Benefit Criteria for Prescribed Pediatric Extended Care Center for Texas Medicaid

Information posted August 28, 2017

**Note:** This article applies only to claims submitted to TMHP for processing. Refer to the Medicaid managed care organizations (MCOs) for information about contracting and credentialing, as well as MCO benefits, limitations, prior authorization, reimbursement, and MCO specific claim processing procedures.

Effective June 1, 2017, Texas Medicaid has made payable a new benefit for Prescribed Pediatric Extended Care Centers (PPECC). While the benefit was effective November 1, 2016, PPECC services were not payable pending a review and finalization of the rates. TMHP will start processing PPECC prior authorization requests for dates of service on or after June 1, 2017.

**Note:** Most potential PPECC clients are enrolled in the STAR Kids Medicaid Managed Care program. Clients may also be enrolled in the STAR Health or STAR Medicaid Managed Care programs.

This benefit was created in response to Senate Bill (SB) 492, 83rd Texas Legislature, Regular Session, 2013, which directed the Department of Aging and Disability Services (DADS) to create a new licensure category and the Health and Human Services Commission (HHSC) to establish a new Medicaid payable benefit for PPECC.

**What is a PPECC?**

The Texas Legislature defines PPECCs as non-residential facilities that provide medical, nursing, psychosocial, therapeutic, and developmental services to four or more medically or technologically dependent children for a maximum of 12 hours per day. “Medically or technologically dependent” means a child who “due to an acute, chronic, or intermittent medically complex or fragile condition or disability requires physician prescribed, ongoing, technology-based skilled nursing care to advert death or further disability or the routine use of a medical device to compensate for a deficit in a life-sustaining body function.” The term "medically dependent or technologically dependent" does not include a minor or occasional medical condition that does not require continuous nursing care, including asthma or diabetes, or a condition that requires an epinephrine injection.

Services must be included in a PPECC plan of care (POC) and are limited to no more than 12 hours in a 24-hour period. PPECC services may not be provided overnight. PPECC services are intended as an alternative to private duty nursing (PDN). When the services duplicate, PPECC services must be a one-to-one replacement of PDN hours, unless additional hours are medically necessary. Skilled nursing (SN) hours are not expected to increase when the client utilizes a combination of both PPECC and PDN services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client's medical needs. PPECCs must comply with:

- Medicaid program rules, as well as PPECC licensing statute and rules
- Mandatory reporting of suspected abuse and neglect of children
- Texas Medicaid provider participation requirements
- The requirements of the Texas Medicaid Provider Procedures Manual
A PPECC does not provide emergency services. PPECCs must follow the safety provisions in PPECC licensure requirements, including the adoption and enforcement of policies and procedures for a client’s medical emergency. PPECCs must call for emergency ambulance transport to the nearest hospital when emergency services are needed by a PPECC client.

**PPECC Services**

Clients who receive PPECC services through THSteps-CCP require ongoing medical supervision by the ordering physician who has a therapeutic relationship with and ongoing clinical knowledge of the client. A face-to-face evaluation must be performed each year by the ordering physician for each client. A physician order is required for each authorization period including initial, revisions, and recertifications. A physician in a relationship with a PPECC (employed by or contracted with a PPECC) cannot provide the physician’s order, unless the physician is the client’s treating physician and has examined the client outside of the PPECC setting.

PPECC services must be:

- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the condition, illness, or injury under treatment, not in excess of the client’s needs
- Consistent with generally accepted professional medical standards as determined by Medicaid and may not be experimental or investigational
- Reflective of the level of service that can be safely and effectively furnished
- Furnished in a manner not primarily intended for the convenience of the client, the client’s responsible adult or the provider

*Note: The fact that a client’s ordering physician has prescribed, recommended, or approved medical care, goods, or services does not, in itself, make such care or services medically necessary or a reimbursable service.*

The PPECC must ensure the provision of the following basic services:

- The development, implementation, and monitoring of a comprehensive POC in collaboration with the client or the client’s responsible adult that addresses the client’s medical, nursing, psychosocial, therapeutic, and developmental services including the following prescribed services:
  - Skilled nursing
  - Personal care services to assist with activities of daily living or instrumental activities of daily living while in the PPECC
  - Functional developmental services
  - Nutritional and dietary services, including nutritional counseling
  - Occupational, physical, and speech therapy
  - Respiratory care
  - Psychosocial services
  - Physician’s oversight of services
Note: Nutritional services must comply with standards in DADS licensure rules related to nutritional counseling and dietary services.

