



Florida Medicaid

**Prescribed Pediatric Extended Care Services
Coverage and Limitations Handbook**

Agency for Health Care Administration





CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

March 28, 2007

Dear PPEC Services Provider:

Florida Medicaid revised the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook effective February 2007. The revised handbook includes updated service authorization policies and fee increases. Please use this handbook in place of the October 2003 version, which is now obsolete.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

UPDATE LOG
PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all handbook updates have been received.

Update No. is the number that appears on the front of the update.
Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
New Handbook	March 1996
97-1-Revised Handbook	August 1997
99-1 Replacement Pages	May 1999
Oct2003 Revised Handbook	October 2003
Feb2007 Revised Handbook	February 2007

PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

Chapter/Topic	Page
Introduction	
Handbook Use and Format.....	ii
Characteristics of the Handbook.....	iii
Handbook Updates	iii
Chapter 1 - Purpose, Background, and Program Specific Information	
Purpose and Description.....	1-1
Provider Qualifications	1-2
Provider Requirements	1-3
Chapter 2 - Covered Services, Limitations, and Exclusions	
Requirements to Receive Services.....	2-1
Plan of Care	2-4
Service Authorization	2-6
Covered Services.....	2-8
Service Limitations and Exclusions.....	2-9
Transportation	2-10
Chapter 3 - Procedure Codes	
Reimbursement Information.....	3-2
Appendix A: PPEC Services Fee Schedule.....	A-1
Appendix B: Service Authorization Request.....	B-1

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.</p>
Provider	<p>The term “provider” is used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

CHAPTER 1

PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES PROVIDER ENROLLMENT AND QUALIFICATIONS

Overview

Introduction

This chapter describes the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program and the provider qualifications.

Legal Basis

PPEC services are authorized by Title XIX of the Social Security Act and Code of Federal Regulations, Title 42, Part 440.130. The program was implemented through Chapter 409.905, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

TOPIC	PAGE
Purpose and Description	1-1
Provider Qualifications	1-2
Provider Requirements	1-3

Purpose and Description

Purpose

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable children with medically-complex conditions to receive medical care at a non-residential pediatric center. PPECs provide a cost effective and less restrictive alternative to private duty nursing (PDN) or institutionalization, and reduce the isolation that homebound children may experience.

Private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.

Purpose and Description, continued

Description

A PPEC is a non-residential facility that serves three or more children under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the child's physiological, developmental, nutritional, and social needs.

Medicaid reimburses a PPEC a fixed rate for providing medically-necessary basic services as described in Chapter 59A-13, F.A.C. and 400.902, F.S., which include: nursing services, psychosocial services, developmental therapies, caregiver training, and personal care during the recipient's stay at the center.

Purpose of This Handbook

This handbook is intended for use by PPECs that provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid Program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Provider Qualifications

Licensure

To enroll as a Medicaid provider, a PPEC must be licensed pursuant to Chapter 400, Part VI, F.S., and be in compliance with Chapter 59A-13, F.A.C.

Out-of-State Providers

A PPEC located in Alabama or Georgia that regularly provides services to Florida Medicaid recipients may enroll as an in-state Florida Medicaid provider. All the enrollment requirements that apply to in-state providers apply to Georgia and Alabama providers, except they must have licenses and permits applicable to the state in which they are located.

Note: See the Florida Medicaid Provider General Handbook and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on out-of-state providers and services.

Provider Qualifications, continued

General Enrollment Requirements	PPECs must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook.
--	---

Provider Requirements

General Requirements	In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, PPEC providers are also responsible for complying with the provisions contained in this section.
-----------------------------	---

Provider Responsibility	<p>Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook contains the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.</p>
--------------------------------	---

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Emergency Procedures	<p>Every PPEC must meet, and have available, at a minimum, the following Fire, Safety and Emergency procedures as defined in Chapter 59A-13.022, F.A.C.:</p> <ul style="list-style-type: none"> • A copy of current fire inspection report; • A working telephone; • Emergency telephone numbers posted in the immediate vicinity of all telephones; • A working, appropriately inspected generator; and • An up to date emergency medical kit to provide basic first aid and cardiopulmonary resuscitation. • Emergency transportation must be performed by a licensed E.M.S. provider accompanied by a PPEC staff member.
-----------------------------	---

CHAPTER 2

PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered by the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program, the requirements for service provision, and the service limits and exclusions.

In This Chapter

This chapter contains:

TOPIC	PAGE
Requirements to Receive Services	2-1
Plan of Care	2-4
Service Authorization	2-6
Covered Services	2-8
Service Limitations and Exclusions	2-9
Transportation	2-10

Requirements to Receive Services

Who Can Receive Services

To receive PPEC services, a recipient must meet the following criteria:

- Be Medicaid eligible;
- Be medically complex or medically fragile, per the definitions on page 2-2 of this handbook;
- Be age 20 or under;
- Be medically stable; and
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing supervision due to a medically-complex condition.

