



PUBLIC HEALTH

**ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON**

CSHCN PROGRAM MANUAL

Section 6000

Authorization & Payment

September 10, 2014

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Webinar Etiquette



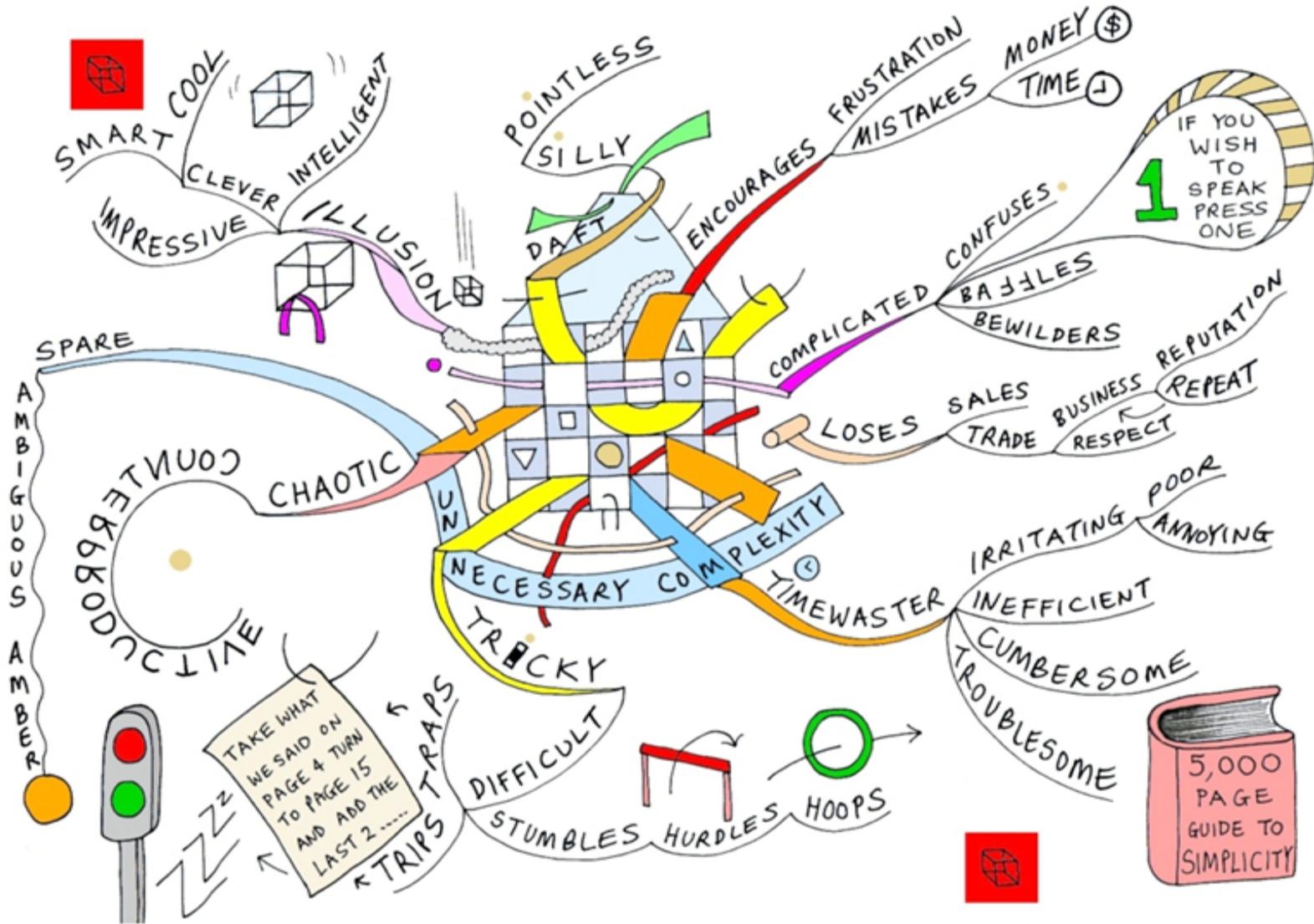
- Please use **question box** to **type** in your question – we will do our best to answer questions during the webinar and will follow-up with the attendees if time does not allow.
- **Hands raised application** – if you have a question that you want to ask verbally, feel free to use the Hand Raising feature. We will unmute you to ask your question.
- Please **DO NOT** place your phone on hold.

History & Background

- **Past use of DX/TX funds** - examples
 - Hearing aid batteries
 - Pediasure®
 - Additional diapers/pull-ups
- **Improvements with Medicaid FFS & MCOs**
 - Expanded coverage
 - Alternative paths for coverage such as
Limitation Extensions and Exception to Rule
 - Plan flexibility

Today's Goals

- Become familiar with Section 6000 and revisions
- Understand the purpose of DX/TX funds
- Understand how to access DX/TX funds



Expectations

- Read Manual
- Be familiar with the processes presented today
- Be thoughtful in how to complete requests and how the service meets medical necessity criteria

What is **not** expected

- To be Medicaid experts either for eligibility or for benefit coverage
- To be billing coding experts

What's New?

...



New Information

- What's covered by Medicaid that CSHCN paid for in the past?
- What's new that could be covered by CSHCN?