The POC must also include the following, as applicable:

- Training for the client's responsible adult associated with caring for the medically or technologically dependent client
- Transportation services needed by a client to access PPECC services

Admission Criteria

Documentation of medical necessity is required for PPECC services. PPECC services are considered medically necessary when a client meets all of the following admission criteria:

- 20 years of age or younger
- Eligible for Texas Health Steps (THSteps)-Comprehensive Care Program (CCP)
- Requires ongoing skilled nursing care and supervision, skillful observations, judgments and therapeutic interventions beyond the level of Home Health Skilled Nursing all or part of the day to correct or ameliorate health status
- Considered medically or technologically dependent
- Has an acute or chronic condition
- Stable for outpatient medical services, and does not present significant risk to other clients or personnel at the PPECC
- Has a signed and dated physician prescription from an ordering physician who has personally examined the client within 30 calendar days prior to admission and reviewed all appropriate medical records
- Requires ongoing and frequent skilled interventions to maintain or ameliorate health status, and delayed skilled intervention is expected to result in:
  - Deterioration of a chronic condition;
  - Loss of function
  - Imminent risk to health status due to medical fragility
  - Or risk of death.
- Has signed and dated client or client responsible adult consent (i.e., the admission must be voluntary)
- Resides with a responsible adult, and not reside in any 24-hour inpatient facility (i.e., hospital, nursing facility [NF], intermediate care facility [ICF] or special care facility, including sub-acute units or facilities for the treatment of acquired immune deficiency syndrome [AIDS.])

The PPECC will hold interdisciplinary conferences related to a client's plan of care when PPECC services are initiated, recertified, or revised, at least every 90 calendar days. The interdisciplinary conferences should include the client’s responsible adult and the following, as applicable:

- The client’s Department of Family and Protective Services case worker
The client’s therapy provider(s)

Hospice provider

*Note: For clients who receive their PPECC services through a Medicaid managed care organization, the MCO service coordinator and/or service manager should be included in the interdisciplinary conferences. Other required interdisciplinary team members are listed in PPECC licensure requirements.*

**Authorization Requirements**

Prior authorization is required for PPECC services, excluding PPECC transportation. All requests for PPECC services must be based on the client’s current medical needs. Texas Medicaid defines medically necessary THSteps services as health care, diagnostic services, treatments, and other measures medically necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.

PPECC services will not be approved for the sole purpose of training and educating the client or the client’s responsible adult on how to manage a chronic condition or how to administer total parenteral nutrition (TPN).

Training in a home setting for certain services such as how to administer TPN may be considered through intermittent home health skilled nursing visits.

*Note: Refer to the Texas Medicaid Provider Procedures Manual, Home Health Nursing and Private Duty Nursing Services Handbook for more details on training and education for the client or the client’s responsible adult on TPN administration in a home setting.*

Prior authorization requests must be submitted to the Texas Medicaid Claims Administrator Prior Authorization Department.

*Note: Clients enrolled in a managed care health plan may receive services from a PPECC. Prior authorization requests for these clients must be submitted solely to the client’s managed care organization.*

**Initial Authorization Requests**

Initial authorization requests may be prior authorized for a maximum of 90 calendar days. Requests for prior authorization, including all required documentation, must be submitted to Texas Medicaid Claims Administrator Prior Authorization Department by electronic portal, fax, or mail no later than three business days following the start of care (SOC). Requests received after the three business day period allowed will be denied for dates of service (DOS) that occurred before the request is received.

When PPECC services are authorized, the authorized period begins on the day of the week that prior authorization starts. For example, if services hours are authorized on a weekly basis, the period would begin from the day of the week the prior authorization period begins and continue for seven calendar days. PPECC services may be authorized on a daily, weekly, or hourly basis.

Consistent with PPECC licensure requirements, an initial nursing assessment must be completed, signed, and dated by the PPECC RN no earlier than three business days before the SOC at the PPECC. The initial nursing assessment must be performed by a PPECC RN and cannot be delegated. The initial nursing assessment is used to establish the POC and must support medical necessity for the client to receive on-going skilled
nursing care. The initial nursing assessment must include, but is not limited to, the following:

- Complexity and intensity of the client’s care
- Stability and predictability for the client’s condition
- Frequency of the client’s need for skilled nursing services
- Identified medical, nursing, psychosocial, therapeutic, nutritional, dietary, functional, educational, and developmental needs and goals, and any training needs for the client or the client’s responsible adult
- Description of wounds, if present
- The client’s equipment needs and whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client
- The comprehension level of the client’s responsible adult
- Receptivity to training and ability level of the responsible adult

**Note:** The PPECC provider may be asked to submit additional documentation to support medical necessity.

**Required Documentation for Initial Requests**

Initial prior authorization requests for PPECC services must include the following documentation:

- A completed [CCP Prior Authorization Request Form](#) signed and dated by the ordering physician
- A completed [Prescribed Pediatric Extended Care Center (PPECC) Plan of Care Form](#) signed and dated by the ordering physician, the PPECC RN completing the POC, and client or client’s responsible adult
- A PPECC may also submit the POC on its own form; however, the POC must contain all of the elements required for a POC

A written or verbal physician approval of the POC must be in place by the SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of the POC verbal approval must be submitted with the POC, followed by the physician signed and dated POC within 14 calendar days from receipt of the authorization request by the Texas Medicaid Claims Administrator.