Requirements to Receive Services, continued

Definition of Medically Complex

Per 59G-1.010, F.A.C., a person is medically complex if he has a chronic debilitating disease or condition of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, health supervision or intervention.

Definition of Medically Fragile

Per 59G-1.010, F.A.C., a person who is medically fragile is an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

Definition of Medically Necessary or Medical Necessity

Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Note: See 59G-1.010, F.A.C., for the Medicaid definition of medically necessary.

Requirements to Receive Services, continued

Children in Medical Foster Care

Short term PPEC services may be reimbursed by Medicaid in addition to medical foster care (MFC) services if the PPEC services are medically necessary and authorized by Medicaid.

Note: See Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook for specific requirements. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

Recommendation for PPEC Services

An attending physician must order PPEC services before the services begin. The order must be written on letterhead or printed prescription, and must:

- Indicate that PPEC is an appropriate place for care; and
- Specify the duration of PPEC service not to exceed six months. (PPEC services must be reordered every six months.)

An order that includes the above constitutes an attending physician's recommendation for PPEC services and medical necessity. An attending physician must sign and date the order. An attending physician's order recommending a PPEC service is required and must be dated prior to or on the date that services begin.

Medicaid reimbursement for PPEC services is based on the definition for medical necessity on page 2-2 of this chapter. Medicaid has the right to deny more costly services such as private duty nursing ordered by an attending physician when PPEC services are medically appropriate for the child.

The Medicaid physician consultant's signed recommendation will suffice as an order for reimbursement purposes in the event the attending physician refuses a PPEC service without medical justification. However, an attending physician must sign the plan of care.

Approval of Services

PPEC services must be:

- Ordered by an attending physician or the Medicaid physician consultant;
- Outlined in the plan of care that is written by the PPEC center that the recipient will attend; and
- Authorized by Medicaid or an approved designee.

Note: See Service Authorization in this chapter for information on service authorization procedures.

Requirements to Receive Services, continued

Parental Availability

Medicaid can reimburse a PPEC for services rendered to a recipient whose parent or guardian is **not** available or able to care for their child. Examples would be if the parent or guardian is working or attending school, lacks knowledge, ability, or training, or has a medical or mental health condition that would prevent him from providing appropriate care for the child.

Plan of Care

Description

A plan of care (POC) is an individualized written program for a recipient developed by health care professionals, and approved by the recipient's attending physician. The POC is designed to meet the medical, health, and rehabilitative needs of the recipient. The POC is written to cover a specific time frame.

Plan of Care Requirement

After an order has been received from an attending physician, the staff at the PPEC center that the recipient will attend must write a POC for the recipient. A POC is required prior to the first day of PPEC services.

PPEC staff must review the POC every one to six months, depending on the approved authorization period, and make any necessary revisions.

A copy of each POC must be retained in the PPEC's record for the recipient.

Initial Plan of Care Components

The POC must include:

- Recipient's name, date of birth, and Medicaid ID number;
- Nursing services to be provided;
- Medications, treatments and any required equipment;
- Description of current medical condition, including the most specific diagnosis code shown in the current *International Classification of Diseases*;
- Monitoring criteria;
- Monitoring equipment and supplies;
- Diet as indicated and how the recipient is to be fed;
- Methods of demonstrating and teaching, which includes the family or other relevant caregivers;
- How this service will be coordinated with other prescribed services;
- A statement of the recipient's rehabilitation potential;
- Measurable goals;
- Discharge plan; and
- Time limits.

Plan of Care, continued

Renewal Plan of Care Review Components

In addition to the above listed components, the following information must be included in the POC renewal:

- A progress report statement that evaluates the recipient's accomplishments toward measurable goals;
- An assessment of the effectiveness of services provided; and
- Modifications to the plan of care.

Plan of Care Approval

The POC must be signed, credentialed, and dated by a PPEC staff member and the attending physician. The physician's signed POC must be submitted within 30 calendar days from the first day of service for the initial service authorization period, and prior to the first day of the recertification period for ongoing PPEC services.

An attending physician must review, sign, credential, and date the POC every one to six months depending on the approved authorization period.

All signatures on the POC must be legible, credentialed, and dated.

Documentation

Daily and per treatment documentation must be recorded including types of services rendered, progress achieved, and any change in the recipient's status for each day the recipient attends the PPEC. These notes must be written by the health care professional providing the services. Each entry must be signed, credentialed, and dated.

Service Authorization

Description

Service authorization (SA) is the approval process required by Medicaid for reimbursement of PPEC services.

Service authorization will not be granted until all of the required documentation is received by Medicaid or an approved designee.

