REIMBURSEMENT

Reimbursement for pediatric day health care (PDHC) services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified beneficiary attends the PDHC facility. Transportation to the facility will be reimbursed separately.

- A full day of service is more than six hours, not to exceed a maximum of 12 hours, per day and reimbursed on a per diem basis.

- A partial day of service is equal to six or less hours per day and reimbursed on an hourly basis.

Reimbursement shall only be made for services that have been prior authorized by the Medicaid Program, its approved designee or managed care organization (MCO).

Prior Authorization

PDHC services must be prior approved by the fiscal intermediary's Prior Authorization Unit (PAU) or the MCO. Prior authorization (PA) requests to the fiscal intermediary's PAU should include the following:

- PA Request form;

- PDHC Physician Order and Plan of Care form;

- PDHC PA Checklist indicating the beneficiary's skilled nursing care requirements; and

- Medical records to support orders and plan of care (needed to establish medical necessity).

Necessity for PDHC services will include consideration of all services the beneficiary may be receiving, including waiver services and other community supports and services. These services must be reflected and documented in the beneficiary's treatment plan.

The beneficiary's parent/guardian, PDHC facility and case manager, if applicable, will receive a written notification informing them of approval or denial of the request. If services are approved, the notice will include the approval period.

NOTE: An approved prior authorization is not a guarantee that Medicaid will reimburse the service. The provider and beneficiary must both be eligible on the date of service, and the service must not exceed the weekly approved hours.

Questions concerning the PA process should be directed to the PAU or the MCO (see Appendix D for contact information).

Renewal of Prior Authorization

Re-evaluation of PDHC services must be performed, at a minimum, every 90 days. At the discretion of the physician prior authorizing PDHC services, exceptions to the 90-day standard may be made. Services shall be revised during evaluation periods to reflect accurate and appropriate provision of services for current medical status. This evaluation must include:

- A review of the beneficiary's current medical plan of care (POC);
- A provider agency documented current assessment and progress toward goals;
- Documentation of a face-to-face evaluation between the prescribing physician and beneficiary which shall be held every 90 days (In exceptional circumstances, at the discretion of the physician prior authorizing PDHC services, the face to face evaluation requirement may be extended to 180 days.);
- A completed prior authorization form; and
- A completed prior authorization checklist indicating the beneficiary's skilled nursing care needs.

The fiscal intermediary or MCO will review the forms to determine the documentation is complete and that services continue to be medically necessary and appropriate to reauthorize the services. A notification of the decision will be sent to the beneficiary, PDHC facility and case manager, if applicable.

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 prior authorization shall not be considered for reimbursement. Services should be billed as described by the fiscal intermediary or MCO.