



# Private Duty Nursing for Children Provider Guide

April 1, 2016

Washington State  
Health Care Authority

## About this guide\*

This publication takes effect April 1, 2016, and supersedes earlier guides to this program.

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
<a href="#">Important Changes to Apple Health Effective April 1, 2016</a>	<b>Effective April 1, 2016</b> , important changes are taking place that <b>all providers</b> need to know. Information has been added regarding a new policy for early enrollment into managed care, the implementation of fully integrated managed care in the SW WA region, Apple Health Core Connections for foster children, Behavioral Health Organizations (formerly RSNs), and contact information for Southwest Washington.	Program changes

## How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

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\* This publication is a billing instruction.

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# Important Changes to Apple Health Effective April 1, 2016

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**These changes are important to all providers  
because they may affect who will pay for services.**

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available [online](#).

## **New MCO enrollment policy – earlier enrollment**

**Beginning April 1, 2016**, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

## How does this policy affect providers?

- 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 new policies.

## Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Provider](#) guide. BHOs use the [Access to Care Standards \(ACS\)](#) for mental health conditions and [American Society of Addiction Medicine \(ASAM\)](#) criteria for SUD conditions to determine client's appropriateness for this level of care.

## Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A [BHSO fact sheet](#) is available online.

## Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18<sup>th</sup> birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

## AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.


## Contact Information for Southwest Washington

**Beginning on April 1, 2016**, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can be located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

 <b>MOLINA</b> HEALTHCARE	<a href="#">Molina Healthcare of Washington, Inc.</a> 1-800-869-7165
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 <b>COMMUNITY HEALTH PLAN</b> of Washington	<a href="#">Community Health Plan of Washington</a> 1-866-418-1009
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<b>Beacon Health Options</b>	<a href="#">Beacon Health Options</a> 1-855-228-6502
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# Important Contacts

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**Note:** This section contains important contact information relevant to private duty nursing for children. For more contact information, see the Agency [Resources Available](#) web page

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency <a href="#">Resources Available</a> web page
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Who do I call for pharmacy authorization?	
Where do I send backup documentation?	
Who do I call for prior authorization?	



# Definitions & Abbreviations

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This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the [Medical Assistance Glossary](#) for a more complete list of definitions.

**Division of Developmental Disabilities –**

The organization within the Department of Social and Health Services that supports individuals enrolled in DDD per [RCW 71A.10.020](#) (3) and (4).

**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 DDD 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 Division of Developmental Disabilities (DDD) 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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## How can I verify a patient's eligibility?

[Refer to WAC 182-551-3000(2)]

To be eligible for private duty nursing services, a patient must meet all of the following:

- Be 17 years of age or younger  
[For patients over 18 years of age or older who require private duty nursing, contact the Aging and Disabilities Services Administration at (360) 493-4512.]
- Need continuous skilled nursing care that can be provided safely outside an institution
- Have prior authorization from the agency

In addition to the above, providers must verify that a patient has Washington 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.

Verifying eligibility is a two-step process:

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

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

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

**Note:** Patients who are not Washington 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 a Agency Managed Care Plan 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 the Agency's managed care plans. When verifying eligibility using ProviderOne, if the client is enrolled in a Agency managed care plan, 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 managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan 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 [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 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.

# Provider/Client Responsibilities

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## Who Must Perform the Private Duty Nursing Services?

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

The 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?” in Section D.

# 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 Division of Developmental Disabilities (DDD) **prior** to providing private duty nursing services to clients. The 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 DDD case manager and request PA by submitting a complete referral to DDD. 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 <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  
Division of Developmental Disabilities  
PO Box 45310  
Olympia WA 98504-5310

## When Does the Agency Approve Requests for Private Duty Nursing Services?

[Refer to WAC 182-511-3000(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 Division of Developmental Disabilities (DDD) 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 DDD 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) 725-3451**

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 **Private Duty Nursing** [Fee Schedule](#)

# Billing and Claim Forms

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## What Are the General Billing Requirements?

Providers must follow the Agency [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 MICHCP 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 CMS-1500 claim form for each client receiving private duty nursing services.

## Services Covering More Than One Month

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

## Completing the CMS-1500 Claim Form

**Note:** Refer to the [Agency Provider One Billing and Resource Guide](#) for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to private duty nursing services:

Field No.	Name	Entry				
24B.	Place of Service	<p>These are the only appropriate codes for this program:</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;"><b>Code Number</b></td> <td style="text-align: center;"><b>To Be Used For</b></td> </tr> <tr> <td style="text-align: center;">12</td> <td style="text-align: center;">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					