Washington State Health Care Authority

Washington Apple Health (Medicaid)

Private Duty Nursing for Children Billing Guide

January 1, 2019

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 January 1, 2019, and supersedes earlier guides to this program.

The Health Care Authority (agency) 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.

Refer also to the agency's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with the agency.

What has changed?

Subject	Change	Reason for Change
Entire Document	General housekeeping	To improve clarity and usability
Client Eligibility: BHO, Changes for January 1, 2019, IMC, and Integrated Apple Health Foster Care	**Effective January 1, 2019,** some existing integrated managed care regions have new counties and many new regions and counties will be implemented.	Apple Health managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services.

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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Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's Billers, providers, and partners web page
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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?	Developmental Disabilities Administration (DDA) Medically Intensive Home Care Program Manager (360) 407-1504

Definitions

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 (DSHS) that administers the Medically Intensive Home Care Program (MICP).

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 clients with acute, short-term intensive courses of treatment.

Medically Intensive Children's Program (MICP) – 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.

Nursing Care Consultant – A registered nurse employed by DSHS to evaluate clinical eligibility for the MICP and provide a written assessment summary.

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.

Private Duty Nursing – 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 – 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 – 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.

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

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

Private Duty Nursing Services

What is the purpose of the program?

Private duty nursing services are administered by the Developmental Disabilities Administration (DDA) through the Medically Intensive Children's Program (MICP). 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 consist 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.

Client Eligibility

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 non-network providers are prior authorized or are providing urgent or emergency care. Providers must follow the policies and procedures of the client's MCO, including prior authorization of services. 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.

Who is eligible for private duty nursing services?

To be eligible for private duty nursing services under the Medically Intensive Children's Program (MICP), clients must meet all of the following:

- Be age 17 or younger
- Meet financial eligibility under the categorically needy program, the medically needy program, or an alternative benefits plan program (see WAC 182-501-0060)
- Meet medical eligibility as follows:
  - ✓ Require four or more continuous hours of active skilled nursing care with consecutive tasks at a level that cannot be delegated at the time of the initial assessment and can be provided safely outside of a hospital in a less restrictive setting
  - ✓ Require two or more tasks of complex skilled nursing, such as:
    - ➢ Systems 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)
    - ➢ Administration of treatment for complex respiratory issues related to technological dependence requiring multistep approaches on a day-to-day basis (e.g., ventilator tracheostomy)

- 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
- Skilled nursing interventions of intravenous/parenteral administration of multiple medications and nutritional substances on a continuing or intermittent basis with frequent interventions
- Skilled nursing interventions of enteral nutrition and medications requiring multistep approaches daily

- 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
- Have prior authorization from the Developmental Disabilities Administration (DDA)
- Have exhausted all other funding sources for private duty nursing (see RCW 74.09.185) prior to accessing these services through the MICP

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

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 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 the following:

- Payment of covered services
- 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 primary care case management (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)

The Health Care Authority (agency) manages the contracts for behavioral health services (mental health and substance use disorder) for the following four Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **North Sound:** Includes Island, San Juan, Skagit, Snohomish, and Whatcom counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage.

See the agency's Mental health services billing guide for details.

Apple Health – Changes for January 1, 2019

Effective January 1, 2019, agency-contracted managed care organizations (MCOs) in certain Regional Services Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated managed care regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. The agency will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne client portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."
- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care 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 regions.

Clients living in an integrated managed care 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.

> **American Indian/Alaska Native (AI/AN)** clients living in an integrated managed care 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 fee-for-service (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 integrated managed care, see the agency's Changes to Apple Health managed care webpage.

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Existing integrated managed care regions – Expanding January 1, 2019

- **North Central** (Chelan, Douglas, Grant, and Okanogan counties)
  The agency expanded this region to include Okanogan County

- **Southwest Washington** (Clark, Klickitat, and Skamania counties)
  The agency expanded this region to include Klickitat County

New integrated managed care regions – Effective January 1, 2019

The following new regions are implemented for integrated managed care:

- **Greater Columbia** (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman counties)

- **King** (King County)

- **Pierce (**Pierce County)
- **Spokane** (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

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 18th birthday (alumni).

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

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency's Mental health services billing guide, under *How do providers identify the correct payer*?

