PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

NOVEMBER 2022

TEXAS
Health and Human
Services

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

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33.1 Enrollment

To enroll in the Children with Special Health Care Needs (CSHCN) Services Program, Prescribed Pediatric Extended Care Centers (PPECC) providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. The provider must be licensed as a PPECC facility by the Texas Health and Human Services Commission (HHSC). Providers cannot be enrolled if their license is due to expire within 30 days.

Out-of-state PPECC providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

PPECCs may enroll or reenroll as CSHCN Services Program providers by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are responsible not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), Part 1, Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

33.2 Benefits, Limitations, and Authorization Requirements

PPECC services are a benefit of the CSHCN Services Program for medically fragile clients who are 20 years of age and younger who have a chronic medically complex or fragile condition or disability that requires extended and complex skilled nursing interventions and monitoring beyond the level of Home Health skilled nursing and Home Health aide services and require the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living.

Chronic medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy, or

- Other diagnoses which may be considered on a case by case basis

Medically dependent and medically fragile clients live with an ongoing risk of deterioration of their clinical condition, loss of function, risk to health status due to medical fragility and/or death.

PPECCs provide nonresidential facility based care as an alternative to extended skilled nursing services for individuals who require ongoing technology based skilled nursing care to avert death or further disability and who require the routine use of a medical device to compensate for a deficit in a life sustaining body function.

Stable, controlled, or occasional medical conditions that do not require ongoing skilled nursing services do not meet the medical necessity requirements for PPECC services.

Note: *PPECC clients require ongoing skilled nursing services for treatment of chronic conditions which are not expected to resolve in 60 calendar days or less and who require the routine use of a medical device or assistive technology.*

A PPECC offers physician prescribed services that meet the client's medical, nursing, psychosocial, therapeutic, and developmental needs.

PPECC services include the following:

- Skilled nursing services
- Personal care services to assist with activities of daily living
- Functional developmental services
- Nutritional and dietary services including nutritional counseling
- Psychosocial services
- Transportation services needed by a client to access PPECC services (as applicable)
- Caregiver training
- Therapies, i.e., speech, physical, occupational, and certified respiratory care practitioner services

Note: *Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Certified Respiratory Care Practitioner services (CRCP), and hospice services that are provided at the PPECC must be billed separately by CSHCN enrolled service providers.*

Note: *Nonemergency ambulance transports are not reimbursed when the physician prescribes transportation services to and from the PPECC. The client must be able to utilize transportation services provided by the PPECC. A Registered Nurse (RN) or Licensed Vocational Nurse (LVN) employed by the PPECC will be on board the transport vehicle.*

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

PPECC services are limited to 12 hours in a 24 hour period and are limited to 400 hours per calendar year.

CSHCN clients who meet PPECC medical necessity criteria must be stable for outpatient medical services and not present significant risk to other clients or personnel at the center.

PPECC services must be furnished in a manner not primarily intended for the convenience of the client, the client's responsible adult, or the provider.

The CSHCN Services Program will not authorize services that duplicate services that are the legal responsibility of the school districts.

Refer to: Chapter 21, "Home Health Services" for additional information about home health services.

Chapter 22, "Home Health (Skilled Nursing) Care" for additional information about home health skilled nursing care services.

Chapter 13, "Certified Respiratory Care Practitioner (CRCP)" for additional information about CRCP services.

Chapter 37, "Speech-Language Pathology (SLP) Services" for additional information about SLP services.

Chapter 30, "Physical Medicine and Rehabilitation" for additional information about physical and occupational therapy services.

Chapter 23, "Hospice" for additional information about hospice services.

33.2.1 Prior Authorization and Authorization Requirements

Prior authorization is required for PPECC. Prior authorization requests must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form to the TMHP CSHCN Services Program Prior Authorization Department.

Medical necessity documentation must be submitted with the request. To avoid unnecessary denials, the PPECC and the ordering/prescribing physician must submit correct and complete information. Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client as outlined in the Documentation Requirements section of this chapter. All prior authorization requests will be reviewed by the CSHCN Services Program.

Note: *A separate prior authorization is required for therapy, respiratory care, and hospice services.*

Verbal orders are not accepted. The prior authorization form must be signed and dated by the ordering/prescribing physician and the PPECC provider. All signatures must be current, unaltered, original, and handwritten.

To complete the prior authorization process electronically, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through any approved electronic method.

