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 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 that have been prior authorized by the Medicaid Program or its approved designee.

Prior Authorization

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

- PA Request form;
- PDHC Physician Order and Plan of Care form;
- PDHC PA Checklist; and
- Any additional supporting medical documentation.

Upon receipt of the request, the PAU will:

- Assign each request a unique PA number,
- Review each request for completion of all required documentation, and
- Determine the recipient's necessity for PDHC services.

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

The recipient, case manager and PDHC facility 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 recipient 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 (see Appendix D for contact information).

Renewal of Prior Authorization

Re-evaluation of PDHC services must be performed, at a minimum, every 120 days. 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 recipient'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 recipient shall be held every four months, and
- A completed "Request for Prior Authorization" PA-16 Form.

The fiscal intermediary 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 recipient, case manager, and PDHC facility.

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, except in the case of retroactive Medicaid eligibility. Services should be billed on the CMS-1500 Form.