Texas Children's	Prescribed Pediatric Extended Care Center (PPECC)	
Guideline # 11219	***Categories*** Clinical →Care Management CM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Bhavana Babber

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all Prescribed Pediatric Extended Care Center requests.

DEFINITIONS:

Prescribed Pediatric Extended Care Center (PPECC) services are those provided in a non-residential facility licensed by HHSC. PPECCs serve four or more medically dependent or technologically dependent members who are 20 years of age or younger and who require ongoing skilled nursing prescribed by the member's physician to avert death or further disability or require the routine use of a medical device to compensate for a deficit in life-sustaining body function.

GUIDELINE

1. All requests for prior authorization for PPECC services are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

2. . The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports PPECC services as an eligible service.
3. PPECC services may be a benefit of the Texas Health Steps (THSteps) Comprehensive Care Program (CCP) for Medicaid members who are:

   3.1 20 years of age and younger;

   3.2 THSteps - CCP eligible;

   3.3 Medically or technologically dependent; ***Note:*** *The term "medically dependent or technologically dependent member" 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.

3.4 Have an acute or chronic condition;

3.5 Require ongoing skilled nursing care beyond the level of Skilling Nursing (SN) visits normally authorized under Texas Medicaid Home Health Skilled Nursing (HHSN) and Home Health Aide (HHA) Services;

3.6 Meet the medical necessity criteria for admission to a PPECC detailed in the authorization and medical necessity requirements, including a prescription from the member's ordering physician, and;

3.7 Have chosen to receive PPECC services.

3.8 A PPECC does not provide emergency services. PPECCs must follow the safety provisions in state PPECC licensure requirements, including the adoption and enforcement of policies and procedures for a member's medical emergency. PPECCs must call for emergency transport to the nearest hospital when emergency services are needed by a PPECC member.

4 Services, Benefits, and Limitations

4.1 PPECC services are provided in a non-residential facility licensed by HHSC. PPECCs serve four or more medically dependent or technologically dependent members who are 20 years of age or younger and who require ongoing skilled nursing prescribed by the member's physician to avert death or further disability or require the routine use of a medical device to compensate for a deficit in life-sustaining body function.

4.2 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).

4.2.1 When the services duplicate, PPECC services must be a one-to-one replacement of private duty nursing (PDN) hours, unless additional hours are medically necessary.

4.3 Members 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 member. **A face-to-face evaluation must be performed each year by the ordering physician for each member.** A physician order is required for each authorization period including initial, revisions, and recertification. 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 member's treating physician and has examined the member outside of the PPECC setting.

5 PPECC services are not intended to supplant the right of a member to access private duty nursing (PDN), personal care services (PCS), home health skilled nursing (HHSN), home health aide (HHA), and therapies (PT, OT, ST), as well as certified respiratory care practitioner services and early childhood intervention (ECI) services rendered in the member's residence when medically necessary.

5.1 PPECC providers must collaborate and coordinate care with the member's existing service providers, including physicians, therapists, certified respiratory care practitioners, and 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.

5.1.1 When a member has a stated need or prescription for transportation, the member 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 non-emergency ambulance.

5.2 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:

5.2.1 Speech, physical, and occupational therapies

5.2.2 Certified respiratory care practitioner services

6 PPECC services must be:

6.1 Individualized, specific, and consistent with symptoms or confirmed diagnosis of the condition, illness or injury under treatment, not in excess of the member's needs;

6.2 Consistent with generally accepted professional medical standards as determined by the Medicaid program and may not be experimental or investigational;

6.3 Reflective of the level of service that can be safely and effectively furnished;

6.4 Furnished in a manner not primarily intended for the convenience of the member, the member's responsible adult, or the provider.

Note: *The fact that a member'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 covered service.*

7 Prior Authorization and Documentation Requirements

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

7.2 Documentation of medical necessity is required for PPECC services.

PPECC services are considered medically necessary when a member meets all of the following admission criteria:

7.2.1 Eligible for THSteps-CCP;

7.2.2 20 years of age or younger;

7.2.3 Requires ongoing skilled nursing care and supervision, skillful observations, judgments and therapeutic interventions all or part of the day to correct or ameliorate health status.

7.3 Considered to be a medically dependent or technologically dependent member in accordance with Texas Health and Safety Code chapter 248A;

7.4 Stable for outpatient medical services, and does not present significant risk to other members or personnel at the PPECC;

7.5 Requires ongoing and frequent skilled interventions to maintain or ameliorate health status, and delayed skilled intervention is expected to result in:

7.5.1 Deterioration of a chronic condition;

7.5.2 Loss of function;

7.5.3 Imminent risk to health status due to medical fragility; **Or**

7.5.4 Risk of death.

7.6 Has a prescription for PPECC services signed and dated by an ordering physician within 30 calendar days prior to admission who has personally examined the member and reviewed all appropriate medical records;

7.7 Has consent for the member's admission to the PPECC signed and dated by the member or the member's responsible adult. Admission must be voluntary and based on the preference for PPECC services in place of PDN by the member or member's responsible adult.

