Washington Apple Health (Medicaid)

Private Duty Nursing for Children Billing Guide

October 1, 2024

Disclaimer

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

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2024**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this billing guide is governed by WAC 182-551-3000 through -3400.

The Health Care Authority 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 HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, visit the HCA website.

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* This publication is a billing instruction.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Coverage Table	Added Juneteenth and Native American Heritage Day to the list of paid holidays	To update the list of paid holidays

Table of Contents

Available Resources

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's **Billers, providers, and partners** webpage.
Finding out about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's **Billers, providers, and partners** webpage.
Electronic billing	See HCA's **Billers, providers, and partners** webpage.
Finding HCA documents (e.g., billing instructions, # memos, fee schedules)	See HCA's **Billers, providers, and partners** webpage.
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's **Billers, providers, and partners** webpage.
Who do I call for pharmacy authorization?	See HCA's **Billers, providers, and partners** webpage.
Where do I send backup documentation?	See HCA's **Billers, providers, and partners** webpage.
Who do I call for prior authorization?	Developmental Disabilities Administration (DDA) Nursing Services Unit Manager (253) 448-7079

Definitions

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Refer to **Chapter 182-500 WAC** and **WAC 182-551-3100** 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 HCA 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?

This optional Medicaid program helps to keep families together by providing equally effective, less restrictive, and less costly treatment in a client's home for children who would otherwise require institutional level of care. Private duty nursing services are administered by the Developmental Disabilities Administration (DDA) in the Department of Social and Health Services (DSHS) through the Medically Intensive Children's Program (MICP).

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?

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 HCA-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 emergency care. Providers must follow the policies and procedures of the client's MCO, including prior authorization of services. See HCA'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:

  o 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

  o 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 HCA will not pay for.

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 HCA'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 HCA's **Program Benefit Packages and Scope of Services** webpage.

> **Note**: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:
>
> - **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older, or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
>
> - **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
>
> - **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.

- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services

- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

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 HCA 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.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

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.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

    Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**

    o   Visit the ProviderOne Client Portal website:

    o   Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

    o   Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services

before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

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 receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 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**."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

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 Services Organization (BHSO). For details, see HCA's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care

- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) American Indian/Alaska Native webpage.

Provider/Client Responsibilities

Who performs private duty nursing services?

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 Department of Social and Health Services (DSHS) 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:

- Client/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?

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:

- An application for DDA services to include the following forms which can be found on the DDA website:

  - 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, when applicable, (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?

Yes. Providers must receive prior authorization (PA) from the Developmental Disabilities Administration (DDA) **prior** to providing private duty nursing services to fee-for-service clients.

HCA 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 HCA's ProviderOne billing and resource guide for more information on requesting authorization.

Where do I send the completed referral?

Completed referrals should be sent via secure email to Erika Parada at erika.parada@dshs.wa.gov.

When does DDA approve requests for private duty nursing services?

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?

Upon approval, the Developmental Disabilities Administration (DDA) Nursing Services Unit Manager (NSUM) will notify the client's case manager of the final determination. The DDA NSUM 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 DDA NSUM may authorize additional hours if they are medically necessary. Additional hours beyond the hours allotted in the client's private duty nursing prior authorization are subject to review as a limitation extension under WAC 182-501-0169.

Process for a limitation extension (LE) for additional requested hours, for fee-for-service clients

(A limitation extension (LE) for private duty nursing hours must be approved through DDA prior authorization **before** the services are provided.)

Requests for an LE for additional PDN hours must be sent to the DDA case manager to review and submit as a DDA prior authorization (PA) approval.

The DDA case manager will submit the PA to the DDA NSUM.

When requesting/submitting a PA to the DDA case manager, the following must be included:

- Client name
- Current authorization number
- Reason for the LE, including the medical necessity which would require additional hours beyond what was determined medically necessary for the client by the nursing care consultant
- Month(s) that require additional hours; and,
- Tentative schedule for utilization of additional hours requested.

The client's DDA case manager will notify the client/guardian/authorized representative of the approval or the denial for the LE request for additional hours. Once the specific nursing agency is selected and prior to the initiation of care, that agency must contact the DDA NSUM to obtain the authorization number and the number of nursing care hours authorized for the client.

It is the nursing agency's responsibility to contact the DDA NSUM 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 DDA NSUM 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 DDA NSUM 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 DDA NSUM upon request.

Coverage Table

HCPCS Procedure Code	Appropriate Modifier(s)	Appropriate Modifier(s)	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***

The temporary add-on rate is associated with procedure codes T1002 and T1031 when billed with modifier CR. For dates of service on and after May 11, 2023, providers should discontinue using the CR modifier. This aligns with the end of the public health emergency.

Key to Modifiers:

TD = RN

TE = LPN

TV = Holiday

TK = Second client

TU = Overtime

Note: Procedure code T1000 **requires prior authorization**. HCA 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, Juneteenth, Independence Day, Labor Day, Veterans Day, Thanksgiving Day, Native American Heritage Day, and Christmas Day.

Where can I find the fee schedule?

See HCA's Private duty nursing fee schedule webpage.

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's **ProviderOne Billing and Resource Guide** webpage and scroll down to *Paperless billing at HCA*. For providers approved to bill paper claims, visit the same webpage and scroll down to *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 HCA 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 HCA's **Billers, providers, and partners** webpage, 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)** webpage.

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** – 12 **To Be Used For** - Home