Examples of Current DX/TX Use

- Extension of breast pumps (temp)
- Rental of baby scales
- Family / child training
 - Sign language DVD
- Components of interdisciplinary teams
- Diagnosis specific camps
- Recreational programs

Navigating Section 6000

- The Table of Contents has hyperlinks that will take you to any particular section
- Footer has hyperlinks to take you back to Table of Contents
- Section 6113, Page 6 has a hyperlink to Federal Poverty Level Guidelines in Section 5332

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Section 6000 - Authorization and Payment

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Decision Tools for Use of DX/TX Funds

- Decision Process
- Determining financial eligibility
- Determination of Medical Necessity
- Troubleshooting

Overview: Decision Process

6111 Decision Process for Use of DX/TX Funds

Decision Process	True?	
	Yes	No
1. The Child		
a) The child has special health care needs.	Yes	No
b) The client is 17 years of age or younger.	Yes	No
c) The client and family are Washington residents.	Yes	No
d) The client's family is financially eligible for DX/TX services.	Yes	No
2. The Child's Medical Service		
a) The service is beyond the scope of routine care common to most children.	Yes	No
b) The service is medically necessary and appropriate for the child.	Yes	No
c) The service is evidence-based, an accepted form of treatment for the condition, and recognized by the medical community.	Yes	No
d) The service is not covered by any other public or private funding source available to child. (For questions about service coverage, see Section 6112.)	Yes	No
e) The service is not the responsibility or component of any other public or private funding source available to child.	Yes	No
3. The Local CSHCN Agency Diagnostic and Treatment Fund Allocation		
a) This payment will be within the limits of the unspent allocation balance available to the local health agency (your agency).	Yes	No
4. The Provider of Service		
a) The provider is qualified to accept payment.	Yes	No
b) The provider agrees to accept CSHCN payment process and fees.	Yes	No
If ALL statements (1-4) above are true, DX/TX funds may be used to cover the service. Use of DX/TX funds are governed by federal and state regulations. DX/TX funds are not entitlement funds and take into consideration a number of variables. Therefore, individual local CSHCN agency or DOH may decide not to use the funds based on other considerations.		

Using the Decision Tools

- To determine financial eligibility
- To determine medical necessity

Financial Eligibility



Does the client have a ProviderOne card?

Yes – Check in ProviderOne

No – Call 800-562-3022



there is a prompt, using the client's social security.

Or

You can quickly calculate this...

<http://wahbexchange.org/news-resources/calculate-your-costs>

Financial Eligibility

- Martha is a single mom with 4 children, one of her children has special health care needs.
- She works
- Her estimated annual income is \$.....



Quick Proxy calculator:

<http://wahbexchange.org/news-resources/calculate-your-costs>

Medical Necessity



"Your medical coverage does not consider that a medical necessity."

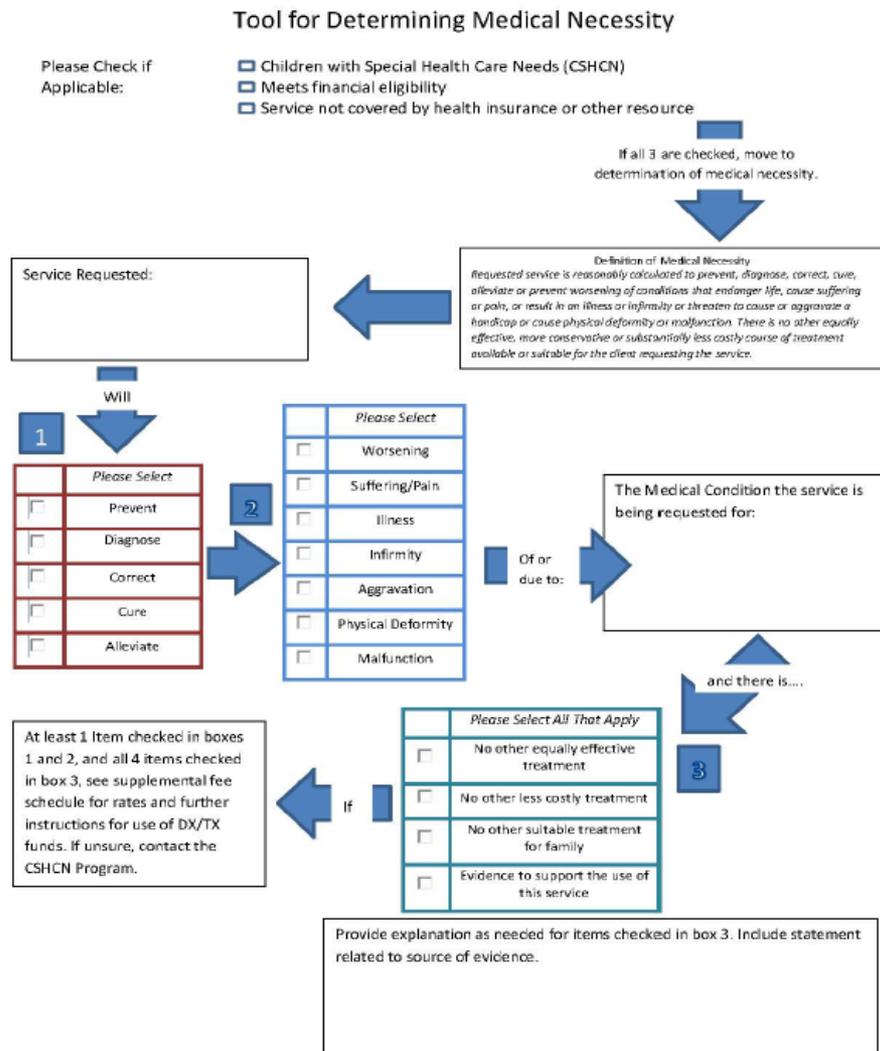
Definition of Medical Necessity

“Medically necessary is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, “course of treatment may include mere observation or, where appropriate, no treatment at all.”