Requesting Service Authorization

All requests for SA must be in writing. At a minimum, the SA request must include:

- Recipient's name, date of birth and Medicaid ID number;
- Parent's or guardian's name and phone number;
- Referring provider's name and phone number;
- Treating physician's name and phone number;
- Recipient's current health status, including diagnosis codes, and brief medical history;
- Attending physician's orders and unsigned plan of care, or a signed plan of care;
- Procedure code;
- Planned dates of service;
- Units of service requested; and
- Any other documentation requested by Medicaid.

Note: See Appendix B for a suggested SA request form.

Note: See Appendix C of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the area Medicaid offices, and a listing of the counties that they serve. A map of the area Medicaid offices with phone numbers and addresses is also available on Medicaid's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices.

Service Authorization, continued

<p>Service Authorization Documentation Requirements</p>	<p>The PPEC providing care to a recipient must submit the following documentation to the area Medicaid office or an approved designee prior to Medicaid reimbursement, for each request for authorization:</p> <ul style="list-style-type: none"> • A written attending physician’s order, an unsigned POC, and the SA request; or • An attending physician’s signed POC (which will suffice as a physician’s order), and the SA request. <p>If the first option above is used, the PPEC will have 30 calendar days from the first day of service to submit an attending physician’s signed POC, for the initial SA period, to the authorizing area Medicaid office or an approved designee. If the first option is used, the POC that is submitted within the 30 calendar days must be signed by the same physician who originally ordered the PPEC services, or an attending physician.</p> <p>For ongoing PPEC services, a physician’s signed POC must be submitted with the SA request prior to the first day of the recertification period, and will act as the ongoing order.</p>
<p>Where to Submit</p>	<p>The provider must submit the written SA request and supporting documentation to the area Medicaid office or an approved designee that serves the county where the recipient lives.</p>
<p>Approval Process</p>	<p>A service authorization nurse in the area Medicaid office or an approved designee will review each request for completion of all required documentation necessary for Medicaid SA. The area Medicaid office or an approved designee will send the PPEC an SA verification letter with the status of the request.</p>
<p>Approved Requests</p>	<p>An approval letter for service authorization contains an SA number for billing and a time period for the approval (up to six months).</p> <p>An approved authorization is not a guarantee that Medicaid will reimburse the service. The provider and recipient must both be eligible on the date of service, and the service must not have exceeded any applicable service limits.</p>

Service Authorization, continued

Submission of a Service Authorization Claim for Payment

PPEC providers should submit a claim for payment for a service-authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the SA number on the claim form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on completing the claim form.

Reauthorization of Services

The PPEC must submit a written SA request and a physician's signed POC every one to six months depending on the authorization period for which the services were approved. Medicaid or an approved designee will review the recipient's renewed POC. If the services continue to be medically necessary, appropriate, and the documentation is complete, Medicaid or an approved designee may reauthorize the services.

Covered Services

Introduction

Medicaid reimburses PPECs for the following services:

- Basic services as defined below;
- Personal care services as defined below; and
- One or more meals and snack(s) depending on the child's length of stay.

The recipient must furnish all durable medical equipment (DME) and medical supplies that are provided to the recipient by the Medicaid DME and Medical Supply Services Program.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at: <http://floridamedicaid.acs-inc.com>. Click on Provider Support and then on Handbooks.

Definition of Basic Services

According to Chapter 400.902, F.S., basic services include the following: development, implementation and monitoring of a comprehensive protocol of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required by the child as well as the caregiver training needs of the child's legal guardian.

Covered Services, continued

Definition of Personal Care	Per 59G-1.010, F.A.C., personal care is defined as medically-necessary assistance with daily living activities.
------------------------------------	---

Service Limitations and Exclusions

Reimbursement Limitations	<p>Medicaid reimbursement for PPEC services is limited to:</p> <ul style="list-style-type: none"> • One unit of service per recipient, per day, for a full day; or • Up to four (4) units of service for a partial day. <p>Reimbursement cannot be made for a full day PPEC and any part of a partial day PPEC service on the same date of service, for the same recipient.</p> <p><u>Note:</u> See Units of Service in Chapter 3 for the definitions of unit of service for a full day and a partial day.</p>
Excluded Services	<p>The Medicaid PPEC rate does not include the following services:</p> <ul style="list-style-type: none"> • Baby food or formulas; • Total parenteral and enteral nutrition; or • Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, child life, and psychological services.
Relatives	<p>Medicaid cannot reimburse a PPEC for services rendered to a recipient who is related to the owner by blood, marriage, or adoption.</p>
DME and Medical Supplies	<p>Medicaid cannot reimburse a PPEC for durable medical equipment and medical supplies that are provided to the recipient by the Medicaid DME and Medical Supply Services Program.</p>
Other Medicaid Services	<p>PPECs that provide Medicaid services that are not covered in the PPEC rate must be enrolled as a Medicaid provider of those services and follow the reimbursement requirements as specified in the provider handbook for the specific service.</p>

Transportation

**Medicaid
Transportation**

The Agency for Health Care Administration (AHCA), Division of Medicaid contracts with a vendor to administer the provision of Medicaid Non-Emergency Medical Transportation (NEMT) services to eligible Medicaid recipients statewide. PPEC providers may provide NEMT services if they have the capability to provide the medically-necessary care required by medically-fragile children, and they have a contract to provide transportation with the transportation vendor's Community Transportation Coordinator in their county.

