REIMBURSEMENT

Reimbursement for PDHC services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified recipient attends the PDHC facility. Transportation to the facility will be reimbursed separately.

- A full day of service is more than four hours, not to exceed a maximum of 12 hours per day.
- A partial day of service is equal to four hours or less per day.

Reimbursement shall only be made for services authorized by the Medicaid Program or its approved designee.

Where to Submit

Each request for PDHC must be submitted to the fiscal intermediary who will review each request for completion of all required documentation.

Approval Process

An approval letter for prior authorization will be sent to the recipient, case manager, and PDHC facility. The approval letter will include a prior authorization (PA) number for billing and a time period for the approval.

Approved Requests

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 exceed the weekly approved hours.

Prior Authorization/Claim for Payment

PDHC providers should submit a claim for payment for prior authorized services once the service has been provided.

In order to receive reimbursement for the service, the provider must enter the PA number on the claim form. Services provided without authorization shall not be considered for reimbursement, except in the case of retroactive Medicaid eligibility. Services should be billed on the CMS-1500 Form.

Renewal of Prior Authorization/Claim for Payment

For continuation of services, a revised Plan of Care (POC) including an evaluation of the child's accomplishments toward goals and the assessment of the effectiveness of the PDHC services shall be provided. In addition, a Prior Authorization request (PA 16) shall be provided.
The fiscal intermediary will review forms and determine if the services continue to be medically necessary, appropriate and the documentation is complete. A decision will be made to reauthorize the services. A face-to-face evaluation between the physician and recipient shall be required at least once a year.