Health Care Authority – Medicaid Program (WAC 182-500-0070)

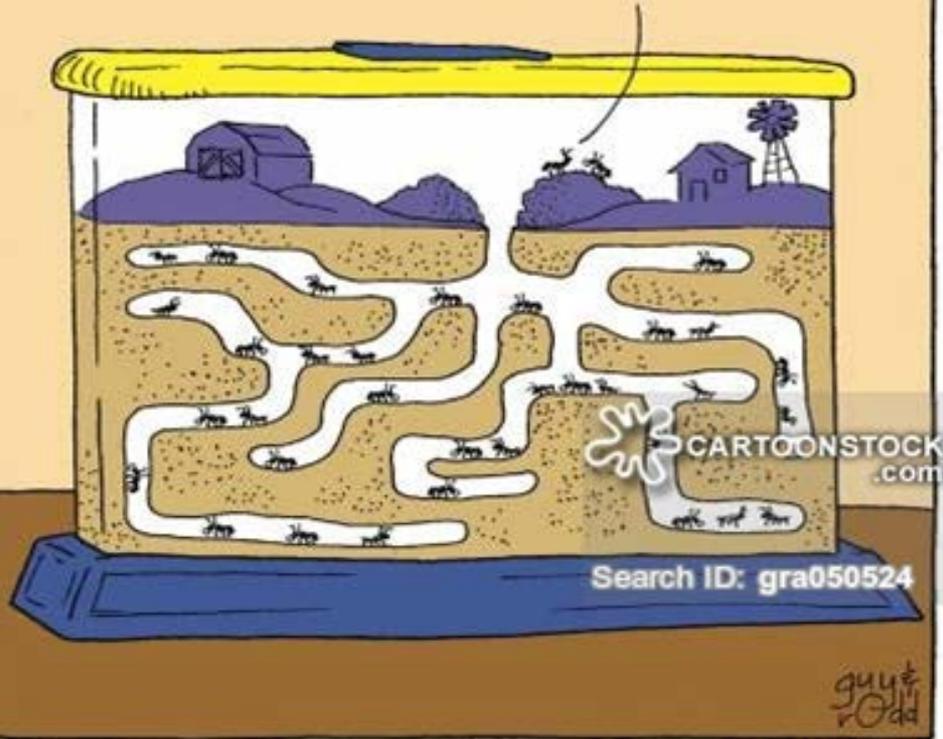
Medical Necessity

Figure 1: Tool for Determining Medical Necessity



© Guy & Rodd/Distributed by Universal Uclick via CartoonStock.com

"HEY, DO WE EVEN NEED THESE TUNNELS?
WHAT IF WE'RE JUST DOING THIS
TO AMUSE THESE PEOPLE?"



Medical Necessity

- Luke is 13 years old and newly diagnosed with diabetes.
- Request for funds to send him to a summer camp to facilitate self management.

Tool for Determining Medical Necessity

Please Check if Applicable:

- Children with Special Health Care Needs (CSHCN)
- Meets financial eligibility
- Service not covered by health insurance or other resource

If all 3 are checked, move to determination of medical necessity.

Definition of Medical Necessity

Requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions that endanger life, cause suffering or pain, or result in an illness or infirmity or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

Service Requested:
Diabetes Camp

1 Will

Please Select	
<input checked="" type="checkbox"/>	Prevent
<input type="checkbox"/>	Diagnose
<input type="checkbox"/>	Correct
<input type="checkbox"/>	Cure
<input checked="" type="checkbox"/>	Alleviate

2

Please Select	
<input checked="" type="checkbox"/>	Worsening
<input type="checkbox"/>	Suffering/Pain
<input type="checkbox"/>	Illness
<input checked="" type="checkbox"/>	Infirmity
<input type="checkbox"/>	Aggravation
<input type="checkbox"/>	Physical Deformity
<input type="checkbox"/>	Malfunction

Of or due to:

The Medical Condition the service is being requested for:
Diabetes

and there is...

At least 1 Item checked in boxes 1 and 2, and all 4 items checked in box 3, see supplemental fee schedule for rates and further instructions for use of DX/TX funds. If unsure, contact the CSHCN Program.

3

Please Select All That Apply	
<input checked="" type="checkbox"/>	No other equally effective treatment
<input checked="" type="checkbox"/>	No other less costly treatment
<input checked="" type="checkbox"/>	No other suitable treatment for family
<input checked="" type="checkbox"/>	Evidence to support the use of this service

Provide explanation as needed for items checked in box 3. Include statement related to source of evidence.

