



Florida Medicaid

Prescribed Pediatric Extended Care Services Coverage Policy

Agency for Health Care Administration
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1.0 Introduction

1.1 Description

Florida Medicaid prescribed pediatric extended care (PPEC) services provide skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients.

1.1.1 Florida Medicaid Policies

This policy is intended for use by PPEC providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

This is not a covered service in the Statewide Medicaid Managed Care program.

1.2 Legal Authority

Prescribed pediatric extended care services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), sections 440.130, 440.167, and 441.61
- Chapter 409.905, Florida Statutes (F.S.)
- Rule 59G-4.260, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADL)

As defined in Rule 59G-1.010, F.A.C.

1.3.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.3.4 Full Day

Five to twelve hours of PPEC services rendered in one day.

1.3.5 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.6 Instrumental Activities of Daily Living (IADL)

As defined in Rule 59G-1.010, F.A.C.

1.3.7 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.8 Partial Day

Four hours or less of PPEC services rendered in one day.

1.3.9 Provider

The term used to describe any entity, facility, person or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.3.10 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary PPEC services and who:

- Require continuous therapeutic interventions or skilled nursing supervision, as described in section 400.902, F.S. and in Rule 59A-13.007, F.A.C.
- Are determined medically stable by a physician and who are not a threat to self or others

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's General Policies on copayment and coinsurance.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid PPEC services.

3.2 Who Can Provide

Services must be rendered by prescribed pediatric extended care centers licensed in accordance with Chapter 400, Part VI, F.S., and Rule 59A-13.004, F.A.C.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers PPEC services provided in accordance with section 400.902, F.S., the applicable Florida Medicaid fee schedule, or as specified in this policy, on a full or partial day basis. Services must include the following at a minimum:

- Caregiver training
- Developmental therapies

- An appropriate escort for travel to and from the PPEC when Florida Medicaid non-emergency transportation is provided
- Medical services
- Nursing services
- Personal care services
- Psychosocial services
- Respiratory therapy services

The PPEC day begins when the recipient arrives at the PPEC or is picked up for escorted transportation to the PPEC.

The PPEC day ends when the recipient departs from the PPEC for the day or is returned home by escorted transportation from the PPEC.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- A full day and a partial day of PPEC services on the same date of service, for the same recipient
- Early intervention services when billed separately
- Food or formulas
- Supportive or contracted services as defined in section 400.902, F.S.
- Transportation services

Some services may be reimbursed through another Florida Medicaid-covered service. Please refer to the service-specific coverage policy for more information.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

6.2 Specific Criteria

Providers must maintain the following in a recipient's file:

- A plan of care that is updated every 180 days, signed, dated, and credentialed by the PPEC registered nurse and physician
- A log that is signed daily by the recipient's parent, legal guardian, or authorized representative indicating one of the following:

- Time the recipient arrived at, and departed from, the PPEC
- Time the recipient was picked up and returned home, if escorted

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from AHCA, or its designee, every 180 days or more frequently if there is a change in the recipient's condition requiring an alteration in services.

Providers must submit a discharge request to AHCA, or its designee, to terminate a recipient's services. The discharge request must include both of the following:

- Last date services were provided to the recipient
- Number of units of service used during the current authorization period (through the discharge date)

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Codes

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.