Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	MEDICALLY INTENSIVE CHILDREN'S PROGRAM	4.04

Authority:

RCW 74.09.520	*Medical Assistance–Care and Services Included–Funding Limitations*
Chapter 182-537 WAC	*School-Based Health Care Services*
WAC 182-501-0169	*Health Care Coverage–Limitation Extension*
WAC 182-513-1210	*Community first choice (CFC)–Overview*
Chapter 388-823 WAC	*DDA Intake and Eligibility Determination*
WAC 388-106-1000 through 388-106-1055	*What services may I receive under private-duty Nursing?*
WAC 182-551-3000 through 182-551-3400	*Private-Duty Nursing for Clients Age Seventeen and Younger*
WAC 246-840-910 through 246-840-970	*Nurse Delegation*

Reference:

DDA Policy 6.15, *Nurse Delegation Services*
Medicaid Billing Guide, *Private-Duty Nursing for Children*
ALTSA LTC Manual, Chapter 25, *Private-Duty Nursing- Aging*
Chapter 3 of the ALTSA Long-Term Care Manual.)

BACKGROUND

The Medically Intensive Children's Program (MICP) provides private-duty nursing services to children aged 17 years or younger, either through fee-for-service or an agency-contracted managed care organization (MCO). MICP is a Title XIX (Medicaid) program that supports children whose complex medical needs cannot be managed within the scope of intermittent home health services.

PURPOSE

This policy establishes procedures for the fee-for-service portion of the MICP, which is provided by DDA staff.

SCOPE

This policy applies to DDA staff and DSHS-contracted providers of private-duty nursing with an in-home service license.

DEFINITIONS

Apple Health is the name for Washington State Medicaid.

Case resource manager or **CRM** means a DDA employee who provides an advanced level of social service, specialized case, or resource management for DDA clients and their families.

Child means a person under age 18 years.

Client means a person who has a developmental disability as defined in RCW 71A.10.020 and has been determined DDA-eligible under Chapter 388-823 WAC.

Community First Choice or **CFC** means the Washington Apple Health state plan benefit authorized under Section 1915K of the Social Security Act. CFC enables the agency and contracted entities to deliver person-centered home and community-based long-term services to Medicaid-enrolled people.

Comprehensive Assessment Reporting Evaluation or **CARE** is the tool used by case resource managers to evaluate strengths and limitations via an in-person interview.

Contracted provider or DSHS-contracted provider is an individual or home health agency contacted with the Department to provide medically intensive services.

Department means the Department of Social and Health Services (DSHS).

Discharge plan means the pre-transition and sustainability activities required to facilitate a client's safe transition from the hospital to a private residence or residential setting with private-duty nursing.

Exception to rule (ETR) means the process in which the Department of Social and Health Services can grant exceptions to program rules.

Group care facility means an agency, other than a foster-family home, which is maintained and operated for the care of a group of children on a 24-hour basis.

Health Care Authority or **HCA** means the state agency that provides Apple Health (Medicaid) coverage for Washington residents.

Legal representative means a parent of a client if the client is under age eighteen, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Limitation extension or **LE** means the request for additional skilled nursing hours, beyond those assessed or recommended by the DDA NCC, when medically necessary.

Managed care organization or **MCO** means an organization that contracts with the Health Care Authority to provide prepaid health care services to enrollees.

Medicaid Fee-For-Service or **FFS** means state payment directly for covered services received by a Medicaid beneficiary, when a client is not assigned to a Managed Care Organization for health care coverage.

Medically Intensive Children's Program or **MICP** means a home-based program for clients age 17 years and under who require complex, long-term care for a condition of such severity and complexity that continuous skilled nursing care is required. Also referred to as Private-Duty Nursing for children.

Nursing care consultant or **NCC** means a registered nurse employed by DDA.

Nurse delegation, under RCW 18.79.260, allows long-term care workers or nursing assistants working in certain settings to perform tasks normally performed by licensed nurses.

Nursing Services Unit Manager or **NSUM** means the DDA headquarters manager who supervises the NCCs and oversees nursing services provided by DDA.

Planned action notice or **PAN** means a notice of a decision by DDA, such as approval, denial, reduction, or termination of a service.

Private-duty nursing or **PDN** means skilled nursing care provided in the home for a client with complex medical needs that cannot be managed through intermittent home health services.