Adolescent who needs to learn self management to transition to adult care. Evidence supports self management and peer influence

Medical Necessity

- 5 year old boy diagnosed with Autism and Failure to Thrive.
- Will only eat applesauce, white bread, milk, and a specific brand of crackers.
- Mom requests coverage for this brand of cracker because she can combine the crackers with other higher nutrient dense foods and he is more likely to accept them.

Tool for Determining Medical Necessity

Please Check if Applicable:

- Children with Special Health Care Needs (CSHCN)
- Meets financial eligibility
- Service not covered by health insurance or other resource

If all 3 are checked, move to determination of medical necessity.

Definition of Medical Necessity

Requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions that endanger life, cause suffering or pain, or result in an illness or infirmity or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

Service Requested:
Special brand of crackers

1 Will

<input type="checkbox"/>	Please Select
<input type="checkbox"/>	Prevent
<input type="checkbox"/>	Diagnose
<input type="checkbox"/>	Correct
<input checked="" type="checkbox"/>	Cure
<input type="checkbox"/>	Alleviate

Please Select

<input type="checkbox"/>	Worsening
<input type="checkbox"/>	Suffering/Pain
<input type="checkbox"/>	Illness
<input checked="" type="checkbox"/>	Infirmity
<input type="checkbox"/>	Aggravation
<input type="checkbox"/>	Physical Deformity
<input type="checkbox"/>	Malfunction

The Medical Condition the service is being requested for:
Failure to thrive

Of or due to:

At least 1 Item checked in boxes 1 and 2, and all 4 items checked in box 3, see supplemental fee schedule for rates and further instructions for use of DX/TX funds. If unsure, contact the CSHCN Program.

and there is....

3

<input type="checkbox"/>	Please Select All That Apply
<input type="checkbox"/>	No other equally effective treatment
<input type="checkbox"/>	No other less costly treatment
<input type="checkbox"/>	No other suitable treatment for family
<input type="checkbox"/>	Evidence to support the use of this service

Provide explanation as needed for items checked in box 3. Include statement related to source of evidence.



Other treatment options are available – not evidence based.

Troubleshooting

6114 Accessing and Troubleshooting Coverage for Medical Services

DX/TX funds are intended for medically necessary services and treatments not covered by an individual's health care plan. The following list of questions will help in determining if a service is covered by an individual's health care plan.

Identifying and Accessing Coverage for Medical Services:

- What health care plan does the family have?
- What service is being requested?
- Is the requested service covered?
 - If not covered by the plan, is it covered directly by Medicaid (i.e., interpreter services, transportation, glasses, hearing aids, etc.)?
- Does the service meet medical necessity criteria?
- What are the required conditions for this service to be covered?
- Does the client meet these conditions?
- Does the service require prior authorization? Was prior authorization obtained?
- Was there an exception to rule filed with the insurance company or Medicaid (add WAC) for a non-covered service?
- Does the client have a primary and secondary insurance?

It may be necessary to do some troubleshooting when a service is denied. The following questions may help determine the reason for denial and/or find alternate means of accessing coverage. This information will also be needed when completing an HSA form (see Section 6500).

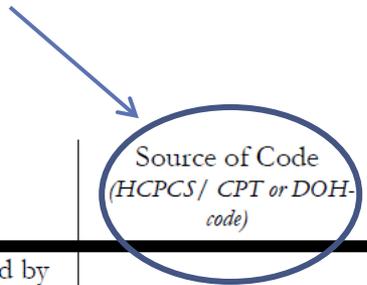
Troubleshooting denial of service coverage:

- Was the service appropriately billed for by the vendor/provider but denied?
- If the service was denied, what is the reason for denial?
 - Billing error
 - Medical necessity questioned
 - Covered service questions
 - Question related to eligible condition
 - Other
- What does it say on provider HCA billing or billing statement?
- What does it say on denial letter?
- Can you work with the plan to support medical justification?
- Can services be coordinated with other payment sources?
- What is the appeal process?
- Has an appeal been filed?
- Will another service or product work just as well?

Fee Schedules

- HCA Medicaid Fee Schedule
- CSHCN Supplemental Fee Schedule

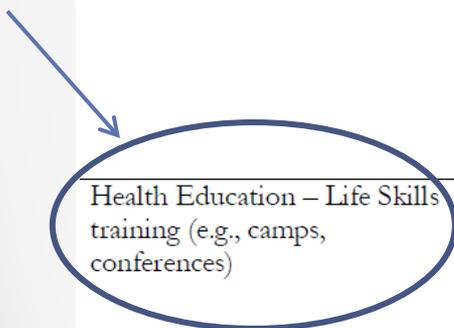
Supplemental Fee Schedule



<i>Description</i>	Source of Code (HCPCS/ CPT or DOH- code)	<i>CSHCN Fee</i>	<i>Comments</i>
Clinics and teams sponsored by CSHCN:			
▪ Physician	HCA	\$100/hr maximum per MD for team meeting time	Interdisciplinary Evaluations and Services. See Section 6330 for clinic policies.
▪ Non-physician	HCA	\$80/hr maximum per non-physician for team meeting time	Need to negotiate the request in advance. Limited to one team evaluation per day per client. Up to a maximum allowable amount of \$1,200 per team per child per year.

Supplemental Fee Schedule

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH- code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Health Education Trainings and Materials	DOH-4000	Up to 100%	<p>In general, to be used for education and training of the eligible child. In some cases, may be used for family members when the activity will directly impact the eligible child.</p> <p>Documentation of denials from other sources are not a requirement to access. Need to submit justification on the HSA form.</p> <p>Local CSHCN Agencies cannot be paid for this activity if it is already a consolidated contract responsibility.</p>
Health Education – Life Skills training (e.g., camps, conferences)	DOH-5000	Up to 100%	<p>Specific to children with special health care needs. Child needs to participate.</p> <p>Need to negotiate the request in advance; might include negotiation in scholarship amounts.</p> <p>Up to a maximum allowable amount of \$1,000 per child per year.</p> <p>Documentation of denials from other sources are not a requirement to access. Need to submit justification on the HSA form.</p>



Supplemental Fee Schedule

UNDER CONSIDERATION,
Respite services (TBD)

HCA or DOH-1000

TBD

Will use HCPCS codes to track the different time frames for respite, i.e., hourly versus daily, etc.

Using Lifespan Respite Voucher System and Qualified Respite Providers

Individual families in need of respite services

Specific to children with special health care needs and medical necessity

Child is not eligible for other systems of respite services

Up to a maximum allowable amount of \$500 per child per year.

Social work

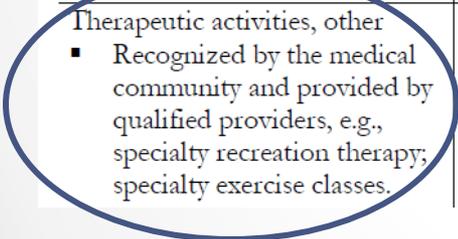
HCA

65% of billed charge.

Roles might include case management; generally the social worker is a member of the interdisciplinary team. This is not for otherwise billable mental health therapy.

Supplemental Fee Schedule

<i>Description</i>	<i>Source of Code (HCPCS/ CPT or DOH- code)</i>	<i>CSHCN Fee</i>	<i>Comments</i>
Therapies: <ul style="list-style-type: none"> ▪ Physical, occupational, speech ▪ Other therapies recognized by the medical community and provided by a qualified health care providers (i.e. vision, behavioral, acupuncture, massage, etc.) 	HCA	HCA Medicaid rate or \$20 flat fee per service maximum or \$80/hr maximum	For children, HCA currently pays for all medically necessary therapy. Annual allowable maximum of \$3,000 per therapy service per child per calendar year. Requires a referral by the primary care provider.
Therapeutic activities, other <ul style="list-style-type: none"> ▪ Recognized by the medical community and provided by qualified providers, e.g., specialty recreation therapy; specialty exercise classes. 	HCA	HCA	Determined on a case-by-case basis using the Tool for Determining Medical Necessity. See Section 6110. Annual allowable maximum of \$3,000 per therapy service per child per calendar year. Requires a referral by the primary care provider.



Supplemental Fee Schedule

Authorization for services paid for with CSHCN funds will be accomplished in accordance with the following:

- Financial eligibility for a client has been determined.
- A request for services to be paid for with CSHCN funds has been reviewed for consistency with program directions. Services must be recognized as an acceptable form of treatment by a significant portion of the professional community.
- No services will be authorized for out-of-state providers if an equivalent service is available within the state of Washington. However, use of resources in bordering states will be authorized when appropriate.

Supplemental Fee Schedule

Services that are **not** covered by CSHCN include, but are not limited to, the following examples, per federal Title V Maternal and Child Health Block Grant funding requirements, liability, and/or CSHCN policy:

- Client travel and/or lodging for client and/or family in connection with any medical health care service (potential duplication of Medicaid).
- Equipment, used medical (per Medicaid rule).
- Equipment, medical, installed to a building, structure or vehicle (per federal rules).
- Insurance or Warranty payments (per Medicaid rule).

Miscellaneous Fees and Services

- CSHCN Special Formulas
- Procedures for Tracking CSHCN Special Formula Use
- Metabolic Products

Payments

- Standard Payments
- Negotiated Payments
- Clinic and Team Payments
- Payment Reimbursement to CSHCN
- Legal Requests and Subrogation Claims

State Administration of CSHCN DX/TX Funds

- Obligating and Tracking Funds
- State Biennium Summary
- Sample Detail Report
- Central Treatment Funds

Estimate of Obligations Form

6413 Sample Estimate of Obligations Form

**Children with Special Health Care Needs Program
Diagnostic and Treatment Allocations**

Estimate of Obligations Form

Next Due Date: _____

Obligations are defined as:

- The estimated amount of known services the local CSHCN agency has obligated or expects to pay from CSHCN Diagnostic and Treatment funds, that have not been processed for payment to the CSHCN Program, and
- Health Services Authorization forms you have written that have not been returned to you by the provider, and so have not been processed for payment to the CSHCN Program.

Estimate of obligations are used to:

- Project statewide expenditures,
- Track expenditure patterns to identify increased use of funds,
- Prepare for decisions involving use of the Central Treatment Fund, and
- Determine if end-of-biennium balance estimates are within required funding limits (CSHCN Manual Section 2330, WAC 246-710-030).