- A completed [Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers Form](#) signed and dated by the ordering physician, the RN completing the assessment, and the client or client’s responsible adult. The completed form must include:
  - Updated problem list
  - Updated rationale and summary page
  - A contingency plan
  - A 24-hour daily care flow sheet
Physician and client acknowledgement

- A written or verbal order for PPECC services from the ordering physician. A physician’s order (written or verbal) must be in place by the SOC. If the PPECC has a verbal order at the time the prior authorization request is submitted, dated documentation of this verbal order must be submitted separately or included in the POC. Per PPECC licensure requirements, the physician order must include:
  - Client’s name, date of birth, gender, and Medicaid ID number
  - Provider name, address, phone number, Texas Provider Identifier (TPI) number and National Provider Identifier (NPI) number
  - Date the client was last seen by the physician
  - Description of current medical diagnosis or condition
  - Nursing services
  - Medication administration, if applicable
  - Dietary needs, if applicable
  - Permitted activities, if applicable
  - Therapies, if applicable
  - Transportation authorization, if applicable
  - Other services, if applicable
  - Approval of the client’s admission to the PPECC

**Note:** For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order as outlined above must be maintained in the client’s medical record.

- Signed and dated consent of the client or client’s responsible adult documenting his/her choice of PPECC services. The signed consent must include an acknowledgement by the client or the client’s responsible adult that he/she has been informed that their PDN might be reduced as a result of accepting PPECC services. Consent to share the client’s personal health information with the client’s other providers to ensure coordination of care must be obtained.

**Note:** A client signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.

- The POC must be developed by a PPECC RN, in collaboration with an interdisciplinary team, in compliance with PPECC licensure requirements. The POC, using either the Prescribed Pediatric Extended Care Center (PPECC) POC form or a PPECC-developed-form, must include the following components:
  - The client’s name, date of birth, and Medicaid number
  - The PPECC’s name, TPI number, NPI number, hours or operation, address, phone and fax numbers
  - The ordering physician’s name, phone number, TPI number, and NPI number
  - The date the PPECC nursing assessment was completed and name, title, and credentials of the RN who completed the POC and his/her dated signature
The name, title, and credentials of the team member who completed the POC and his/her dated signature

The date the client was last seen by the ordering physician

The requested SOC date for PPECC services

All pertinent diagnoses and known allergies

The nursing services to be provided, including amount, duration, and frequency

The client’s prognosis

The client’s mental status

The client’s rehabilitation potential

The equipment and/or supplies required

Therapies (occupational, physical, speech, and respiratory care), including how those therapies are accessed, amount, duration, and frequency. Therapies provided in the PPECC, as well as outside the PPECC (e.g., school based) must be documented

Other prescribed services, including amount, duration, and frequency

Nutritional requirements, including type, method of administration, and frequency

Medications, including the dose, route, frequency, and any medication-related allergies if known

Treatments, including amount and frequency

Wound care orders and measurements

Safety measures to protect against injury

Functional and developmental services and psychosocial services, including the amount, duration, and frequency

Name, phone number, and signature of the responsible adult when the client is a minor child

Client emergency contact name and phone number

Confirmation that a signed contingency plan is in place in circumstances when PPECC services are not available (e.g., fire, flood, windstorm, or electrical malfunctions), and for emergencies that occur while the client is in the care of the PPECC

List of services the client receives in the home and school settings. (e.g., ECI, therapies, school-based services (SHARS), PCS, PDN, skilled home health, case management, hospice, and Medicaid waiver programs such as: Medically Dependent Children’s Program (MDCP); Home and Community-Based Services (HCS); Deaf-Blind Multiples Disabilities (DBMD); Texas Home Living (TxHmL); and Community Living Assistance and Support Services (CLASS)

Note: Services provided under these programs will not prevent a client from obtaining medically necessary services.

Client-specific measurable goals, including, if receiving PDN, the goal of ensuring coordination of ongoing skilled nursing services with the PDN provider
o Responsible adult training needs
o Prior and current functional or medical limitations
o Permitted activities
o Client’s scheduled days and hours of attendance
o Confirmation of a discharge plan, including instructions for timely discharge or referral
o Emergency contact information
o Method of transportation
o PDN provider name, TPI number, NPI number, phone, address, and fax number
o Ordering physician signature and date of signature

- The ordering physician, PPECC RN, and client or client’s responsible adult signatures must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC. When services are initiated with a verbal order, physician signatures are current if signed and dated within 14 calendar days following receipt of the authorization request by the Texas Medicaid Claims Administrator.

- All of the following documentation requires the ordering physician’s signature with date:
  - CCP Prior Authorization Form
  - Prescribed Pediatric Extended Care Center (PPECC) Plan of Care
  - Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

- If the documentation is submitted solely with the ordering physician’s verbal order, it must be resubmitted with the ordering physician’s dated signature within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator.

- If the request is not received with a dated physician signature within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator, the prior authorization will be considered incomplete and will be denied.

- When there is documentation of a verbal order, if all required documentation is not signed and dated by the ordering physician and received by Texas Medicaid Claims Administrator Prior Authorization Department within 14 calendar days of the receipt of the order, claims with dates of service prior to the receipt of the signed and dated documentation will be denied.