Records Management Tool (RMT) means a system embedded in CARE to download and store electronic client records.

Service episode record or **SER** is a screen in CARE where DDA staff document contacts and activities during the client's assessment, service planning, coordination and monitoring of care, and termination of services.

Skilled nursing services means the management and administration of skilled nursing care requiring the specialized judgement, knowledge, and skills of a registered nurse or licensed practical nurse.

Third-party liability or **TPL** means the legal responsibility of an identified third party or parties to pay all or part of the cost of health care (i.e., private insurance).

POLICY

A. MICP Eligibility. A child may be eligible for the DDA's Medically Intensive Children's Program (MICP) if the child meets criteria under WAC 182-551-3100.

B. DDA Eligibility

1. If not already DDA eligible, the child's legal representative or designee must submit:

   a. DSHS 14-151, *Request for DDA Eligibility Determination*;

   b. DSHS 14-012, *Consent*;

   c. DSHS 03-387, *DSHS Notice of Privacy Practices for Client Medical Information*; and

   d. Documentation to support the child's developmental disability as described in DSHS 14-459, *Eligible Conditions with Age and Type of Evidence*.

2. To determine eligibility, DDA will review the application and supporting documentation in accordance with DDA Policy 11.01, *Intake and Eligibility Determination*.

3. If the child is determined DDA eligible and the legal representative requests an MICP assessment, the CRM or supervisor must alert the NSUM.

4. The CRM must schedule a DDA assessment with the child's legal representative and include the NCC, if available.

   Note: If a client was determined DDA-eligible solely for Fee-for-Service (FFS) MICP, DDA reviews the client's DDA eligibility when the client is no longer eligible for MICP.

PROCEDURES

A. MICP Application

1. For a client requesting private-duty nursing through the Developmental Disabilities Administrations MICP FFS program, the client's legal representative must:

   a. Complete, sign, and send DSHS 15-398, *Medically Intensive Children's Program Application*, and accompanying medical records to micp@dshs.wa.gov;

   b. If the client has third-party liability insurance, submit a denial letter from the TPL stating private-duty nursing will not be covered; and

   c. If the client is enrolled in an MCO, request an MICP assessment through their assigned MCO.

2. A decision on eligibility for the MICP program will not be made until a completed application is received and an NCC has assessed the client's skilled nursing needs. The MICP application is complete when all the required information is included on the MICP application form, including the signature of the client's legal representative.

3. The Nursing Services Unit Manager (NSUM) must contact the client's legal representative or hospital within five business days if an incomplete application is received.

4. Once the completed application is received, the NSUM must:

   a. Verify the client is enrolled in Medicaid fee-for-service;

   b. If the client has an MCO, encourage the client's legal representative to request an assessment through the MCO;

   c. Verify all clinical documentation has been received, including a denial letter from the TPL insurer, if applicable;

   d. Create a client folder on the Nursing Services SharePoint and save the MICP application and supporting documentation;

   e. Input client information into the MICP client database, located on the Nursing Services SharePoint; and

f. Forward all documentation to the CRM and assigned NCC.

5. The NCC must complete the MICP Assessment within 30 calendar days of receiving a completed application, supporting documentation, and DDA eligibility. The NCC may request additional documentation to determine clinical eligibility for the client.

6. The NSUM, NCC, and case resource manager (CRM) must document in the service episode record (SER) the coordination of services between DDA, the hospital, medical providers, insurers, and nursing agencies.

B. MICP Assessment

1. No more than five business days after the client's DDA assessment is completed, the NCC must work with the client's DDA CRM to send a referral to a contracted nurse delegator.

a. If the nurse delegation assessment states all skilled nursing tasks are delegable, the NCC must not continue with the MICP assessment, and the CRM must complete a denial planned action notice (PAN) stating the client is not eligible for MICP based on WAC 182-551-3100.

b. If the nurse delegation assessment states delegation is not appropriate, the NCC must continue with the MICP assessment process.

2. The NCC must review the medical documentation received and schedule the MICP assessment with the client, the client's legal representative, and the client's CRM if available.

Note: The MICP assessment may be conducted in a setting chosen by the client or the client's legal representative. An in-person visit must be completed before assessment finalization.

3. The NCC must use DSHS 10-339, *NCC Assessment*, when conducting the MICP assessment and determine MICP medically eligibility under WAC 182-551-3100.

