AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	**Pediatric Day Health Care**	Page:	1 of 23
Department:	**Medical Management**	Policy Number:	A-LA XXXX
Subsection:		**Effective Date:**	**Pending**
Applies to:	■ **Medicaid Health Plans**		

PURPOSE:

The purpose of this policy is to describe Aetna Better Health's process prior authorization decision-making for pediatric day healthcare services.

STATEMENT OF OBJECTIVE:

The objectives of the policy are to assure appropriate authorization of services for pediatric day healthcare including:

- **Documentation requirements**
- **Certification period**
- **Parental/guardian consent**
- **Durable medical equipment**
- **Medication**
- **Transportation**
- **Pediatric day healthcare transportation/contracted transportation**
- **Pediatric day healthcare facility**

DEFINITIONS:

Aetna Medicaid Medical Management (Aetna Medicaid MM)	**Provides oversight, support and resources to the Aetna Medicaid health plans. MM teams assist health plans. MM teams assist health plans with problem-solving, development of solutions, best practice dissemination and development of key systems, policies and processes.**
Aetna Medicaid Medical Management (MM) Chief Medical Officer	**A full-time physician who is board certified with an active unencumbered license and who serves as the lead for the Aetna Medicaid MM unit.**
Medically Complex Condition	**A medically complex condition involves one or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional, registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health**

	status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life.
Medically Necessary/Medical Necessity	**Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service and meets 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, more integrated 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 covered service.** **Note: As defined in the Louisiana Medicaid Program Manual, Chapter 45: Pediatric Day Health Care**

National Committee for Quality Assurance (NCQA)	**A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans.**
Peer-to-peer consultation	**A discussion between a requesting practitioner and a medical director/physician reviewer concerning a denial of coverage based on medical necessity. The discussion may occur before or after the medical necessity decision. A peer-to-peer review is optional and is not part of or a prerequisite for an appeal.**
Practitioner Reviewer	**A physician or dentist who conducts utilization review on behalf of an Aetna Medicaid health plan. The reviewer can be either employed by the health plan or contracted by the health plan to perform utilization review. This does not include individuals who are employed or contracted by entities to which a health plan has delegated utilization management decision-making.**

LEGAL/CONTRACT REFERENCE:

- **RFP# 305PUT-LDHRFP-BH-MCO-201-MVA, Section 8.**
- **Louisiana Medicaid Services Manual, Chapter 45 – Pediatric Day Health Care Provider Manual**
- **National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans**

FOCUS/DISPOSITION:

Aetna Medicaid confirms decisions associated with the utilization review of pediatric day health care are in compliance with the Louisiana Medicaid Program Manual.

Responsibilities[1]

The chief medical officer (CMO) is responsible for directly overseeing the prior authorization of pediatric day health care services. Aetna Better Health develops and

[1] **NCQA HP 2018/2019 UM1 B, C**

maintains policies and procedures relative to pediatric day health care services and will assure the decision making of pediatric day health care services are in compliance with the Louisiana Medicaid Services Manual, Chapter 45. The prior authorization department is primarily responsible for carrying out the day-to-day operations (e.g., evaluating requests, documenting requests and decisions, and issuing authorization numbers for approved requests) under the supervision of a medical director or designated licensed clinical professional qualified by training, experience, and certification/licensure to conduct the utilization (UM) functions in accordance with the Louisiana Medicaid Services Manual, Chapter 45. Departments with authority to authorize services will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and service authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name; and upon request, verbally inform member, facility personnel, the attending physician and other ordering practitioners/providers of specific UM requirements and procedures. Aetna Better Health must triage incoming standard and expedited requests for services based upon the need for urgency due to the member's health condition. Aetna Better Health must identify the qualification of staff who will determine medical necessity.[2]

Nonclinical staff is responsible for:[3]

- **Documenting incoming prior authorization requests and screening for member's enrollment, member eligibility, and practitioner/provider affiliation**
- **Forwarding to clinical reviewers any requests that require a medical necessity review**

[2] RFP # 305 PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.1.13
[3] NCQA HP 2018/2019 UM4 A2

Clinical reviewer's responsibilities include:[4]

- **Identifying service requests that may potentially be denied or reduced on the basis of medical necessity**
- **Forwarding potential denials or reductions to the CMO or designated medical director for review**
- **If services are to be denied or reduced:**
  - **Providing written notification of denials/reductions to members**
  - **Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within the applicable time frame**
  - **Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module**

Medical Director Reviewer Responsibilities

Authorization requests that do not meet Louisiana Medicaid Services Manual, Chapter 45 for pediatric day health care services will be presented to the medical director for review. The medical director will make a medical necessity decision using clinical judgment to approve or deny the request while maintaining compliance with the Louisiana Medicaid Services Manual, Chapter 45.

