Prescribed Pediatric Extended Care
December *2020*

Who can receive PPEC services?

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

PPEC Specific Criteria

Florida Medicaid covers PPEC services provided in accordance with section 400.902, F.S.

Services must include the following at a minimum:

- ✓ Caregiver training
- ✓ Developmental therapies
- ✓ Medical services
- ✓ Nursing services
- ✓ Personal care services
- ✓ Psychosocial services
- ✓ Respiratory therapy services

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.

Non-covered Criteria

Services are not covered when any of the following apply:

- ✓ The service does not meet the medical necessity criteria
- ✓ The recipient does not meet the eligibility requirements
- ✓ The service unnecessarily duplicates another provider's service
- ✓ 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.

When to Request Authorization

New Admission (initial request)

Providers must submit within 5 business days of the first day of service for an initial request.

Continued Stay Authorization Requests

Providers must submit requests to continue a service past the authorized end date within the time frame specified by the QIO; at least 10 business days prior to but no more than 15 business days prior to the current authorized end date .

Modifications

- Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized.
- Providers must submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.
- Modifications to an authorization must be requested during the timeframe authorized.

Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

Requesting Authorization

Providers must submit authorization requests to the QIO's in paper format and include the following information at a minimum:

- Recipient information, including Florida Medicaid identification number
- Requesting provider information, including the provider's National Provider Identifier (NPI)
- Rendering provider information, including the provider's NPI (if different from the requesting provider)
- Ordering provider information, including the practitioner's NPI
- Procedure code(s) (with modifier(s) when applicable)
- Full description of the service(s) requested (including amount, duration, and frequency)
- Summary of the recipient's current health status, including diagnosis(es) pertinent to the recipient's need for the service being requested ? Nursing Assessment??
- Service delivery address
- Unit(s) of service requested
- Dates of service
- A copy of the physician's order, if applicable
- A copy of the recipient's current plan of care signed by the physician
- Any additional documentation requested by the QIO

Authorization Requirements

Documentation	Required Documents
Nursing Assessment Admission/Continued stay And Modification requests	➢ Signed and dated by the RN completing the Assessment. ➢ Nursing assessments dated within 10 days, and no more than 15 days prior to the end of each certification period , are acceptable.
Physician Order Initial request only	A written order form the treating or attending Physician. ➢ Must include, ICD 10 DX Code (s), Frequency &Duration, signed with Credentials and dated ➢ Verbal orders are not accepted for the initial request. ➢ Initial request must be a prescription
Plan of Care (POC) All requests	Required with each admission (initial) and continued stay request. Use AHCA's Physician Plan of Care for PPEC Services Form(AHCA Form 5000-3507). ➢ Developed prior to requesting authorization ➢ Signed and dated by PPEC registered nurse with credentials noted ➢ Signed and dated by the treating or attending physician prior to submission to eQHealth, credentials noted. If signed by an ARNP or PA, the physician must countersign; ➢ Must be completed in its entirety ➢ Current Medical Condition is the medical condition of the recipient at the time POC is being submitted. Must be updated and current. ➢ Statement that evaluates the recipient's accomplishments toward measurable goals should be included in the POC. **The service duration and valid/current POC may not exceed 180 days.**

Authorization Requirements

Documentation	Required Documents
Additional Documentation	➢ PPEC documentation including logs, nursing notes and MAR's should be submitted with initial documents when the POC documents or the physician has ordered specific vital sign(s) (including BP, pulse, oxygen saturation, temp, respirations), seizure, apnea, weight and/ or dietary monitoring, oxygen usage, medication administration and respiratory treatments (including CPT manual or vest). ➢ PCP, Specialists and/ or Hospital notes will be requested, as needed, to assist with determination of medical necessity.

Care Coordination

- We use the nursing process to meet the needs of our recipients and their families. The process requires the mindset of a true multidisciplinary approach that focuses on assessment, planning, implementation and evaluation.
- The approach and timelines will differ depending upon the services (PPEC vs PDN) provided.
- As we consider the tools that we have available for each of these elements – *our process emerges*.

Care Coordination Process

TIMEFRAME	PROCESS	TOOLS	ACTION
Upon Admission	Assessment	Survey (completed with the recipient's guardian)	Assess the needs of the recipient and their family (within 5 business days of admission)
Upon Admission	Utilization Review	Medical Necessity Criteria	Respond to ALL requests by calling the guardian and provider within 1 business day of receiving request. Enter and complete or refer the review within 1 business day once required documentation is received.
Upon Admission	Assessment	Develop Individualized Service Plan	Create an Individualized Service Plan based on the needs of the recipient and the family. The Service Plan is updated every three months.

Care Coordination Process

TIMEFRAME	PROCESS	TOOLS	ACTION
Within 60 days of admission to program	Assessment/Planning/ Implementation	MDT/ MTM	Collaboration with the entire team to establish goals and objectives of care for the recipient. Establish responsibilities for each member of the team to meet the goals and objectives
At least every 180 days while enrolled in program	Evaluation/Planning	MDT/ MTM	Evaluate progress toward the goals and objectives and plan for next authorization period. Not all team members may need to be involved but certainly those individuals who are affecting the goals.
Recertification/Transition	Planning/Implementation	Recertification Review	Review of documents, authorize services or refer to PR within 1 business day of required documentation received.