4. The NCC must indicate which tasks are delegable and record details pertaining to the client's skilled nursing needs on the NCC assessment.

5. After conducting the MICP assessment, the NCC must determine the total number of non-delegable and continuous skilled nursing hours required per day. If the client requires four or more continuous hours of skilled nursing per day, the NCC will recommend the number of daily hours, which must not exceed 16 hours per day.

6. The NCC must review the recommendation with the client, the client's legal representative and the CRM.

7. The NCC must:

   a. Review with the client and the client's legal representative DSHS 11-148, *Medically Intensive Children's Program: What do I need to know now that my child has been approved?* and obtain a signature; and

   b. Scan the signed MICP letter into the records management tool (RMT).

8. The NCC must document comments regarding nursing tasks in the client's DDA assessment. The NCC does not score DDA assessment questions.

9. The NCC must enter a SER note with their recommendation and scan a copy of the NCC assessment form into the RMT.

10. After the MICP assessment and recommendation have been made, the NCC must:

    a. Provide the client and legal representative a copy of the DSHS PDN provider list, which can be found on the Nursing Services SharePoint, under Medically Intensive Children's Program Provider List; and

    b. Work with the client and family to identify a contracted home health agency to provide services.

11. The CRM must send the client's legal representative a PAN outlining MICP eligibility under WAC 182-551-3100 and the recommended hours per day.

12. Once a contracted home health agency is available, the NCC must alert the CRM and NSUM.

13. The NSUM must enter the MICP authorization in ProviderOne, enter a SER, and document in CARE under the MICP screen.

C. MICP Annual and Six-Month Assessment

1. The NCC must complete an MICP assessment every six months. The NCC must complete the MICP assessment with the CRM, when available, in a setting of the client's choice. An in-person visit to the client's home must be completed at least annually.

2. The NCC must discuss transition planning with the client and client legal representative at each MICP assessment. Transition planning may include:

   a. Reduction to MICP skilled nursing hours;
   b. CFC;
   c. Nurse delegation;
   d. Waiver skilled nursing; or
   e. Respite.

3. If the client's skilled nursing care needs change, the MICP hours may be adjusted. If a change in MICP hours occurs:

   a. The NCC must discuss the change with the client, the client's legal representative, the CRM, and the NSUM.

   b. The CRM must send a PAN to the client and the legal representative explaining the change in eligibility.

   c. The NSUM must update the MICP authorization in ProviderOne, enter a SER, and document in CARE under the MICP screen.

D. Care Consultation

1. If the client is hospitalized and awaiting discharge, the NCC must:

   a. Coordinate with the CRM, hospital, the client's legal representative, and contracted home health agency to determine availability of nursing and document response in a SER.

   b. If no nursing availability, the NCC must meet with the CRM, the client, the client's legal representative, and hospital staff no more than five business days after determining no nursing is available.

   c. During the meeting, the CRM and NCC must discuss barriers to discharge and review alternatives, such as:

      i. CFC;
      ii. Nurse delegation; and
      iii. Single-case agreement.

2. Before the client is discharged, the NCC must work with the client's care team to review:

   a. Staffing;
   b. Access to medical providers; and
   c. Access to medical equipment.

E. MICP Authorization

1. The NSUM must review the PAN before authorizing MICP skilled nursing hours in ProviderOne.

2. The NSUM must authorize the number of skilled nursing hours based on the NCC's clinical recommendation (up to 16 hours per day) and as verified in the PAN.

3. If the client's legal representative disagrees with the NCC recommendation, they may appeal according to WAC 388-825-120 or the administrative hearing rights listed in the PAN.

4. For a client receiving in-home MICP skilled nursing, the NSUM must:

   a. Enter the NCC recommended authorization in ProviderOne for six months; and

   b. Authorize services using MICP Code T1000.

5. For a client receiving MICP skilled nursing in a group care facility for medically fragile children, the NSUM must:

   a. Enter the NCC recommended authorization in ProviderOne for six months; and

   b. Authorize services using HCPCS Code T1030 for a daily rate and T1000 for a per diem rate.