7.8 Resides with the responsible adult and does not reside in any 24-hour inpatient facility, including the following:

7.8.1.1.1 General acute hospital

7.8.1.1.2 Skilled nursing facility

7.8.1.1.3 Intermediate care facility

7.8.1.1.4 Special care facility, including sub-acute units or facilities for the treatment of AIDS.

7.9 When the sole purpose of PPECC services is to train and educate the member's responsible adult or the member (e.g., how to administer total parenteral nutrition (TPN) or how to manage a chronic condition), **PPECC services will not be approved.**

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

8 Initial Authorization Requests

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

8.2 Consistent with PPECC licensure requirements, an initial nursing assessment must be completed, signed and dated by the PPECC Registered Nurse (RN) no earlier than 3 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 member to receive on-going skilled nursing care. The assessment must include, but is not limited to the following:

8.2.1 Complexity and intensity of the member's care;

8.2.2 Stability and predictability of the member's condition;

8.2.3 Frequency of the member's need for skilled nursing services;

8.2.4 Identified medical, nursing, psychosocial, therapeutic, nutritional, dietary, functional, educational, and developmental needs and goals, and any training needs for the member or the member's responsible adult;

8.2.5 Description of wounds, if present;

8.2.6 The member's equipment needs and whether the setting can support the health and safety needs of the member and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the member;

8.2.7 The comprehension level of the member's responsible adult; and receptivity to training and ability level of the responsible adult.

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

8.2.9 A completed CCP Prior Authorization Request form signed and dated by the ordering physician.

8.2.10 A completed Prescribed Pediatric Extended Care Center (PPECC) Plan of Care (POC) form signed and dated by the ordering physician, the PPECC RN completing the POC, and member or member's responsible adult.

8.2.11 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, RN completing the assessment, and member or member's responsible adult. This completed form must include:

8.2.11.1 Updated problem list

8.2.11.2 Updated rationale and summary page

8.2.11.3 A contingency plan

8.2.11.4 A 24-hour daily care flow sheet

8.2.11.5 Physician and member acknowledgment

8.2.11.6 An order for PPECC services from the ordering physician.

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

8.2.11.8 Ordering physician signature and date of signature

9 Revisions to the Plan of Care

9.1 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 member's condition, or the authorized services are not commensurate with the member's medical needs and additional authorized hours are medically necessary.

9.2 When a member'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 member's condition.

9.3 Revisions require all the following documentation:

9.3.1 A completed CCP Prior Authorization Request form signed and dated by the ordering physician.

9.3.2 An updated Prescribed Pediatric Extended Care Center (PPECC) Plan of Care form signed and dated by the ordering physician, the PPECC RN completing the POC, and member's or member's responsible adult.

9.3.3 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, RN completing the assessment, and member's or member's responsible adult.

10 PPECC Provider Change During an Existing Authorization Period

10.1 If a provider or member discontinues PPECC services during an existing prior authorized period and the member requests services through a new PPECC provider, the new PPECC provider must follow all of the processes and submit documentation required for an initial request, as well as the following:

10.2 **A change of provider letter signed and dated by the member's or member's responsible adult** documenting the date the member ended PPECC services (effective date of the change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

10.3 When the new provider submits an authorization request, including all required documentation for an initial request, it will be authorized for no more than 90 calendar days. Regardless of the number of provider changes, members may not receive PPECC services beyond the limitations outlined in this section.

11 Recertification

11.1 A recertification is a new authorization period that may be approved for up to a maximum of 180 calendar days when the member meets medical necessity criteria.

11.2 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 member's condition, the POC must document medical necessity to support continued PPECC services.

11.3 The following documentation is required for a recertification request:

11.3.1 A completed CCP Prior Authorization Request form signed and dated by the ordering physician within 30 calendar days prior to the SOC date.

11.3.2 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 member or member s responsible adult within 30 calendar days prior to the SOC date. A PPECC may also submit the POC on their own form, but the POC must contain the elements listed under “Initial Authorization Request” requirements in this section.

11.3.3 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 and this documentation must be maintained in the member s record.