Prior Authorization of Pediatric Day Health Care[5]

The Medicaid Pediatric Day Health Care (PDHC) program is designed to provide an array of services to meet the medical, social and developmental needs of children from birth up to 21 years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extended in- home nursing care. PDHC does

[4] **NCQA HP 2018/2019 UM4 A1-2**
[5] **Louisiana Medicaid Services Manual, Chapter 45 – Pediatric Day Health Care Provider Manual**

not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care. All PDHC services must be prior authorized. Services may be provided seven days a week and up to 12 hours per day for qualified Medicaid recipients as documented in the plan of care.

PDHC is intended to be for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting.

The pediatric day health care (PDHC) facility Medicaid per diem rate includes the following services/equipment:

- **Nursing care;**
- **Respiratory care;**
- **Physical therapy;**
- **Speech-language therapy;**
- **Occupational therapy;**
- **Social services;**
- **Personal care services (activities of daily living); and**
- **Transportation to and from the PDHC facility. Transportation shall be paid in a separate per diem.**

PDHC services require prior authorization from the fiscal intermediary (FI) or the managed care organization (MCO). The PDHC prior authorization (PA) form is standardized regardless of the health plan covering the services. To receive prior authorization from the FI or the MCO, the following documentation must be sent for each request:

- **Standardized prior authorization form which must include why the services provided at the PDHC cannot be provided elsewhere, including the school system;**
- **Physician's most recent note documenting medical necessity for the PDHC;**
- **The physician's order and plan of care for PDHC; and**
- **The Prior Authorization checklist indicating the recipient's skilled nursing care requirements**

NOTE: PDHC services must be approved prior to the delivery of services.

Services shall be ordered by the recipient's prescribing physician. A face-to-face evaluation must be held every 90 days between the recipient and prescribing physician. 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.

The physician's order for service is required to individually meet the needs of the recipient and shall not be in excess of the recipient's needs.

The order shall contain:

- **The recipient's name;**
- **Date of birth;**
- **Sex;**
- **Medicaid ID number;**
- **Description of current medical conditions, including the specific diagnosis codes;**

- **The parent/guardian's name and phone number; and**
- **The provider's name and phone number.**

The physician shall acknowledge if the recipient is a candidate for outpatient medical services in a home or community-based setting. The physician shall sign, date and provide his National Provider Identifier (NPI) number.

NOTE: In addition to the standardized prior authorization form, the MCO or FI may request specific medical records from the physician.

Certification Period

The prior authorized case shall be certified for a period not to exceed 90 days.

Parental/Guardian Consent

A signed parental/guardian consent is required for participation in PDHC. The consent form shall outline the purpose of the facility, parental/guardian's responsibilities, authorized treatment and emergency disposition plans.

A conference shall be scheduled prior to admission with the parent/guardian(s) and the PDHC representative to develop the plan of care based upon documentation of medical necessity provided by the physician.

If the recipient is hospitalized at the time of the referral, planning for PDHC participation shall include the parent/guardian(s), relevant hospital medical, nursing, social services and developmental staff to begin the development of the plan of care that will be implemented following acceptance to the PDHC facility.

DURABLE MEDICAL EQUIPMENT

The Medicaid Program nor the contracted MCO will reimburse a PDHC for durable medical equipment (DME) and supplies that are provided to the recipient through the Medicaid DME program.

MEDICATION

The parent or guardian is to supply medications each day as prescribed by the recipient's attending physician or by a specialty physician after consultation and coordination with the PDHC facility. PDHC staff shall administer these medications, as ordered or prescribed, while the recipient is on site.