6. After entering the authorization in ProviderOne, the NSUM must:

   a. Using secure email, contact the contracted home health agency or group care facility for medically fragile children providing care, the CRM, and the NCC confirmation of the authorization;

   b. Update MICP client file in SharePoint;

c. Update CARE MICP screen with authorization information; and

d. Document authorization in an SER.

F. MICP Rates

MICP rates are set prospectively in accordance with state legislative appropriation. Rates are posted in the private-duty nursing fee schedule on the Health Care Authority's website.

G. Third-Party Liability (TPL)

For a client with TPL coverage, the benefit must be utilized as first payor. Medicaid may act as a payor of last resort for private-duty nursing when an NCC determines the daily skilled nursing is greater than the TPL coverage.

Example: The client has been assessed by the NCC as requiring 16 hours of MICP skilled nursing per day. The TPL authorizes 10 hours per day. Fee-for-service may cover the additional 6 hours per day, to total 16 hours of MICP skilled nursing per day.

H. MICP Exception to Rule (ETR)

1. If the client's legal representative requests an ETR, the CRM must complete an ETR in CARE. (See Chapter 3 of the ALTSA Long-Term Care Manual.)

2. Before submitting the ETR, the CRM must staff the case with their supervisor and regional NCC, to consider any other formal or informal supports available.

3. The DDA ETR Coordinator must review the MICP ETR with the NSUM before finalization.

I. Limitation Extension (LE) – Additional MICP skilled nursing hours for clients under age 18 years.

1. If a client's legal representative requests additional MICP hours, the CRM must submit a request for prior approval. The request must include:

a. The client's name;
b. Current authorization number;
c. The reason the additional hours are medically necessary;
d. Month(s) requiring additional hours; and
e. Tentative schedule for utilization of hours requested.

2. The DDA CRM must submit the prior approval request to the DDA NSUM.

3. The DDA NSUM must:

   a. Review the request with members of DDA's Nursing Services Unit and the Health Care Authority's MICP Program Manager; and

   b. Document the decision in the DDA prior approval and notify the DDA CRM.

4. The DDA CRM must notify the client's legal representative of the decision and complete a PAN.

5. The NSUM must update the MICP authorization to reflect the prior approval decision.

6. It is the client's legal representative's responsibility to monitor utilization of hours. In accordance with WAC 182-551-3400, the nursing agency will not be reimbursed for overutilization of approved hours.

J. Single-Case Agreements (SCA)

1. If unable to find nursing due to an extraordinary circumstance or skilled nursing care needs, the contracted home health agency may request an SCA through the NCC, CRM, or NSUM. Only the Health Care Authority can approve an SCA.

2. After receiving a request for an SCA from a home health agency:

   a. The NCC must review the request and forward to the NSUM after verifying support of the request.

   b. The NSUM must review the request and forward the HCA MICP Program Manager after verifying support of the request.

   c. The HCA MICP Program Manager makes the final determination.

3. If the HCA MICP Program Manager approves the request, HCA will coordinate with HCA contracts department and the home health agency for contracting and authorization of the SCA.

K. School Nursing

1. The MICP may cover skilled nursing services for a client who attends a private school.

2. The MICP does not cover skilled nursing services provided to a client who attends public school. The following applies only to clients attending public schools:

   a. Public school hours are considered out-of-home nursing and does not affect their hours in-home;

   b. The school district must provide skilled nursing services as determined by the client's individualized education plan (IEP) under Chapter 182-537 WAC; and

   c. Nursing agency staff who provide in-home and in-school nursing hours to the client must communicate with school staff regarding any changes in the client's health condition to maintain the continuity of care.

L. MICP Client Turning 18

At least six months before an MICP client's 18th birthday, the NCC must meet with the client and the client's legal representative to discuss care options. If the client would like to continue receiving private-duty nursing through DDA, the NCC must discuss and provide them with the PDN rules and proceed with the PDN eligibility process. The NCC must follow direction outlined in the ALTSA Long-Term Care Manual, Chapter 25, and WAC 388-106-1010 for eligibility.

M. A client age 18 or older may receive PDN services in their home or a DSHS-contracted PDN Adult Family Home. PDN Adult Family Homes may be found using the AFH Locator.

1. If the client is no longer DDA-eligible or not eligible for PDN, the NCC must:

   a. Consult with the CRM to review current DDA assessment to determine other services available to the client (e.g., Home and Community Services, Skilled Nursing, or Nurse Delegation Services) and meet with CRM and the client to discuss these options.
   b. Discuss assessment results with contracted home health agencies actively providing services.