11.3.4 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, RN completing the assessment, and member or member’s responsible adult within 30 calendar days prior to the SOC date. The addendum must include an updated 24-hour nursing services flow sheet and if there are changes, an updated problem list, and updated rationale summary page, a contingency plan, and a signed physician and member acknowledgment.

11.3.5 A written order for PPECC services signed and dated by the member’s ordering physician. A physician’s order must be in place by the SOC.

11.3.6 Signed, dated consent of the member or member’s responsible adult documenting their choice of PPECC services. The signed consent must include an acknowledgment by the member or the member’s responsible adult that he/she has been informed that other services such as private duty nursing might be reduced as a result of accepting PPECC services. Signed and dated consent to share the member’s personal health information with the member’s other providers, as needed to ensure coordination of care, must also be obtained.

11.3.7 The provider may request a revision of a recertification at any time during the recertification period. Revisions must follow the instructions outlined under Revisions in this section.

12 Termination of Authorizations

12.1 Authorization for PPECC services will be terminated when:

12.1.1 The member is no longer eligible for THSteps-CCP.

12.1.2 The member no longer meets the medical necessity criteria for PPECC services.

12.1.3 The place of service cannot ensure the health and safety of the member

12.1.4 The member or the member's responsible adult refuses to comply with the service plan and compliance is necessary to assure the health and safety of the member.

12.1.5 The member changes providers, and the change of notification is submitted to the claims administrator in writing with a PA request from the new provider.

12.1.6 After receiving PPECC services, the member 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 authorization documentation to the claims administrator.

13 PPECC services may be denied when:

13.1 The member does not meet medical necessity criteria for admission.

13.2 The member does not have an ordering physician.

13.3 The member is not 20 years of age or younger.

13.4 The member's needs are not beyond the scope of services available through Medicaid Title XIX Home Health SN and/or HHA Services because the needs can be met on a part-time or intermittent basis through a visiting nurse.

13.5 The services are primarily intended to provide respite care or child care.

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

13.7 The request is incomplete.

13.8 The information in the request is inconsistent.

13.9 The requested services are not ongoing skilled nursing services.

13.10 There is a duplication of services.

13.11 PPECC services rendered to a member who does not meet the definition of a medically or technologically dependent minor.

13.12 Services covered separately by Texas Medicaid, such as:

13.12.1 Speech, occupational, physical, respiratory therapy services, and early childhood intervention services.

13.12.2 Durable medical equipment (DME), medical supplies, nutritional products provided to the member by Medicaid's DME and medical supply service providers.

13.12.3 Private duty nursing, skilled nursing and home health aid services provided in the home setting when medically needed in addition to the PPECC services authorized.

13.12.4 Services that are the legal responsibility of a local school district.

13.12.5 Individualized comprehensive case management beyond required service coordination.

14 Claims Filing and Reimbursement

14.1 PPECC services may be reimbursed when billed with procedure codes T1025, T1026, or T2002.

14.2 Providers must use appropriate procedure codes for the PPECC services performed. Procedure codes T1025 and T2002 are limited to once per day.

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

14.4 Procedure code T1026 is allowed on an hourly basis, up to four hours. Services beyond four hours must be billed using T1025. At a minimum, four hours and fifteen minutes of services must be provided before T1025 may be billed.

14.5 Procedure code T2002 is not allowed without a PPECC service on the same day, same provider.

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

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

14.8 If hospice services are rendered in a PPECC setting, they must be billed separately by Medicaid-enrolled hospice providers, and are subject to prior authorization and policies governing hospice reimbursement.

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

14.9.1 Private Duty Nursing

14.9.2 Home Health Skilled Nursing

14.9.3 Home Health Aide services

14.9.4 PCS services provided in a PPECC are considered part of the PPECC billable rate. PCS services rendered in a member's home may be billed before or after PPECC services on the same day.

14.10 ***Note:*** *Texas Medicaid will not reimburse PPECC services that duplicate services that are the legal responsibility of the school districts. The school district, through the SHARS program, is required to meet the member's skilled nursing needs while the member is at school. However, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted for consideration.*

14.11 Non-emergency ambulance service providers will not be reimbursed for transportation to and from a PPECC.

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

15 .Requests that do not meet the criteria established by this procedure will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

16. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment

REFERENCES:

Peer Reviewed Publications:

Government Agency, Medical Society, and Other Publications:

Texas Medicaid Provider Procedures Manual: Children's Services Handbook. (Accessed August 1, 2021) https://www.tmhp.com/resources/provider-manuals/tmppm

Star Kids Handbook, Texas Health and Human Servcies: Prescribed Pediatric Extended Care Centers (Accessed August 1, 2021) https://www.hhs.texas.gov/laws-regulations/handbooks/skh/star-kids-handbook

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