Provider/Client Responsibilities

Who performs private duty nursing services?

(Refer to WAC 182-551-3200)

Providers qualified to deliver private duty nursing services under the Medically Intensive Children's Program (MICP) must have all of the following:

- An in-home services license with the state of Washington to provide private duty nursing
- A contract with the Developmental Disabilities Administration (DDA) to provide private duty nursing
- A signed core provider agreement with the Health Care Authority (HCA)

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 Medicaid 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
- Discharge planner

See "How do I request PA?"

What are the application requirements?

(Refer to WAC 182-551-3300)

Clients requesting private duty nursing services through fee-for-service must submit a completed and signed Medically Intensive Children's Program (MICP) Application form (DSHS 15-398). The MICP application must include all of the following:

- DSHS 14-012 Consent form
- DSHS 14-151 Request for DDA Eligibility Determination form (for clients not already determined DDA-eligible)
- DSHS 03-387 Notice of Practices for Client Medical Information form
- Appropriate and current medical documentation including a medical plan of treatment or plan of care (WAC 246-335-540) with the client's age, medical history, diagnoses, and the parent or guardian contact information including address and phone number
- A list of current treatments or treatment records
- Information about ventilator, bi-level positive airway pressure (BiPAP), or continuous positive airway pressure (CPAP) hours per day or frequency of use
- History and physical examination from current hospital admission, recent discharge summary, or recent primary physician exam
- A recent interim summary, discharge summary, or clinical summary
- Recent daily nursing notes within the past five to seven days of hospitalization or in-home nursing documentation
- Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities
- An emergency medical plan that includes strategies to address loss of power to the home 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.
- A psycho-social history/summary with all of the following information, as available:
  - ✓ Family arrangement and current situation
  - ✓ Available personal support systems
  - ✓ Presence of other stresses within and upon the family

- Statement that the home care plan is safe for the client and is agreed to by the client's parent or legal guardian.

- Information about other family supports such as Medicaid, school hours, or hours paid by a third-party insurance or trust

- 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

Prior Authorization

Is prior authorization (PA) required?

(Refer to WAC 182-551-3400)

Yes. Providers must receive prior authorization (PA) 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 PA?

(Refer to WAC 182-551-3400)

A provider must coordinate with a DDA case manager and request PA by submitting a complete referral to DDA. This referral must include a complete signed Medically Intensive Children's Program (MICP) application form (DSHS 15-398). See What are the application requirements?

> **Note:** Please see the agency's ProviderOne billing and resource guide for more information on requesting authorization.

Where do I send the completed referral?

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

When does DDA approve requests for private duty nursing services?

(Refer to WAC 182-551-3400)

The Developmental Disabilities Administration (DDA) approves requests for private duty nursing services for eligible clients on a case-by-case basis when both of the following apply:

- The application requirements listed under WAC 182-551-3300 are met.
- 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.

Coverage

What is covered?

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

Upon approval, the Medically Intensive Children's Program (MICP) manager will notify the client's Developmental Disabilities Administration (DDA) case manager of the final determination. The MICP manager will authorize medically necessary 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 MICP manager may authorize additional hours if they are medically necessary. Additional hours beyond 16 per day are subject to review as a limitation extension under WAC 182-501-0169.

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 MICP manager to obtain the authorization number and the number of nursing care hours allowed for each MICP client.

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

It is the nursing agency's responsibility to contact the MICP 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 MICP manager may 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 MICP manager may be the financial responsibility of the client, family, or guardian. Providers must follow the provisions of WAC 182-502-0160 when billing the client.

The nursing notes and plan of care (see WAC 246-335-540) must be kept in the client's file and made available for review by the MICP Manager upon request.

Coverage Table

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

Key to Modifiers:

TD = RN
TE = LPN
TV = Holiday
TK = Second client
TU = Overtime

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.

Where can I find the fee schedule?

See the agency's Private duty nursing fee schedule web page.

Billing

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 all of the following:

- 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
- Record keeping requirements

May RN and LPN service hours be performed in combination?

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

What about multiple clients in the same home?

The Medically Intensive Home Care Program (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.

How do I bill services covering more than one month?

If you receive prior authorization from the MICP 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, providers, and partners 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: **Code Number** — **To Be Used For** 12 — Home