To complete the prior authorization process by paper, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through fax or mail.

33.2.1.1 Initial Prior Authorization Requests

Initial prior authorization requests may be authorized for a maximum of 90 calendar days.

Prior authorization must be obtained before the delivery date or start of care (SOC) of the service.

If the service is medically necessary, provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form, a PPECC Plan of Care, and a PPECC nursing assessment must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program to correct incomplete prior authorization requests.

Note: *PPECC providers may submit a form developed by the PPECC for the POC and the nursing assessment. The forms must contain all criteria specified in this chapter.*

PPECC services will not be authorized when the client is receiving Home Health skilled nursing services or Home Health aide services billed with procedure codes G0299, G0300, and G0156.

Services of a clinical social worker billed with G0155 will not be reimbursed when the client is receiving PPECC services.

Medical nutritional therapy procedure codes 97802 and 97803 and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

Note: *The request for services (as noted above) with language to deny authorization or reimbursement must be reviewed by the CSHCN Services Program before a denial is issued.*

Services must be provided according to an individualized written Plan of Care (POC) which is reviewed, signed, and dated by the ordering/prescribing physician who will provide ongoing supervision of the client and the POC.

The ordering/prescribing physician must be familiar with the client and the client's medical condition(s) and must have examined the client within 30 days prior to initiation of PPECC services.

Physician orders must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form and include the following:

- Client name, date of birth, gender, and CSHCN Services Program identification number
- Ordering/prescribing physician name, address, contact information, National Provider Identifier (NPI) number
- Date client last seen by the ordering/prescribing physician
- Diagnoses and description of current medical condition(s) and documentation of medical necessity that the client requires ongoing extended skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services, and the client has a chronic medically complex or fragile condition, which requires the routine use of medical device or assistive technology.
- Attestation that the client's medical condition is stable and will allow for safe delivery of PPECC services in accordance with the PPECC POC.
- Nursing Services required
- Medication administration, if applicable
- Dietary and nutritional needs
- Permitted activities
- Therapies, if applicable
- Transportation authorization, if applicable
- Other services as needed

The POC must be developed in conjunction with the client and/or the client's responsible adult. A signed and dated copy of the POC must be submitted with the Prior Authorization request. The POC must be signed before the SOC date by the ordering/prescribing physician who ordered PPECC services. The SOC date must be documented in the POC. Providers are required to deliver the requested services from the SOC date agreed to by the ordering/prescribing physician, the PPECC, the client, and/or the client's responsible adult.

An initial nursing assessment that is signed and dated by a PPECC RN must be completed no earlier than three business days before the client's SOC at the PPECC and must be submitted with the PA request. The initial nursing assessment is used to establish the POC and must support medical necessity for the client to receive ongoing skilled nursing care.

The assessment must include but is not limited to the following:

- Complexity and intensity of the client's condition.

- Frequency of the client's need for skilled nursing care.
- Stability and predictability of the client's condition.
- Description of the client's wounds if present.
- Comprehension level of the client and the client's responsible adult.
- Receptivity to training and ability level of the client and the client's responsible adult.
- The client's equipment needs and if the PPECC is adequate to accommodate use of the equipment.
- Identified medical, nursing, psychosocial, therapeutic, nutritional/dietary, functional/developmental, and educational needs and goals and any training needs for the client's caregiver or the client's responsible adult.

The POC must be initiated and signed and dated by a qualified individual, e.g., RN, APRN, PA, or physician employed by the PPECC in coordination with the interdisciplinary team, the client, and/or the client's responsible adult prior to the SOC and include all of the following:

- The client's name, date of birth, gender, CSHCN number, the ordering/prescribing physician's license number, and the PPECC provider's NPI
- Date the PPECC nursing assessment was completed
- The name, title, credentials, and signature of the team member preparing the POC
- Date the client was last seen by the ordering/prescribing physician
- The SOC date for PPECC services, including scheduled days, and hours of attendance
- All diagnoses and known allergies
- Prognosis
- Nursing Services to be provided including amount, duration, and frequency
- The client's mental status
- The types of therapies requested including amount, duration, and frequency including how the therapies are accessed and who will provide the service.
- Equipment and supplies needed
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements including type, method of administration, and frequency
- Medications including dose, route, and frequency
- Treatments including amount and frequency
- Wound care orders and measurements
- Individualized client goals and objectives
- Safety measures to protect against injury
- Method of transportation to the PPECC
- Discharge Plan
- Responsible adult training needs

The PPECC must ensure the requested services are supported by the client assessment, the POC, and the ordering/prescribing physician orders, and the PPECC must maintain the following in the client's medical record:

- A signed consent by the client or the client's responsible adult for PPECC services.
- Emergency contact information.
- A contingency plan for client emergencies and a plan when PPECC services are not available which has been signed by the client or the client's responsible adult.
- List of services the client receives in the home and in the school setting.
- Documentation of interdisciplinary team meetings at least every 90 calendar days or more frequently if there is a change in the client's condition or needs.