The medications shall be:

- **Kept in their original packaging and contain the original labeling from the pharmacy; and**
- **Be individually stored in a secure location at the appropriate temperature recommended.**

NOTE: The facility shall have established policies and procedures for the handling and administration of controlled substances. Schedule II substances shall be kept in a separately locked and secure box in a secured designated area.

Each PDHC facility shall maintain a record of medication administration. The record shall contain:

- **Each medication ordered and administered;**
- **The date, time and dosage of each medication administered; and**
- **The initials of the person administering the medication.**

TRANSPORTATION

The PDHC facility shall provide or arrange transportation of the recipient to and from the facility; however, no recipient, regardless of his/her region of origin, may be in transport for more than one hour on any single trip. The PDHC facility is responsible for the safety of the recipient during transport. The family may choose to provide their own transportation.

Providers who offer transportation or contract transportation with an agency must adhere to all of the rules and regulations outlined in the PDHC Facilities, Licensing Standards governing transportation.

Transportation to and from the PDHC facility will be reimbursed a daily per diem on a per case basis in accordance with 42 CFR 440.170(a).

PDHC FACILITY TRANSPORTATION/CONTRACTED TRANSPORTATION

All transportation provided by a PDHC must meet the standards for commercial transport as specified under the Americans with Disabilities Act (ADA) and the U.S. Department of Transportation (DOT) regulations.

The recipients may not be transported in a private vehicle owned or operated by any employee and/or owner.

The transporting vehicle must be licensed in the state and meet all vehicle inspection criteria. Appropriate insurance is required according to state laws.

The driver or attendant shall be provided with a current master transportation list including:

- **Each recipient's name;**
- **Pick up and drop off locations; and**
- **Authorized persons to whom the recipient may be released to.**

An attendance record shall be maintained by the driver or attendant for each trip. The record shall include the following:

- **Driver's name;**
- **Date of the trip;**
- **Names of all passengers (recipient and adults) in the vehicle; and**
- **Name to whom the recipient was released to and the time of the release.**

This record shall be signed by the driver or attendant and the PDHC representative who accepts and releases the recipient each day.

The driver and one appropriately trained staff member shall be required at all times in each vehicle when transporting any recipient. Staff shall be appropriately trained on the needs of each recipient, and shall be capable and responsible for administering interventions when appropriate.

All contracted transportation providers must meet the same standards as specified above if the purpose of the contract is to transport recipients to any PDHC facility.

Each recipient shall be safely and properly:

- **Assisted into the vehicle;**
- **Restrained in the vehicle;**
- **Transported in the vehicle; and**
- **Assisted out of the vehicle.**

The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no recipient is left in the vehicle.

During field trips, the driver or staff member shall check the vehicle and account for each recipient upon arrival at, and departure from, each destination to ensure that no recipient is left in the vehicle or at any destination.

Appropriate staff person(s) shall be present when each recipient is delivered to the facility.

Parent/Guardian Authorization

The parent/guardian shall provide a signed authorization designating the person(s) the recipient can be released to for transportation purposes. The authorization shall provide the location where the recipient can be picked up or dropped off. The release shall name the facility and to whom the recipient shall be released.

PDHC FACILITY RESPONSIBILITIES

The facility shall maintain an attendance record for each trip. The record shall include:

- **Method used to transport the recipient to and from the facility;**
- **Name of the person transporting the recipient;**
- **Date and time of the trip release; and**
- **Signatures of the driver or parent/guardian and the PDHC representative.**

SERVICES NOT COVERED

The PDHC per diem rate does not include the following services:

- **Education and training services;**
- **Before and after school care;**

- **Respite services;**
- **Child care due to work or other parental time constraints;**
- **Medical equipment, supplies and appliances;**
- **Parenteral or enteral nutrition; and**
- **Infant food or formula.**

RECIPIENT CRITERIA

In order to qualify for pediatric day health care (PDHC) services, a recipient must meet all of the following criteria. The recipient must:

- **Be Louisiana Medicaid eligible;**
- **Be from birth up to 21 years of age;**
- **Have a medically complex condition which involves one or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions, and/or prolong life.**
- **Be a candidate for outpatient medical services in a home or community-based setting; and**

- **Have a signed physician's order and plan of care for PDHC by the recipient's physician specifying the frequency and duration of services. The plan of care must clearly outline the skilled nursing care and therapeutic interventions that will be performed in the PDHC. The plan of care must be individualized, specific and consistent with the symptoms or confirmed diagnosis of the disease, condition, or injury under treatment, and not in excess of the recipient's needs.**

In the event, the medical director of the PDHC facility is also the recipient's prescribing physician, the Louisiana Department of Health (LDH), fiscal intermediary (FI) or managed care organization (MCO) will review the order and plan of care for the recommendation of the recipient's participation in the PDHC Program.