- Requests for authorizations of PPECC services should always be commensurate with the client’s medical needs.

- The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or client’s responsible adult. PPECC services will not be authorized for more than 90 calendar days from the SOC for an initial authorization.
Note: Clients enrolled in a Medicaid managed care health plan may receive services from a PPECC. Authorization must be received from the health plan.

Revisions to the Plan of Care

The PPECC provider may request a revision to the plan of care at any time during an authorization period. Requests for changes in the service hours during a current authorization period should be submitted if there is a change in the client’s condition, or the authorized services are not commensurate with the client’s medical needs and additional authorized hours are medically necessary.

Note: Schedule changes that do not affect overall authorized ongoing skilled nursing hours do not require a revision authorization request, but must be documented in the client’s medical record.

Requests for revisions must be submitted to the Texas Medicaid Claims Administrator Prior Authorization Department as soon as the PPECC identifies a need for a revision. Revision requests may be submitted by electronic portal, fax, or mail within three business days of the revised SOC date. Requests received after the three business day period will be denied for dates of service (DOS) that occurred before the request is received.

If a client’s condition changes during the course of the authorization period that impacts the amount or duration of services, a reassessment performed by a PPECC RN is required. A reassessment is not necessary if there is not a change in the client’s condition.

The PPECC provider must notify TMHP and the client’s ordering physician at any time during the authorization period for the following:

- Changes in the client’s condition
- Authorized services are not commensurate with the client’s medical needs
- Client requires additional hours of ongoing skilled nursing services

Submission of a revision authorization request, with physician signatures on required documentation will meet the notification requirement.

Required Documentation for Revisions

Revision requests require all of the following documentation:

- A completed CCP Prior Authorization Form signed and dated by the ordering physician
- An updated Prescribed Pediatric Extended Care Center (PPECC) Plan of Care Form signed by the ordering physician, the PPECC RN that completes the POC, and the client and client’s responsible adult.
- A PPECC may also submit the POC on its own form; however, the POC must contain all required elements listed under Initial Authorizations.
- A written or verbal physician approval of the POC must be in place by the revised SOC. If the PPECC has a verbal approval of the POC at the time the prior authorization request is submitted, the dated documentation of the POC verbal approval must be submitted with the POC, followed by the physician signed and
dated POC within 14 calendar days from the receipt of the authorization request by the Texas Medicaid Claims Administrator.

- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers Form signed and dated by the ordering physician, the RN completing the assessment, and the client or client's responsible adult. The completed form must include:
  - Updated problem list
  - Updated rationale and summary page
  - A contingency plan
  - A 24-hour daily care flow sheet
  - Physician and client acknowledgement

- A written or verbal order for PPECC services from the ordering physician. A physician’s order (written or verbal) must be in place by the SOC. If the PPECC has a verbal order at the time the prior authorization request is submitted, dated documentation of this verbal order must be submitted separately or included in the POC. The signed and dated order must be received within 14 calendar days of the receipt of the authorization request by the Texas Medicaid Claims Administrator.

**Note:** For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order, as detailed in “Initial Authorizations,” must be maintained in the client's medical records.

- Signed and dated consent of the client or client’s responsible adult documenting his/her choice of PPECC services. The signed consent must include an acknowledgement by the client or the client’s responsible adult that he/she has been informed that their PDN might be reduced as a result of accepting PPECC services. Consent to share the client’s personal health information with the client’s other providers to ensure coordination of care must be obtained.

**Note:** A client signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.

The signatures of the ordering physician, PPECC RN, client, or client’s responsible adult must be current. Current is defined as signed and dated within the 30 calendar day period before the SOC.

Revisions requests during a current authorization period must fall within that authorization period. If the revision is requested beyond the existing authorization period, the provider must request a recertification authorization and submit all required documentation for a recertification.

When a revision has been requested, and documentation is submitted solely with the ordering physician’s verbal order, it must be resubmitted with the ordering physician’s signature and date within 14 business days of the receipt of the authorization request by the Texas Medicaid Claims Administrator. Physician signatures received within the 14 business day time period will be considered current.

If the required documentation is not received with a dated physician signature within 14 calendar days of the receipt of the authorization request, the prior authorization will be considered incomplete and will be denied.
When there is documentation of a verbal order, if all required documentation is not signed and dated by the ordering physician and received by Texas Medicaid Claims Administrator Prior Authorization Department within 14 calendar days of the receipt of the order, claims with dates of service prior to the receipt of the signed and dated documentation will be denied.

**Recertification**

A recertification is a new authorization period that may be approved for up a maximum for 180 calendar days when the client meets medical necessary criteria. Recertification requests may be submitted by electronic portal, fax or mail. The client or the client’s responsible adult, physician, and the PPECC provider must agree in writing that the recertification is appropriate for each certification period.