2. The CRM must:

   a. At least 60 days before the client's 18th birthday, assist the client and the client's legal representative to make a referral to the ALTSA Home and Community Services Division intake office for application for services.

   b. At least 10 days before the client's 18th birthday, send the DDA/MICP termination PAN.

   c. Prepare a case closure in CARE, including a case summary and the most recent NCC review.

3. The NSUM must:

   a. Ensure the authorization for MICP services are discontinued in ProviderOne on the client's 18th birthday.

   b. End-date MICP on the MICP screen in CARE.

N. Nursing Related Triggered Referrals

1. If an MICP client triggers in CARE for a nursing-related triggered referral, the CRM may send a referral and request an assessment by the home health agency or group care facility for medically fragile children. The nurse working with the client, with the home health agency or group care facility may complete the assessment.

2. Triggers for nursing-related referrals include:

   a. Unstable or potentially unstable diagnosis;
   b. Nutritional status affecting plan;
   c. Medication regimen affecting plan;
   d. Current or potential skin problems;
   e. Immobility issues affecting plan; and
   f. Skin observation protocol (SOP).

3. Nursing-related triggered referrals must be made according to the timelines below.

   a. No more than two business days after the referral triggers in CARE, the CRM may refer using DSHS 13-911, *DDA Nursing Service Referral*. No authorization is needed, as the assessment can take place under MICP.

b. No more than two business days after receiving the referral, the home health agency or group care facility for medically fragile children must confirm receipt of the referral.

c. No more than 10 business days after receiving the referral, the nurse must assess the client. If the nurse is unable to assess within the timeframe, they must document the barriers to assessing and inform the CRM. The CRM may staff with their supervisor and NCC as needed.

d. No more than 15 business days after the nurse has assessed the client, the nurse must send their completed assessment note to the CRM. The CRM must document the outcome of the assessment in a SER.

e. For Skin Observation Protocol referral timelines, see DDA Policy 9.13, *Skin Observation Protocol*.

O. Case Manager Responsibilities

1. Review MICP application to determine which services are being requested.

2. Inform the client, the client's legal representative, nursing agency, or group care facility for medically fragile children they are the client's CRM.

3. Conduct annual assessment with the NCC, when available.

4. Complete the DDA assessment (annual, interim, or significant change) for the client.

5. Advise the client and their legal representative to notify the CRM if there is no nursing or limited access to nursing.

6. Notify the NCC if Medicaid coverage is discontinued or terminated.

P. NCC Responsibilities

1. Review MICP application to determine which services are being requested.

2. Contact the referral source if additional information is needed.

3. Assess the client's medical eligibility under WAC 182-551-3100 and determine the number of continuous skilled nursing hours needed.

4. Document relevant information in the CARE comment fields.

5. Document clinical eligibility determination, recommended hours, and provider in a SER.

6. Save completed NCC assessment in the RMT.

7. Inform the client, client's legal representative, CRM, and NSUM of determination.

8. Coordinate with the client, client's legal representative, CRM, hospitals, nursing agencies, and medical provider to determine nursing availability. Document interactions in an SER.

9. Discuss transition planning with the client, client's legal representative, and CRM as needs change.

Q. MICP Provider Qualifications

1. To become an MICP provider, an entity must be:

   a. A home health agency; or
   b. A group care facility for medically fragile children.

2. To be a home health agency, an entity must:

   a. Hold an in-home services license through the Washington state Department of Health;

   b. Be contracted with the Aging and Long-Term Support Administration, to provide private-duty nursing; and

   c. Have a core provider agreement with the Health Care Authority.

3. To be a group care facility for medically fragile children, an entity must:

   a. Hold an in-home services license through the Washington state Department of Health;

   b. Be contracted with the Department of Children, Youth, and Families as a group care facility for medically fragile children;

c. Be contracted with the Aging and Long-Term Support Administration to provide private-duty nursing.

d. Be contracted with DDA to provide MICP fee-for-service.

e. Have a core provider agreement with the Health Care Authority.

EXCEPTION

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary or designee.

SUPERSESSION

DDA Policy 4.04, *Medically Intensive Children's Program*
Issued December 15, 2018

Approved: _____ Date: February 1, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration