Washington State Department of HEALTH

Children & Youth with Special Health Care Needs

www.doh.wa.gov/cyshcn

Diagnostic and Treatment Fund (DxTx) Guidelines:

What are these funds?

The DxTx funds are a small pot of funds, available to Children and Youth with Special Healthcare Needs (CYSHCN), for **medically necessary services, resources, products or equipment** not covered by any other funding source. A total of $5,000.00 is available for use for all of Washington State. These funds are from our federal Title V Maternal and Child Health Block Grant (MCHBG).

Apple Health Managed Care Plans have the responsibility to cover medically necessary services for eligible children. CYSHCN DxTx funds are intended for medical services which are not covered by Apple Health (Medicaid) and are beyond the scope of routine care common to most children. Decisions about the use of these funds are made on a case-by-case basis, according to CYSHCN policies, which are protected by law in alignment with Washington Administrative Code 246-710-050. CYSHCN DxTx funds are not entitlement funds. This means they may be used to pay for one child and not for another.

The CYSHCN team member will need to use a problem-solving approach to decide whether it is appropriate to use CYSHCN DxTx funds; the following questions may help with this. They will use the following questions to guide their problem-solving process, identify systems of care, and progress to a point where DxTx funds are an option.

Determination of Medical Necessity based on Health Care Authority WAC 182-500-0070:

"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 purposes of this section, the “course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Consider these questions first:

1. Is the client a child or youth with special health care needs?
2. Is the request for this service from a qualified provider, accompanied by an evaluation?
3. Does the provider support this service as medically necessary and deem it appropriate for the client?
4. Is the service or need evidence based in research?

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5. Does the product have a HCPC code, and can it be purchased through a qualified DME vendor?
6. Does the product have an alternative non-brand name to reduce the expense?
7. Does this request cover basic needs or is it for convenience? Is it medically necessary?
8. Does the client have an Apple Health Managed Care Plan (Medicaid)?
    a. **Please help the family apply if not.**
9. What Managed Care Organization (MCO) is the client enrolled in, and have you reached out to the MCO for coverage? *
10. Is this service covered by Medicaid?
    a. Has the request been denied by Medicaid or the MCO?
    b. Why was the request denied?
    c. Has it been appealed and denied again?
    d. If the request is not covered, did the provider submit an exception to the rule? WAC 182-501-0160:
    e. Are they requesting more product that is being covered by Medicaid? If so, the provider needs to submit a limitation extension: WAC 182-501-0169:
11. Is there another service system that should support this service?
    a. DDA (Developmental Disability Administration services), private insurance, school, local grants?
    b. National organizations, local resources and community groups, like churches, firehouses, and civic clubs like Rotary?

Apple Health Managed Care Contacts for Children with Special Health Care Needs (CYSHCN):

*Each Apple Health Managed Care Organizations (MCOs) has dedicated care coordinators for individuals with special health care needs to assist in problem-solving for children with special health care needs and their families. They can assist in understanding and accessing benefits, coordinate complex health problems, and offer referrals to community resources such as WithinReach. Please find the MCO contact for referrals here or on our website, located under the health tab.

Who is Eligible? As review:

CYSHCN who meet **all** the following:

- The request is from a qualified provider accompanied by an evaluation
- The service/product is considered **medically necessary** and is evidenced based in research
- The request is for a client who has Apple Health Managed Care Plan medical coverage (Medicaid)

- The service/resource request has been denied by Medicaid, MCOs, and other potential payers **AND** an appeal for the denial has been rejected from potential payers.
- Payor of last resort

How to Request Funds:

- Reach out to the Dx/Tx lead for a consultation if you think your client may be eligible:

  Khimberly.Schoenacker@doh.wa.gov (CYSHCN Nutrition Consultant)

- If the client is eligible: complete a Health Services Authorization form for submission to the CYSHCN program for review. A sample completed form is below.

Children with Special Health Care Needs (CSHCN)

HEALTH SERVICES AUTHORIZATION

Asterisk (*) = Required Data for Payment

AUTHORIZATION NO.	
1. PATIENT*:	Martha A Washington
2. PROVIDERONE (P1) ID*	123456789WA
3. CHIF ID (if P1 not available)	
4. ADDRESS:	2014 Cherry Blossom Lane, Olympia, WA 98501
5. DIAGNOSIS*:	734
10. BIRTH YEAR*	2014
11. COUNTY OF RESIDENCE & CODE*	34-001
6. VENDOR OR PROVIDER*	Olympia Orthotics 2014 Capitol Boulevard Olympia, WA 98501
RETURN AUTHORIZATION BY	
12. AUTHORIZATION DATE*	5/1/2014
13. AUTHORIZATION EXPIRES*	7/1/2014
7. VENDOR/PROVIDER FEDERAL TAX ID NO.*	91-90000000
8. VENDOR/PROVIDER NPI	9090909090
9. VENDOR/PROVIDER TAXONOMY	335E00000X
14. INSURANCE/POLICY NO./NAME*	Not covered by Medicaid

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 Emergency

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	MOD	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: Local CSHCN Agency, PO Box 2014, Olympia, WA 98501

22. PREPARED BY:

23. AUTHORIZED BY: Christy Polkinghorn

Washington State Department of Health

DOH-910-002(Rev. 05/14)

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