- An updated nursing assessment must be performed by the PPECC RN no more than 30 calendar days before the current authorization period expires. If there is no change in the client’s condition, the POC must document medical necessity to support continued PPECC services.
- A recertification request must be submitted no more than 30 calendar days and no fewer than seven calendar days before a current authorization period will expire. Requests received after the current authorization expires will be denied for dates of service that occurred before the date the request is received.

**Required Documentation for Recertification**

Recertification requests require all of the following documentation:

- A completed CCP Prior Authorization Form signed and dated by the ordering physician within 30 calendar days prior to the SOC date
- An completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care Form signed by the ordering physician, the PPECC RN that completes the POC, and the client and client’s responsible adult within 30 calendar days prior to the SOC date
- A PPECC may also submit the POC on its own form; however, the POC must contain the elements listed in this article under “Initial Authorization Request” requirements
  - The PPECC provider is responsible for ensuring that the ordering physician reviews and signs the POC within 30 calendar days of the expiration of the authorization period
- A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers Form signed and dated by the ordering physician, the RN completing the assessment, and the client or client’s responsible adult within 30 calendar days prior to the SOC date. The nursing addendum must include the following:
  - Updated 24-hour nursing services flow sheet
  - Updated problem list, if applicable
  - Updated rationale summary page
  - A contingency plan
Signed and dated physician and client acknowledgement

- A written order for PPECC services, signed and dated by the client’s ordering physician by the SOC.

**Note:** For authorization purposes, a physician signature on the PPECC plan of care serves as the physician order. However, the physician order, as detailed in “Initial Authorizations,” must be maintained in the client’s medical records.

- Signed and dated consent of the client or client’s responsible adult documenting their choice of PPECC services. The signed consent must include an acknowledgement by the client or the client’s responsible adult that he/she has been informed that their PDN might be reduced as a result of accepting PPECC services. Consent to share the client’s personal health information with the client’s other providers to ensure coordination of care must be obtained.

**Note:** A client signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form meets the client consent requirements.

The provider may request a revision of a recertification at any time during the recertification period. Revisions must follow the instructions outlined under Revisions. The provider must notify TMHP at any time during a recertification period if the client’s condition changes and the authorized services are not commensurate with the client’s medical needs.

**Change in PPECC Provider during an Existing Authorization Period**

If a provider or a client discontinues PPECC services during an existing authorization period and the client requests services through a new PPECC provider, the new PPECC provider must follow all of the processes for submitting documentation for an initial authorization request along with the following:

- A change of provider letter signed and dated by the client or the client’s responsible adult documenting the date the client ended PPECC services with the previous provider as well as the names of the previous and new providers and an explanation of why the client changed providers
- When a new provider submits an authorization request, including all required documentation for an initial request, the authorization will be for no more than 90 calendar days
- Clients may not receive services beyond the limitations outlined in this article

**Termination of Authorizations**

Authorization for PPECC services will be terminated when:

- The client is no longer eligible for THSteps-CPP
- The client no longer meets the medical necessity criteria for PPECC services
- The place of service cannot ensure the health and safety of the client
• The client or the client’s responsible adult refuses to comply with the service plan and compliance is necessary to assure the health and safety of the client

• The client changes providers, and the change of notification is submitted to Texas Medicaid Claims Administrator Prior Authorization Department in writing with a prior authorization request from the new provider

• After receiving PPECC services, the client opts to decline PPECC services and receive his or her services at home. The home health agency or independent provider offering ongoing skilled nursing (e.g., PDN) must submit or update all required documentation to Texas Medicaid Claims Administrator Prior Authorization Department

Appeal of Authorization Decisions

Providers may appeal denials or modifications of requested PPECC services with documentation to support the medical necessity of the requested PPECC services. Appeals must be submitted to TMHP’s CCP department with complete documentation and any additional information within two weeks of the date on the decision letter.

If changes are made to the authorization based on this documentation, CCP claims administrators will go back no more than:

• Three business days for initial or revision requests

• No more than seven calendar days for recertification requests when additional documentation is submitted.

The client or the client’s responsible adult will be notified of any denial or modifications of requested services and will be given information about how to appeal the claims administrator’s decision or to request a fair hearing.

PPECC services may deny when:

• The client does not meet medical necessity criteria for admission

• The client does not have an ordering physician

• The client is not 20 years of age or younger

• The client’s needs are not beyond the scope of services available through Medicaid Title XIX Home Health Skilled Nursing and/or Home Health Aide Services because the needs can be met on a part-time or intermittent basis through a visiting nurse

• The services are primarily intended to provide respite care or child care

• The services are provided for the sole purpose of responsible adult training.

• The signed and dated POC is not received by the claims administrator within 14 business days from the SOC date

• The request is incomplete

• The information in the request is inconsistent

• The requested services are not ongoing skilled nursing skills

• There is a duplication of services
Reimbursement

**Note:** As a reminder, reimbursement for clients enrolled in Medicaid managed care will come from the client's Managed Care Organization (MCO).