Period being reviewed: July 1, _____ through June 30, _____ (dates of service)

Total Outstanding Obligation (current): \$ _____

Signature

Date

Local Agency

Submit to: Children with Special Health Care Needs Program
DOH/Prevention and Community Health
PO Box 47880
Olympia WA 98504-7880

Or: Email: cshcn.support@doh.wa.gov
FAX: (360) 586-7868

Reporting obligation estimates is a contractual requirement.
See CSHCN Manual, Section 6411, for Policy.

State Biennium Summary

2013-15 STATE BIENNIUM SUMMARY

CHILDREN WITH SPECIAL HEALTH CARE NEEDS											
STATE SUMMARY OF DIAGNOSTIC AND TREATMENT ALLOCATIONS											
1	2	3	4	5	6	7	8	9	10	11	12
			SUBMITTED	ALLOCATIONS			TOTAL	UNSPENT	TOTAL	CURRENT	PERCENT
REGION	CO#	AGENCY	EST OF OBLIG	INITIAL	CTF	CURRENT	EXPENDED TO DATE	BALANCE	OUTSTANDING OBLIGATIONS	ESTIMATED BALANCE	EXPENDED TO DATE
E	01	ADAMS		2,000	-	2,000	-	2,000		2,000	0%
E	02	ASOTIN		500	-	500	-	500		500	0%
C	03	BEN-FRANK		500	-	500	-	500		500	0%
C	04	CHEL-DOUG		500	-	500	-	500		500	0%
NW	05	CLALLAM		3,000	-	3,000	-	3,000		3,000	0%
SW	06	CLARK		2,000	-	2,000	-	2,000		2,000	0%
E	07	COLUMBIA		500	-	500	-	500		500	0%
SW	08	COWLITZ		3,000	-	3,000	-	3,000		3,000	0%
E	12	GARFIELD		500	-	500	-	500		500	0%
C	13	GRANT		500	-	500	-	500		500	0%
SW	14	GRAYS HARB		1,000	-	1,000	-	1,000		1,000	0%
NW	15	ISLAND		1,000	-	1,000	-	1,000		1,000	0%
NW	16	JEFFERSON		500	-	500	195	305		305	39%
NW	18	KITSAP		500	-	500	-	500		500	0%
C	19	KITTITAS		1,000	-	1,000	-	1,000		1,000	0%
SW	20	KLICKITAT		500	-	500	-	500		500	0%
SW	21	LEWIS		500	-	500	-	500		500	0%
E	22	LINCOLN		500	-	500	-	500		500	0%
SW	23	MASON		500	-	500	-	500		500	0%
E	33	NE TRI		2,000	-	2,000	-	2,000		2,000	0%
C	24	OKANOGAN		500	-	500	-	500		500	0%
SW	25	PACIFIC		500	-	500	-	500		500	0%
NW	28	SAN JUAN		500	-	500	-	500		500	0%
NW	17	SEA-KING		8,000	-	8,000	1,001	6,999		6,999	13%
NW	29	SKAGIT		500	-	500	-	500		500	0%
SW	30	SKAMANIA		500	-	500	-	500		500	0%
NW	31	SNOHOMISH		7,000	-	7,000	581	6,419		6,419	8%
E	32	SPOKANE		14,000	-	14,000	1,000	13,000		13,000	7%
SW	27	TAC-PIERCE		4,000	-	4,000	141	3,859		3,859	4%
SW	34	THURSTON		5,000	-	5,000	-	5,000		5,000	0%
SW	35	WAHIAKUM		500	-	500	-	500		500	0%
C	36	WALLA WALLA		500	-	500	-	500		500	0%
NW	37	WHATCOM		9,000	-	9,000	-	9,000		9,000	0%
E	38	WHITMAN		500	-	500	-	500		500	0%
C	39	YVMH		3,000	-	3,000	1,138	1,864		1,864	38%
		SUBTOTAL		75,000	-	75,000	4,055	70,945	-	70,945	
		CTF*		13,000	-	13,000		13,000	-	13,000	
		Metabolics**		12,000	-	12,000	2,329	9,671		9,671	19%
		TOTAL		100,000	-	100,000	6,383	93,617	-	93,617	6%
		* Central Treatment Fund									
		** Newborn Screening Program Medical Foods and Formulas									

Column explanations:

- Column 1 = **REGION** is the CSHCN region to which the county is assigned. (4 regions: Northwest, Southwest, Central, East)
- Column 2 = **CO#** is the assigned county number. All HSA requests should be numbered using this county number along with a unique sequential number (field #10 on HSA).
- Column 3 = **AGENCY** is the local health jurisdiction or agency with CSHCN contract responsibility to manage the diagnostic and treatment allocation.
- Column 4 = **ESTIMATE OF OBLIGATION** is a Yes/No field used at the end of the fiscal periods to tracking the receipt of estimate worksheets. (The estimate reported is recorded in Column 10.) Reporting obligations is a contract responsibility and reported periodically by local health jurisdictions when requested by the CSHCN Program. To verify that expenditures, obligations and balances are within available funding limits, which is required by law. Obligations are usually requested every 6-12 months.
- Column 5 = **INITIAL** allocations are diagnostic and treatment amounts allocated at the beginning of the biennium, July 1, 2013.
- Column 6 = **ACTIVITY** is any change in allocation amounts throughout the biennium, most commonly being approvals for Central Treatment Funds.
- Column 7 = **CURRENT** allocation is the sum of the initial allocation (Column 5) and any additional activity (Column 6).
- Column 8 = **TOTAL EXPENDED TO DATE** is the total amount of all Health Service Authorization payments-to-date per processing by the CSHCN Program. See agency-specific detail by month in the companion document titled "2013-15 Treatment Allocation Report".
- Column 9 = **UNSPENT BALANCE** is the amount remaining in current allocation (Column 7) after expenditures (Column 8).
- Column 10 = **TOTAL OUTSTANDING OBLIGATIONS** is the estimated amount of all known services the agency has obligated to pay from diagnostic and treatment funds, which have not been processed for payment to the CSHCN Program. This amount is periodically reported by agencies when requested.
- Column 11 = **CURRENT ESTIMATED BALANCE** is the balance remaining in current allocation after expenditures and obligations.
- Column 12 = **PERCENT EXPENDED TO DATE** is periodically included as a tool agencies can use to measure the total biennium expenditures to date against the initial allocation.

The 2013-15 State Biennium effective dates are July 1, 2013 through June 30, 2015 (dates of the service).

CSHCN policies and additional information about Diagnostic and Treatment Allocations are located in the CSHCN Manual, Section 6000.

Agency Detail Report

YVMH 3202

CHILDREN WITH SPECIAL HEALTH CARE NEEDS						MONTHLY SUMMARY			
2013-15 TREATMENT ALLOCATION REPORT						TOTAL	OTHER	BALANCE	
COUNTY: YAKIMA VALLEY MEMORIAL HOSP						PAID	ACTIVITY		
MONTH: APRIL 2014						INITIAL ALLOCATION = 3,000.00			
HEALTH SERVICES AUTHORIZATION PAYMENT LEDGER									
DATE POSTED	HSA NUMBER	DATE FROM	DATE TO	TOTAL PAID	REMARKS				
4/8/2014	101714	3/25/2014	6/25/2014	71.40	39-085	2013 JULY	29.75	-	
4/8/2014	101814	3/25/2014	6/25/2014	71.40	39-086	2013 AUG	357.00	-	
						2013 SEPT	-	-	
						2013 OCT	107.10	-	
						2013 NOV	-	-	
						2013 DEC	214.20	-	
						2014 JAN	142.80	-	
						2014 FEB	214.20	-	
						2014 MAR	71.40	-	
						2014 APR	142.80	-	
						2014 MAY			
						2014 JUNE			
						2014 JULY			
						2014 AUG			
						2014 SEPT			
						2014 OCT			
						2014 NOV			
						2014 DEC			
						2015 JAN			
						2015 FEB			
						2015 MAR			
						2015 APR			
						2015 MAY			
						2015 JUNE			
						(CLOSING:)			
						2015 JULY			
						2015 AUG			
						2015 SEPT			
TOTAL PAID IN THIS MONTH				142.80	Questions? Call Christy Polking (360-236-3571)	TOTAL	1,279.25	-	1,720.75

Central Treatment Fund

6423 Central Treatment Form

Central Treatment Fund (CTF) Request Form

This form is used by CSHCN Coordinators to request central treatment funds when the agency's diagnostic and treatment allocation is depleted, or expected to be depleted, and additional expenses or obligations are anticipated before the close of the current state biennium.

1. CSHCN Coordinator: _____
Date: _____
County or Local CSHCN Agency: _____
CSHCN Region: _____
Initial 2013-2015 Biennium Allocation: \$ _____
Total Expended to Date: \$ _____

2. The amount requested from the CTF is \$ _____

List the payments in process, obligations, and/or future planned expenditures here to equal the amount requested:

3. Explain the reasons for this request:

(For more space, use reverse side or attach additional sheet)

CSHCN Regional Recommendation: Approve Deny

Regional Representative Signature: _____

Date _____

Comments:

CSHCN: Approve Deny

Manager Signature: _____

Date _____

Comments:

Revised HSA Form

What's new:

- Box #2 -- ProviderOne ID
- Box #7-9 -- Federal Tax ID, Vendor NPI, Vendor Taxonomy
- Box #15 -- CPT/HCPCS/DOH
 - Providers and DOH staff
- Box #16 -- Description / Begin/End Dates of Service
- Things to remember when completing form:
 - Box #11 -- County of Residence & Code
 - Name brand versus arch/foot supports and compression garments

