Care Program Manager                      (360) 407-1504</p>

# Definitions

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This section defines terms and abbreviations, including acronyms, used in these billing instructions. Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

## **Developmental Disabilities**

**Administration (DDA)** –The organization within the Department of Social and Health Services that administers the Medically Intensive Home Care Program.

**Home Health Agency** - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

**Intermittent Home Health** – Skilled nursing services and specialized therapies provided in a client’s residence. Services are for client’s with acute, short-term intensive courses of treatment.

**Medically Intensive Home Care Program** – A program managed by DDA that provides a home-based program for clients age 17 and under who require complex, long-term care for a condition of such severity and/or complexity that continuous skilled nursing care is required. Persons with medically intensive needs require more individual and continuous care than is available from an intermittent visiting nurse.

**Plan of Treatment (POT)** – (Also known as “plan of care” [POC]) The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

**Usual and Customary Charge** - The rate that may be billed to the agency for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

# Private Duty Nursing Services

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## What is the Purpose of the Program?

Private duty nursing services are administered by the Developmental Disabilities Administration (DDA) through the Medically Intensive Home Care Program (MIHCP). The purpose of this program is to reduce the cost of health care services by providing equally effective, more conservative, and/or less costly treatment in a client's home.

Private duty nursing services are considered *supportive* to the care provided to the client by family members or guardians. Private duty nursing services are decreased as the family/guardian or other caregiver becomes able to meet the client's needs, or when the client's needs diminish.

## What Are Private Duty Nursing Services?

[Refer to WAC 182-551-3000]

Private duty nursing services consists of four or more hours of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services.

Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

- **Assessments** (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);
- **Administration of treatment related to technological dependence** (e.g., ventilator, tracheotomy, BIPAP (bilevel positive airway pressure), IV (intravenous) administration of medications and fluids, feeding pumps, nasal stints, central lines);
- **Monitoring and maintaining parameters/machinery** (e.g., oximetry, blood pressure, lab draws, end tidal CO<sub>2</sub>s, ventilator settings, humidification systems, fluid balance, etc.); and
- **Interventions** (e.g., medications, suctioning, IVs, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

# Client Eligibility

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Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

**It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.**

## How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

### Verifying eligibility is a two-step process:

**Step 1. Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

**Step 2. Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) web page.

**Note:** Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at:  
[www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:  
Washington Healthplanfinder  
PO Box 946  
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) or call the Customer Support Center.

## Are clients enrolled in an agency-contracted managed care organization eligible?

[Refer to WAC 182-538-060 and 095 or WAC 182-538-063]

**YES!** Private duty nursing services are included in the scope of service under agency-contracted managed care organizations (MCOs). When verifying eligibility using ProviderOne, if the client is enrolled in an MCO, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

All medical services covered under an MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

**Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.



Women enrolled in the PCCM model of Healthy Options must have a referral from their PCP in order for women's health care services to be paid to an outside provider. The reason for this is the Indian clinics that contract with the agency as PCCMs do not meet the definition of health carriers in chapter 48.42 RCW. These clinics are not any of the organizations listed in Section 1 of this RCW; thus, they are exempt from the requirements spelled out in this act, including self-referrals by women to women's health care services.

## Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

### Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

## Behavioral Health Organization (BHO)

**Effective July 1, 2018**, the Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have [fully integrated managed care \(FIMC\)](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

## Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

**Effective July 1, 2017, American Indian/Alaska Native (AI/AN)** clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on FIMC, see the agency's [Changes to Apple Health managed care webpage](#).

## FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Apple Health managed care webpage](#).

### **North Central Region – Douglas, Chelan and Grant Counties**

**Effective January 1, 2018**, the agency implemented the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

### **Southwest Washington Region – Clark and Skamania Counties**

**Effective April 1, 2016**, the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

## Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18<sup>th</sup> birthday (alumni)

These clients are identified in ProviderOne as  
**“Coordinated Care Healthy Options Foster Care.”**

See the agency’s [Apple Health managed care page](#), Apple Health Foster Care for further details.

# Provider/Client Responsibilities

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## Who must perform the private duty nursing services?

[Refer to WAC 182-551-3000(3)]

The Medicaid agency or its designee contracts only with home health agencies licensed by Washington State to provide private duty nursing services. The licensed home health agency must also be enrolled with the agency as a medical provider.

Within the home health agency, Private Duty Nursing services must be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the direction of a physician. [WAC 182-551-3000(5)(e)]

Appropriate medical training for the nurses and the family/guardian is the responsibility of the discharging hospital and the receiving licensed home health agency. Training costs due to nurse turnover or client transfers are the responsibility of the licensed home health agency.

The licensed home health agency is responsible for meeting all of the client's nursing needs. The agency will not approve intermittent nursing visits in addition to Private Duty Nursing services.

## Who is responsible for choosing a private duty nursing agency?

Choosing a licensed home health agency is the responsibility of one, or a combination, of the following caregivers involved with the client's care:

- Family member/guardian;
- Attending physician;
- Client's social worker or case manager; or
- Discharge planner.

See [“How do I request prior authorization?”](#)

# Prior Authorization

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## Is prior authorization required?

[Refer to WAC 182-551-3000(4)]

**Yes!** Providers must receive prior authorization from the Developmental Disabilities Administration (DDA) **prior** to providing private duty nursing services to clients. The Medicaid agency approves requests for private duty nursing services on a case-by-case basis.