The following procedure codes may be reimbursed for services rendered in a PPECC:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Limitations</th>
<th>Billing Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1025</td>
<td>Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental, and psychosocial impairments, per diem</td>
<td>Once per day</td>
<td>Services beyond 4 hours</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>A minimum of 4 hours and 15 minutes of services must be provided before T1025 may be billed</td>
</tr>
<tr>
<td>T1026</td>
<td>Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental, and psychosocial impairments, per hour</td>
<td>4 units a day</td>
<td>Hourly up to 4 hours</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>A minimum of 15 minutes of service is required to round up to a full hour after the first hour</td>
</tr>
<tr>
<td>T2002</td>
<td>Nonemergency transportation, per diem</td>
<td>Once per day</td>
<td></td>
</tr>
</tbody>
</table>

Services begin when the PPECC assumes responsibility for the care of the client (i.e., the point the client boards the PPECC transportation, or when the client is brought to the PPECC by a responsible adult) and ends when the care is relinquished to the client’s responsible adult.

Providers must use the appropriate procedure code for the PPECC service performed. Billing codes 1-T1025 and 9-T2002 are limited to once per day.

The PPECC per diem procedure code (T1025) and hourly procedure code (T1026) may not be billed on the same date of service.

Transportation procedure code T2002 is not allowed without a PPECC service procedure code (T1025 or T1026) on the same day to the same provider.

PPECC services should be billed using a professional claim form (CMS 1500) and are considered an outpatient hospital, provider type 15, provider specialty A4.

PPECC services may be reimbursed only to a licensed PPECC.

**Note:** Texas Medicaid will not reimburse PPECC services that duplicate services that are the legal responsibilities of the school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client’s skilled nursing needs while the client is in school. However, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the Texas Medicaid Claims Administrator.

Parental accompaniment is not required for PPECC reimbursement.
Nonemergency ambulance providers will not be reimbursed for transportation to and from a PPECC.

PPECC services are subject to retrospective review and possible recoupment when the medical record does not document the provision of PPECC services is medically necessary based on the client’s situation and needs. The PPECC provider must explain all discrepancies between the service hours approved and the service hours provided.

Payment will not be rendered for services that are not prior authorized.

The following services may be billed on the same day as PPECC services, but may not be billed simultaneously with PPECC services. These services may be billed before or after PPECC services:

- Private Duty Nursing
- Home Health Skilled Nursing
- Home Health Aide Services

In addition, personal care services (PCS) services rendered in a client's home may be billed before or after PPECC services on the same day. Personal care services (PCS) provided in a PPECC are considered part of the PPECC billable rate.

**Therapy and Hospice Services and Reimbursement When Rendered in a PPECC**

The following services may be rendered at a PPECC, but are not considered part of the PPECC services covered by Texas Medicaid, and must be billed separately by Medicaid-enrolled service providers:

- Speech, physical, and occupational therapies
- Certified respiratory care practitioner services
- Early intervention services provided through the ECI program

When the client’s plan of care indicates that therapy services are required while the client is at the PPECC, clients must be provided a choice in speech, occupational, and physical therapy providers, as well as certified respiratory care providers.

PPECC providers must coordinate care with the following therapy providers to ensure the client receives therapy services required in the PPECC setting:

- ECI service providers
  - Clients from birth to 36 months of age must be given the option of receiving ECI services
  - ECI services are provided by entities that are contracted with the state to provide early intervention services
- Therapy services providers for occupational, speech, and/or physical therapy, or certified respiratory care services
  - Medicaid-enrolled providers contracted with or employed by the PPECC or Medicaid-enrolled providers not employed by or contracted with the PPECC
  - Independent therapists
o Home health therapists;

o Certified respiratory care providers

Therapy services are billed separately by Medicaid-enrolled licensed therapists, including Early Childhood Intervention (ECI) providers, and are subject to prior authorization and requirements for Physical, Occupational, and Speech Therapy-Children (Acute and Chronic) or ECI services, as applicable.

Providers may refer to the following information on PPECC Services:

- “Physical, Occupational, and Speech Therapy Benefits for All Ages to Change for Texas Medicaid September 1, 2017”
- “Benefit Update for Early Childhood Intervention for Texas Medicaid Effective September 1, 2017”
- PPECC Job Aid
- PPECC FAQs

When services are rendered in a PPECC facility, Home Health providers rendering therapy services (PT/OT/ST) and Hospice providers rendering hospice services will be required to bill with the PPECC Facility NPI in the Other A or Other B field (Blocks 78 and 79) on the UB-04 claim form. Respiratory Therapists, Early Childhood Intervention (ECI) providers, and independent PT, OT, and ST providers will be required to bill with the PPECC facility NPI in the facility NPI field (Block 32) on the CMS-1500 when rendering services in a PPECC. If submitting electronically using TexMedConnect, therapy or ECI providers must enter the PPECC facility NPI in the Facility Provider NPI field.

If hospice services are rendered in a PPECC, they must be billed separately by Medicaid-enrolled hospice providers and are subject to prior authorization and requirements for hospice.