  Note: *The PPECC must convene an interdisciplinary conference for the initial development of the POC as well as for any reauthorizations and when the POC is changed.*

- Documentation of the client's and/or the client's responsible adult's participation in the interdisciplinary team meetings.
- Documentation that the client and/or the client's responsible adult has reviewed and agrees with the PPECC POC.
- Transportation needs of the client.

  Note: *If a client or PPECC provider discontinues services during an existing PPECC prior authorization period and the client requests services through a new PPECC provider, the ordering/prescribing physician and the new PPECC provider must submit a new prior authorization form, POC, nursing assessment, and all required documentation as specified under the Initial Prior Authorization section of this chapter before the client's SOC. A change of provider letter is required documenting the date the client ended PPECC services with the previous provider, the name of the new provider, and an explanation why providers were changed. The letter must be signed and dated by the client or the client's responsible adult. A change of provider is treated as a request for initial prior authorization.*

33.2.1.2 Revisions to the POC

The PPECC provider may request a revision to the POC at any time during the prior authorization period due to a change in the client's condition or due to a change in the schedule of the client or the client's responsible adult that affects the amount and duration of PPECC services.

Note: *A prior authorization request for a revision to the POC must fall within the current authorization period. All revision requests will be reviewed by the CSHCN Services Program.*

A nursing reassessment (completed by a PPECC RN) is required when changes in the client's condition occur during the course of the prior authorization period that impact the amount and duration of PPECC services.

Revision requests must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services along with a revised POC and a revised nursing assessment.

The revised POC, nursing reassessment, and new prior authorization request form must be submitted to the TMHP CSHCN Prior Authorization Department as soon as the need is identified but no later than three business days from the date of the revision.

The ordering physician must sign and date the revised POC and prior authorization request form prior to submission to TMHP.

A nursing reassessment, revised POC, and a new prior authorization request form is also required when there is an unexpected change in the client or the responsible adult's schedule even if there is no change in the client's condition. A reason for the revision request must be provided, and medical necessity to support continued PPECC services must be documented on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC services as soon as the need is identified but no later than three business days from the date of the revision request.

Note: *Requests received after the three business days allowed will be denied for dates of service that occurred before the revision is approved.*

The ordering physician must sign and date the new prior authorization request form prior to submission to TMHP.

Note: *Schedule changes that affect previously ordered medical services to the client and a disruption of clinical services provided to the client such as nursing services or therapy services require updated medical orders addressing the client's needs which must be submitted along with the revision request.*

33.2.1.3 Extension of PPECC Services

Requests to extend PPECC services must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services. Extension requests will be reviewed by the CSHCN Services Program.

A current signed and dated copy of the POC and a current nursing assessment must be submitted with the extension request.

Extensions may be granted for up to a maximum of 180 days.

PPECC services must not exceed 400 hours per calendar year.

Extension requests must be received before the end of the current prior authorization period but no sooner than 30 days before and no less than 7 days before the current prior authorization expires.

Note: *Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.*

The ordering/prescribing physician must sign and date the extension request and the POC.

If there is no change in the client's condition the POC must document medical necessity as defined in the Statement of Benefits to support continuing PPECC services.

33.3 Documentation Requirements

In addition to the documentation requirements outlined in the Prior Authorization and Authorization Requirements section the following requirements apply:

- All services outlined in this chapter 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.
- Services not supported by documentation are subject to recoupment.
- The ordering/prescribing physician must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- The PPECC must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- If the client utilizes PPECC transportation the responsible adult must sign, date, and indicate the time that the client was put on the vehicle and must also sign, date, and indicate the time when the client was returned to the responsible adult's care.