Review Completion Timeframes

PPEC	Description of services
T1025	Full Day PPEC Services (over four hours, up to twelve hours per day.)
T1026	Partial-Day PPEC Services four hours or less per day billed in units of one hour (A minimum required to round up to full hour.)

Authorization Request	1st Level Review	2nd Level Review (Physician Reviewer)
Admission **Continued Stay** Continuation of services submit no more than 15 days prior to start date **Modification**	• Within 2 Business Day **<u>Upon receipt of all required documentation</u>**	• Within 3 Business days
Retrospective Requests Applies to Retroactive Medicaid Eligibility only	•Within 20 business days	

Denials & Reconsiderations

Denial

- The physician reviewer may render a (full) medical necessity denial of one or more service line items.

Partial Denial

- When a partial denial is rendered, some of the services are approved and some are denied. Therefore there is not a complete denial of the services.

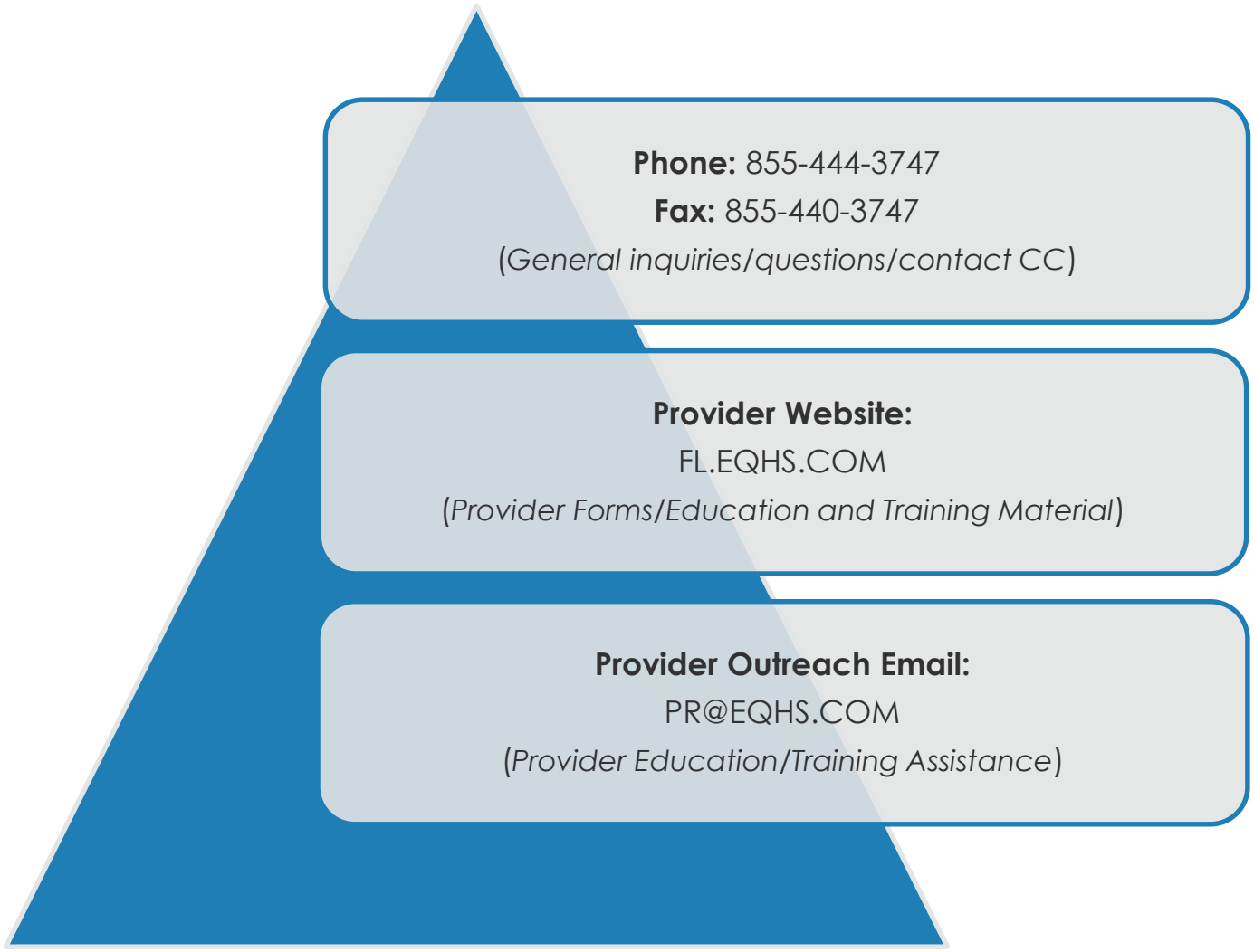
Technical Denial

- Please note all PPEC requests must be submitted as Prior Authorization. If you are submitting a request for dates of service that have already passed this will result in a Technical Denial.
- The request must be submitted with all required documentation.
- **NOTE:** If the recipient has retroactive eligibility please indicate this information.

Reconsideration and Fair Hearing Rights

Partial and full denials have reconsideration and Fair Hearing Rights. Recipients or their parent/legal guardian are made aware of this process. There are time limitations for the requests outlined in the denial letter.

eQHealth Resources



Provider Resources

- Forms & Downloads
  PPEC Forms

- Education Resources on our provider portal
  Provider Education and Training Material

- FL Medicaid Authorization Requirements Policy June 2016
  Authorization Requirements Policy

- FL Medicaid PPEC Coverage Policy Feb 2018
  PPEC Coverage Policy