The PPECC must have a written agreement for each client regarding the provision of therapy services when therapy services (ECI, occupational, speech, physical, and respiratory care) are provided at the PPECC. Similarly, the PPECC and hospice provider must have a written agreement for each client regarding the provision of hospice services when hospice is provided at the PPECC. These written agreements must address responsibilities of both parties, and how the parties will coordinate related to the client’s plan of care. The written agreements must be kept in the client’s record.

**Transportation**

PPECC transportation services do not require prior authorization. Transportation services needed by a client to access PPECC services must be provided by a PPECC when a client has a stated need or a prescription for transportation to the PPECC. When a PPECC provides transportation to a PPECC client, a registered nurse (RN) or licensed vocational nurse (LVN) employed by the PPECC must be on board the transport vehicle.

The client does not need to be accompanied by the client’s responsible adult when a PPECC provides transportation.
When a client has a stated need or prescription for transportation, the client must be able to utilize transportation services offered by the PPECC with the assistance of a PPECC nurse to and from the PPECC, rather than a nonemergency ambulance.

A nonemergency ambulance may not be utilized for transport to and from a PPECC.

**Note:** A client may decline a PPECC’s transportation and choose to be transported by other means, including the client’s responsible adult.

Providers may refer to the article titled “Update for PPECC Nonemergency Transports in the Ambulance Services Handbook” for more information.

### Transportation Documentation Requirements

The PPECC must sign, date, and indicate the time the client is boarded on PPECC transportation and the time when the client arrives at the PPECC. The PPECC must also sign, date, and indicate the time when the client is boarded for a return trip from PPECC services, as well as the arrival time of the client’s destination.

For any Medicaid client that is in transport for longer than one hour, the PPECC must document the reason for the extended time in transport.

A responsible adult must sign and confirm the time that the client is boarded on PPECC transportation, as well as when a client returns from the PPECC. If a responsible adult provides the transportation, the responsible adult must sign and indicate the time that the client is dropped off and picked up from a PPECC. The PPECC provider must keep these records in case of an audit or monitoring.

### Coordination of Care

PPECC providers must collaborate and coordinate care with the client’s existing service providers including:

- Physicians
- Therapists (occupational, speech, and/or physical)
- Certified respiratory care practitioners
- Home health agencies rendering services such as:
  - Private duty nursing and/or home health skilled nursing
  - Home Health aide services
  - Personal care services
- Hospice, and other providers who render medically necessary services

### Coordination with Private Duty Nursing

PPECC services are intended as an alternative to PDN. However, an admission to a PPECC is not intended to supplant the right of a client to access PDN; personal care services (PCS); home health skilled nursing (HHSN); home health aide (HHA); and occupational, physical, and/or speech therapies, as well as respiratory therapy and ECI services rendered in the client's residence when medically necessary.
When a client or client’s physician notifies the PPECC that the client also receives PDN from a Medicaid-enrolled PDN provider, the PPECC must coordinate services with the PDN provider. Both PDN and PPECC services are considered ongoing skilled nursing. PPECC and PDN services may not be rendered simultaneously. PDN services may be rendered before or after any PPECC services have been provided on the same day.

A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for medically necessary ongoing skilled nursing where PPECC services are available. Skilled nursing services are authorized for a set number of hours based on the client’s medical necessity at the time of the authorization request.

Skilled nursing hours are not expected to increase when the client uses a combination of both PPECC and PDN services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client’s medical needs and additional hours are medically necessary.

- PPECC and PDN providers must collaborate in developing their respective 24-hour flow charts found in the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers Form each time a client’s authorization for ongoing skilled nursing is initiated, renewed and revised.

- Both providers must maintain documentation that the client or the client’s responsible adult has participated in the development of the POC. (The completed PPECC Plan of Care and Nursing Addendum to the Plan of Care for Private Duty Nursing and/or PPECCs, with the client or client responsible adult signatures satisfies the documentation requirement.)

- Both providers must discuss with the client or the client’s responsible adult how care will be coordinated between the two providers.

- When a new service is initiated for ongoing skilled nursing services, and the client wants to receive both PDN and PPECC services, TMHP will compare the Nursing Addendum 24-hour daily care flow sheets and medical necessity documentation.

- Upon subsequent approval of PDN or PPECC services, the provider that submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorization hours reduced to prevent duplication. (e.g., if the client currently has PDN, and then adds PPECC services, the PDN hours will be reduced.)

- When hours are reduced, the PDN or PPECC provider affected by the reduction will be notified by TMHP when the reduction is effective and the revised amount of authorized hours.
  - A revision request from the provider affected by the reduction, with documentation of medical necessity, is required only if there is a change in the client’s medical condition or the client’s medical needs are not commensurate with authorized hours and additional ongoing skilled nursing hours are medically necessary.

**Client Receives both PPECC and PDN Services and Shifts Services from One to the Other**

A client receiving both PPECC and PDN services may choose to shift approved hours from one ongoing skilled nursing provider to another.
The receiving provider (PPECC or PDN provider who will gain hours in the shift) must submit all required documentation for a revision.