- The PPECC must sign, date, and indicate the arrival time of the client at the PPECC and must also sign, date, and indicate the time when the client is put on the vehicle to return the client to their place of residence.
- If a responsible adult provides the transportation, the responsible adult must sign and indicate the date and time that the client is dropped off and picked up from a PPECC. The PPECC provider must document and retain arrival and departure times from the PPECC.

  Note: *The PPECC provider may use any reliable method to record times, dates, and signatures provided that is accurate and allows for an auditable review of the records, including electronic census, timestamp, scanning, and signature records.*
- The PPECC must maintain documentation in the client's medical record 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.
  - Documentation of the personal contact with the client and/or the client's responsible adult.
  - Documentation that the client's prescribing physician was notified of the date of transfer or discharge.

Documentation must be maintained in the client's medical record that a written one page summary of services provided to the client has been provided to the client's responsible adult for each day the client is at the PPECC.

Documentation must be maintained in the client's medical record of all discrepancies between approved weekly service hours scheduled and the service hours provided, (e.g., the PPECC was closed for a day, the client is hospitalized, or the responsible adult's schedule changed).

33.4 Coordination of Services

A PPECC must ensure appropriate coordination of services between the client and providers rendering services to the client (if known by the PPECC) including, but not limited to, Home Health extended skilled nursing, PT, OT, ST, CRCP, and Hospice providers not employed or contracted by the PPECC.

Documentation must be maintained in the client's medical record that reflects coordination of services that includes the effective exchange of information, reporting, and coordination of the client's services.

The PPECC may not duplicate or provide services that conflict with a client's plan of care, or service plan with another provider.

The PPECC and the provider must have a written agreement for the provision of services that will be provided by a Home Health Agency therapist or independent therapist at the PPECC. The written agreement must address how the providers will coordinate care related to the client's POC, (e.g., participation in the client's interdisciplinary team meetings and inclusion in planning activities for the client).

The PPECC, client, and or the client's responsible adult must agree that the provision of services by the provider is appropriate.

The written agreement must include the provider's compliance with PPECC policies and procedures.

33.5 Exclusions

Examples of services not covered under PPECC reimbursement include, but are not limited to, the following:

- Services that have not been prior authorized
- Services that have been requested for the sole purpose of the responsible adult's training needs

- Routine baby food or formula
- PPECC services for clients related to the PPECC owner by blood, marriage, or adoption
- Skilled home health nursing and home health aide services for medical conditions expected to resolve within 60 days or less will not be authorized at the same time PPECC services are authorized.
- Dietary and nutritional counseling services will not be authorized at the same time PPECC services are authorized.
- Services intended to provide respite care or child care
- Services covered separately by the CSHCN Services Program such as:
  - Occupational, speech, physical and certified respiratory care practitioner services
  - Behavioral health services
  - Durable medical equipment (DME), medical supplies, nutritional products provided to the client by a CSHCN DME and/or medical supply providers

33.6 Reimbursement

PPECC services may be reimbursed when billed with procedure codes T1026 and T2002.

Procedure code T1026 is limited to 12 hours per day and to 400 hours per calendar year.

A minimum of 15 minutes of service is required to round up to a full hour for procedure code T1026 after the first hour of service.

Procedure Code T2002 is reimbursed once per day when the PPECC transports the client. Procedure code T2002 is not allowed without a PPECC service procedure code billed on the same day by the same provider.

PT, OT, ST, CRCP services and hospice services require separate prior authorization subject to the prior authorization requirements of CSHCN therapy, certified respiratory care practitioner services and hospice policies. These services may be rendered at a PPECC but are not included in the reimbursement rate for T1026.

> ***Note:*** *Therapy and respiratory care services and hospice services may be provided by CSHCN-enrolled providers contracted with or employed by a PPECC or by CSHCN enrolled providers not employed or contracted with a PPECC.*

All therapy, respiratory care services and hospice services must meet prior authorization and policy requirements as specified by the CSHCN Services Program.

Transportation and the time the client spends in transit to and from the PPECC are billed with procedure code T2002 when the client utilizes PPECC transportation.

Transportation time does not count towards the 400 hour per year limitation.

> ***Note:*** *A nonemergency ambulance may not be billed and will not be reimbursed to transport a client to and from home to a PPECC.*

Services begin when the client is boarded onto PPECC transportation or when the client is brought to the PPECC by the client's responsible adult.

Extended skilled nursing procedure codes S9123 and S9124 may be billed on the same date of service but not at the same time as PPECC services.

33.7 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.