Revised HSA Form

Children with Special Health Care Needs (CSHCN) HEALTH SERVICES AUTHORIZATION

Asterisk (*) = Required Data for Payment

										AUTHORIZATION NO.					
1. PATIENT*:										2. PROVIDER ONE (P1) ID*					
4. ADDRESS:										3. CHIF ID (if P1 not available)					
5. DIAGNOSIS*:										10. BIRTH YEAR*					
6. VENDOR OR PROVIDER*										11. COUNTY OF RESIDENCE & CODE*					
										12. AUTHORIZATION DATE*					
										13. AUTHORIZATION EXPIRES*					
7. VENDOR/PROVIDER FEDERAL TAX ID No.*			8. VENDOR/PROVIDER NPI		9. VENDOR/PROVIDER TAXONOMY			14. INSURANCE/POLICY No./NAME*							
<p>You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom.</p>															
15. CPT/HCPCS/DOH*			16. DESCRIPTION/DATE(S) OF SERVICE(S)*						17. AMOUNT AUTHORIZED		18. FOR AGENCY USE				
			DESCRIPTION: BEGIN DATE OF SERVICE(S) END DATE OF SERVICE(S)												
<small>Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services.</small>															
19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.						Instructions to receive payment: Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources.									
VENDOR/PROVIDER SIGNATURE X															
20. ACCOUNT CODE – FOR AGENCY USE															
PREPARED BY			TELEPHONE NUMBER			DATE			AGENCY APPROVAL			DATE			
DOC DATE		PMT DUE DATE		CURRENT DOC No.		REF. DOC. No.		VENDOR NUMBER		VENDOR MESSAGE		Use TAX	UBI NUMBER		
MASTER INDEX				WORKCLASS				COUNTY		CITY/TOWN					
REF DOC SUF	TRANS CODE	M O D	APPN INDEX	PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	BUDGET UNIT	MOS	PROJECT	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE NUMBER
ACCOUNTING APPROVAL FOR PAYMENT								DATE		WARRANT TOTAL		WARRANT NUMBER			
21. RETURN TO:										22. PREPARED BY:					
										23. AUTHORIZED BY:					

Children with Special Health Care Needs (CSHCN) HEALTH SERVICES AUTHORIZATION

Asterisk (*) = Required Data for Payment

AUTHORIZATION NO.
[Blank]

1. PATIENT*: Martha A Washington		2. PROVIDER ONE (P1) ID*: 123456789WA	
4. ADDRESS: 2014 Cherry Blossom Lane, Olympia, WA 98501		3. CHIF ID (if P1 not available)	
5. DIAGNOSIS*: 734		10. BIRTH YEAR*: 2014	
6. VENDOR OR PROVIDER*: Olympia Orthotics 2014 Capitol Boulevard Olympia, WA 98501		11. COUNTY OF RESIDENCE & CODE*: 34-001	
7. VENDOR/PROVIDER FEDERAL TAX ID NO.*: 91-9000000		12. AUTHORIZATION DATE*: 5/1/2014	
8. VENDOR/PROVIDER NPI: 909090909		13. AUTHORIZATION EXPIRES*: 7/1/2014	
9. VENDOR/PROVIDER TAXONOMY: 335E0000X		14. INSURANCE/POLICY No./NAME*: Not covered by Medicaid	

Return Authorization By: [Red Stamp]

You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom.

15. CPT/HCPCS/DOH*	16. DESCRIPTION/DATE(S) OF SERVICE(S)*	17. AMOUNT AUTHORIZED	18. FOR AGENCY USE
L3060	DESCRIPTION: Bilateral Foot Orthotics BEGIN DATE OF SERVICE(S) 5/15/15 END DATE OF SERVICE(S) 6/15/14		

Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services.

19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.

VENDOR/PROVIDER SIGNATURE X: *George E. [Signature]*

Instructions to receive payment: Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources.

20. ACCOUNT CODE - FOR AGENCY USE

PREPARED BY		TELEPHONE NUMBER		DATE		AGENCY APPROVAL		DATE						
DOC DATE	PMT DUE DATE	CURRENT DOC NO.	REF. DOC. NO.	VENDOR NUMBER	VENDOR MESSAGE	USE TAX	UBI NUMBER							
MASTER INDEX			WORKCLASS			COUNTY		CITY/TOWN						
REF. DOC. SUF	TRANS. CODE	M O D	APPR. INDEX	PROGRAM. INDEX	SUB. OBJ	SUB. SUB. OBJ	ORG. INDEX	ALLOC. BUDGET UNIT	MDS	PROJECT	SUB. PROJ.	PROJ. PHAS	AMOUNT	INVOICE NUMBER
ACCOUNTING APPROVAL FOR PAYMENT										DATE		WARRANT TOTAL		WARRANT NUMBER

21. RETURN TO: Local CSHCN Agency
PO Box 2014
Olympia, WA 98501

22. PREPARED BY: [Blank]

23. AUTHORIZED BY: *Christy Polking*

CSHCN Health Care Coverage & Services

- CSHCN and Medicaid Coverage
- CSHCN Clients Without Medicaid
- TRICARE
- HCA Hearing Aid Services
- HCA Neurodevelopmental Therapy Services
- HCA Orthodontic and Maxillofacial Services

Resources

- Washington Apple Health (Medicaid) Provider Guides
<http://www.hca.wa.gov/medicaid/billing/Pages/bi.aspx>
- Modified Adjusted Gross Income (MAGI)
<http://wahbexchange.org/news-resources/calculate-your-costs>
- “Healthplanfinder”
<https://www.wahealthplanfinder.org>
- e-mail: cshcn.support@doh.wa.gov
- CSHCN Manual appendices

Questions



Evaluation



The End

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON

Maria Nardella, Christy Polking,
Ellen Silverman, and Joan Zerzan