The sending provider (PPECC or PDN provider who will lose hours in the shift) will receive a notice from HHSC’s Claim Administrator with revised (decreased) hours and the effective date of the reduction.

- The sending provider does not need to take any action unless there is a change in the client’s medical condition, or the authorized hours are not commensurate with the client’s medical needs, and ongoing skilled nursing hours are medically necessary.

- If there is a medical need for additional ongoing skilled nursing hours, the sending provider may submit a revision request.

The total combined hours between PPECC and PDN services are not expected to increase without client medical necessity for additional hours.

**Documentation Requirements**

In addition to the documentation requirements outlined in the “Authorization Requirements” section of this article, the following documentation requirements apply. Services not supported by documentation are subject to recoupment.

All services outlined in this article are subject to retrospective review to ensure that the documentation in the client’s medical record supports the medical necessity of the service(s) provided.

- PPECC’s must maintain documentation in the client’s medical record, including, but not limited to:
  - Evidence that the client’s condition will allow safe delivery of PPECC services as described in the POC
  - The PPECC nursing assessment
  - The client’s individualized PPECC plan of care and documentation of medical necessity
  - The physician’s specific, written, signed and dated orders for PPECC services. Documentation of verbal orders must also be maintained.

- All prior authorization request forms for Medicaid
- The signed, dated consent of the client or the client’s responsible adult
  - The PPECC must provide documentation that the client or the client’s responsible adult has been informed about how care will be coordinated between the client’s providers (e.g., client signature on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers Form)
  - The PPECC must maintain evidence in the client’s medical record that the client or client’s responsible adult has been involved in the development of the POC (e.g., client signature on the Prescribed Pediatric Extended Care Centers [PPECC] Plan of Care)
- Evidence of PDN provider notification when a client receives PDN, and the date the notification was provided.
- Notes from interdisciplinary team meetings
- Documentation of all discrepancies between the weekly service hours scheduled and the service hours provided. (Examples include client doctor's appointment, PPECC closure for unforeseen reasons, client hospitalization or illness, responsible adult illness preventing usual care at home.)
- For each day that PPECC services are provided, the client's medical record must identify:
  - The name/s of the specific person (e.g., nursing, direct care staff, therapist) providing services
  - Date of service
  - Type of services performed
  - Start and end times of services performed
  - The PPECC must be able calculate the cost of services by practitioner and type of service provided, as requested by HHSC.

To complete a prior authorization process by paper, the provider must complete and submit the prior authorization documentation through fax or mail and must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the PPECC’s place of business.

To complete a prior authorization process electronically, the provider must complete and submit the prior authorization documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the PPECC’s place of business.

The ordering physician must also maintain a copy of the signed and dated physician order and signed and dated POC in the client’s medical record.

PPECC service providers must provide written notice to clients of their intent to voluntarily terminate PPECC services at least fifteen calendar days prior to terminating services, except in situations of a potential threat to the provider’s personal safety.

A responsible adult must be given daily a written, one-page summary of services provided to the client for each day that client is in the PPECC’s care.

The PPECC must maintain documentation of the notification provided to the client and/or the client’s responsible adult of an intent to transfer or discharge the client as follows:
- A copy of the written notification provided
- Personal contact with the client and/or the client’s responsible adult
- The client’s ordering physician was notified of the date of transfer or discharge

The PPECC and the therapy provider must have a written agreement for each client regarding the provision of therapy services when therapy services (occupational, speech, physical, and respiratory care) are provided at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client’s plan of care.

The PPECC and hospice provider must have a written agreement for each client regarding the provision of hospice services when hospice is provided at the PPECC.
The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client’s plan of care.  

**Note:** Refer to *Transportation Documentation in this article.*

## Exclusions

The following services are not included in the PPECC benefit:

- Baby food or formula
- PPECC services to clients related to the PPECC owner by blood, marriage, or adoption
- Services that are intended to provide mainly respite care or child care and do not directly relate to the client’s medical needs or disability
- PPECC services rendered to a client who does not meet the definition of medically or technologically dependent minor
- Services covered separately by Texas Medicaid, such as:
  - Speech, occupational, physical, respiratory therapy services, and early childhood intervention services
  - Durable medical equipment, medical supplies, nutritional products provided to the client by Medicaid’s DME and medical supply service providers
  - Private duty nursing, skilled nursing and home health aide services provided in the home setting when medically needed, in addition to the PPECC services authorized
- Individualized comprehensive case management beyond required service coordination
- Services that are the legal responsibility of a local school district

Providers may refer to the following information on PPECC Services:

- Provider Enrollment on the Portal (PEP) for Prescribed Pediatric Extended Care Center (PPECC) Job Aid
- PPECC Job Aid
- PPECC Webinar on Learning Management System
- PPECC FAQs
- “Updated Texas Medicaid Prior Authorization Forms Now Available on This Website for CCP and Home Health Services”

Providers may also call the TMHP Contact Center at 1-800-925-9126.