## How do I request prior authorization?

[Refer to WAC 182-551-3000(4)]

A provider must coordinate with a DDA case manager and request PA by submitting a complete referral to DDA. This referral must include all of the following:

- The client’s age, medical history, diagnosis, and current prescribed treatment plan as developed by the individual’s physician;
- Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;
- An emergency medical plan which includes notification of electric, gas, and telephone companies, as well as local fire agency;
- A written request from the client or the client’s legally authorized representative for home care; and
- Psycho-social history/summary which provides the following information:
  - ✓ Family constellation and current situation;
  - ✓ Available personal support systems;
  - ✓ Presence of other stresses within and upon the family; and
  - ✓ Projected number of nursing hours needed in the home, after discussion with the family or guardian.

<p><b>Note:</b> Please see the agency’s <a href="#">ProviderOne Billing and Resource Guide</a> for more information on requesting authorization.</p>
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## Where do I send the completed referral?

MIHCP Manager  
PO Box 45310  
Olympia WA 98504-5310  
Fax: (360) 407-0954

## When does the agency approve requests for private duty nursing services?

[Refer to WAC 182-551-3000(5)]

The agency approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

- The information submitted by the provider is complete;
- The care will be provided in the client's home;
- The cost of private duty nursing does not exceed the cost to the agency for institutional care;
- An adult family member or guardian has been trained and is capable of providing the skilled nursing care;
- A registered or licensed practical nurse will provide the care under the direction of a physician; and
- Based on the referral submitted by the provider, the agency determines:
  - ✓ The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;
  - ✓ The client requires more nursing care than is available through the home health services program; and
  - ✓ The home care plan is safe for the client.

# Coverage

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## What is covered?

[Refer to WAC 182-551-3000(6)]

Upon approval, the Medically Intensive Home Care Program (MIHCP) manager will notify the client's Developmental Disabilities Administration (DDA) case manager of the final determination. The MIHCP manager will authorize private duty nursing services **up to a maximum of 16 hours per day** (see **exception** listed below), restricted to the least costly, equally effective amount of care.

**Exception:** The MIHCP manager may authorize additional hours for a maximum of 30 days, if any of the following apply:

- The family or guardian is being trained in care and procedures;
- There is an acute episode that would otherwise require hospitalization and the treating physician determines that noninstitutional care is still safe for the client;
- The family or guardian caregiver is ill or temporarily unable to provide care;
- There is a family emergency; or
- The agency or its designee determines it is medically necessary.

The client's DDA case manager will notify the client's caregivers. Once the specific nursing agency is selected and prior to the initiation of care, that agency must contact the MIHCP manager to obtain the authorization number and the number of nursing care hours allowed for each MIHCP client.

**Before starting the care, call:  
MIHCP Manager  
(360) 407-1504**

It is the nursing agency's responsibility to contact the MIHCP nursing coordinator to obtain an authorization number and verify the total number of hours authorized at the beginning of each approved time span. Additional nursing hours beyond the allotted monthly hours must be prior authorized.

The MIHCP manager will adjust the number of authorized hours when the client's condition or situation changes. Any hours of nursing care services in excess of those authorized by the MIHCP manager must be paid for by the client, family, or guardian.

## Private Duty Nursing for Children

The nursing notes and plan of care must be kept in the client's file and made available for review by the MIHCP Manager upon request.

The plan of care must be updated every 62 days to include:

- Physician assessment;
- Current orders;
- Current signature;
- Current nursing assessment;
- Current nursing care plan;
- Nursing notes for past week; and
- Medical necessity for current nursing hours.



# Coverage Table

HCPCS Procedure Code	Appropriate Modifier(s)			Description of Services
T1000	TD			RN, per 15 min.
T1000	TD	TU		RN, per 15 min, <b>overtime</b>
T1000	TD	TV		RN, per 15 min., <b>holiday*</b>
T1000	TD	TK		RN – second client; same home, per 15 min.
T1000	TD	TK	TV	RN – second client; same home, per 15 min., <b>holiday*</b>
T1000	TE			LPN, per 15 min.
T1000	TE	TU		LPN, per 15 min, <b>overtime</b>
T1000	TE	TV		LPN, per 15 min., <b>holiday*</b>
T1000	TE	TK		LPN – second client; same home, per 15 min.
T1000	TE	TK	TV	LPN – second client; same home, per 15 min., <b>holiday*</b>

## Key to Modifiers:

TD = RN

TK = Second client

TE = LPN

TU = Overtime

TV = Holiday

**Note:** Procedure code T1000 **requires prior authorization.** The agency pays for private duty nursing services per unit. 1 unit = 15 minutes.

## Bill Your Usual and Customary Fee.

\* **Paid holidays are limited to:** New Year's Day, Martin Luther King Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving Day, and Christmas Day.

## Fee Schedule

You may view the agency's [Private Duty Nursing Fee Schedule](#)

# Billing

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All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

## What are the general billing requirements?

Providers must follow the [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

## Scheduling of hours

RN service hours may be performed in combination with LPN service hours. The combination must not exceed the total hours that have been prior approved for each calendar month of care.

## Multiple clients in the same home

The MICHP Manager may authorize additional payment when the private duty nurse cares for more than one client in the same home. Be sure to use a separate claim for each client receiving private duty nursing services.

## Services covering more than one month

If you receive prior authorization from the MICHP Manager to provide more than one month of services, bill each month on a separate line.

## How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) web page, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.

The following claim instructions relate to private duty nursing services:

Name	Entry				
Place of Service	These are the only appropriate codes for this program:  <table data-bbox="716 772 1192 844"><tr><td data-bbox="716 772 954 806"><b>Code Number</b></td><td data-bbox="954 772 1192 806"><b>To Be Used For</b></td></tr><tr><td data-bbox="716 806 954 844">12</td><td data-bbox="954 806 1192 844">Home</td></tr></table>	<b>Code Number</b>	<b>To Be Used For</b>	12	Home
<b>Code Number</b>	<b>To Be Used For</b>				
12	Home				