NEMT providers allow a PPEC to provide an escort during transportation of the child at no additional charge. If a child requires a PPEC escort, the PPEC escort can be picked up from or returned to a different location than the recipient. If a PPEC escort is picked up from a different location from the recipient, the escort must be picked up prior to the recipient and dropped off after the recipient.

NEMT services are available to eligible Medicaid recipients and an escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy. The NEMT provider will confirm the eligibility and determine the appropriate mode of transportation through an established gatekeeping process.

CHAPTER 3 PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES PROCEDURE CODES

Overview

Introduction

This chapter lists the procedure codes and maximum fees that Medicaid reimburses for Prescribed Pediatric Extended Care (PPEC) services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level II. The codes are part of the standard code set described in HCPCS Level II book. Please refer to the HCPCS Level II book for complete descriptions of the standard codes. Level 2 codes are national codes usually used to describe medical services and supplies. They are distinguished from Level I codes by beginning with a single letter (A through V) followed by four numeric digits.

In compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

Diagnosis Codes

Diagnosis codes are found in the International Classification of Diseases, Clinical Modifications (ICD-9-CM). A diagnosis code is required on the CMS-1500 claim. The most specific code, including fourth and fifth digits, when available, must be used.

Reimbursement Information, continued

Units of Service

Medicaid reimburses PPEC services a fixed rate based on the number of hours per day that the recipient attends the PPEC. There are two reimbursement rates, one for a full day, up to twelve (12) hours, and one for a partial-day of services billed per hour up to four (4) hours.

Note: See Appendix A in this handbook for the procedure codes, descriptions, and maximum fees that are reimbursed by Medicaid.

Definition of Day of Service

A full day of service is more than four (4) hours, but not more than twelve (12) hours. A partial-day of service is four (4) hours or less billed in increments of one (1) hour units. Any portion of the hour of service is rounded up to a full hour for billing purposes.

For reimbursement purposes, PPEC services begin when the PPEC staff assumes responsibility for the care of the child and ends when care is relinquished to the parent or guardian.

APPENDIX A
PPEC SERVICES FEE SCHEDULE

<u>Procedure codes effective for dates of service from October 16, 2003 to July 1, 2006</u>		
CODE	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1025	Full-Day PPEC Services (over four hours up to twelve hours per day)	\$160.05
T1026	Half-Day PPEC Services (four hours or less per day billed in units of one hour each unit with any fraction of hour rounded up to full hour)	\$20.61

<u>Procedure codes effective for dates of service on or after July 1, 2006</u>		
CODE	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1025	Full-Day PPEC Services (over four hours up to twelve hours per day)	\$176.05 per day
T1026	Partial-Day PPEC Services (four hours or less per day billed in units of one hour each unit with any fraction of an hour rounded up to full hour)	\$22.67 per hour



APPENDIX B

SERVICE AUTHORIZATION REQUEST

RECIPIENT: _____

DATES OF SERVICE: FROM: ____/____/____ TO: ____/____/____

MEDICAID I.D. NUMBER: _____ RECIPIENT D.O.B.: ____/____/____

PARENT/GUARDIAN: _____ PHONE: _____

REFERRING PROVIDER NAME: _____ PHONE: _____

TREATING PHYSICIAN NAME: _____ PHONE: _____

PRIMARY DIAGNOSIS: _____ ICD-9: _____

SECONDARY DIAGNOSIS: _____ ICD-9: _____

BRIEF MEDICAL HISTORY:

CURRENT STATUS:

PHYSICIAN'S ORDERS/TREATMENT PLAN (PROVIDE FREQUENCY, DURATION, AND PROVIDER TYPE FOR SERVICES REQUIRED):

PROCEDURE CODE	DESCRIPTOR/ REQUIREMENTS	UNITS OF SERVICE	CUSTOMARY FEE CHARGED
----------------	--------------------------	------------------	-----------------------

PROVIDER NAME: _____ PROVIDER NUMBER: _____

PHONE: _____

CARE COORDINATOR: _____ PHONE: _____



Charlie Crist
Governor

Andrew C. Agwunobi, M.D.
Secretary

2727 Mahan Drive
Tallahassee, FL 32308

<http://ahca.myflorida.com>