NOTE: PDHC does not provide respite care and is not intended to be an auxiliary (back-up) for respite care.

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 recipient'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 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'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 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 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 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 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 recipient'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 recipient, PDHC facility and case manager, if applicable.

PLAN OF CARE

An individualized plan of care (POC) addressing the recipient's medically complex condition, goals, skilled nursing care and therapeutic interventions needed to achieve the desired outcomes shall be developed under the direction of the facility's nursing director in collaboration with the prescribing physician prior to placement in the facility. The POC shall ensure the recipient's skilled nursing care and therapeutic needs are addressed, identify specific goals for care and plans for transition to discontinuation of care. The POC must be signed by the parent/guardian, pediatric day health care (PDHC) representative and prescribing physician. A copy shall be given to the prescribing physician and to the parent/guardian if requested. The facility shall retain a copy in their records. Services shall be administered in accordance with the POC. The POC is written to cover a specific time frame. The plan for achieving the goals shall be determined and a schedule for evaluation of progress shall be established.

REQUIREMENT

The development of the plan shall begin within 72 hours of the referral. A POC is required prior to the first day PDHC services begin.

The recipient's treatment plan must consider and reflect all services the recipient is receiving, including waiver and other community supports and services. The POC for continuation of services shall be reviewed and updated, at a minimum, every 90 days or as indicated by the needs of the recipient.

INITIAL PLAN OF CARE

Components

The initial POC should consist of the following components:

- **Provider Information - Name and Medicaid provider number;**
- **Start of care date and certification period;**
- **Recipient's functional limitations, rehabilitation potential, mental status, level of activity status, precautions, method of transportation to and from facility and allergies;**
- **Other special orders/instructions;**
- **Medications, treatments and any required equipment;**
- **Monitoring criteria, monitoring equipment and supplies;**
- **Nursing services to be provided;**
- **Diet as indicated and how recipient is to be fed;**

- **Recipient's current medical condition and hospitalizations within last six months;**
- **Risk factors associated with medical diagnoses;**
- **Special goals for care identified: Plans for achieving the goals shall be determined and an evaluation schedule of progress shall be established;**
- **Frequency/Duration of PDHC services – number of days/week, hours/day and anticipated duration;**
- **All services the recipient is receiving, including waiver and other community supports and services must be considered and reflected; and**
- **Discharge plans – contain specific criteria for transitioning from or discontinuing participation in the PDHC with the facility.**

NOTE: For Recertification only – Accomplishments toward goals, assessment of effectiveness of services, acknowledgment of face-to-face evaluation between recipient and prescribing physician 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.

Approval

The POC must be signed by the prescribing physician, an authorized representative of the facility and the recipient's parent/guardian. All signatures on the POC must be legible and dated.

The facility staff shall administer services and treatments in accordance with the POC as ordered by the physician.

Renewal

The POC for continuation of services shall include the above components. In addition, the revised POC shall include accomplishments toward goals, assessment of the effectiveness of services and acknowledgment of face-to-face evaluation between the recipient and prescribing physician 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.

The renewal must:

- **Be reviewed and updated, at a minimum, every 90 days or as indicated by the needs of the recipient;**
- **Consider and reflect all services the recipient is receiving, including waiver and other community supports and services;**
- **Be completed by a registered nurse of the facility;**
- **Be reviewed and ordered by the prescribing physician:**
    - **The PDHC shall send medical documentation to the referring physician that demonstrates services rendered as well as progress reports on the child;**
    - **Physician shall provide updated medical information and progress notes from the required face-to-face visits;**
    - **The physician will certify on the prior authorization form that he/she has read the progress report from the previous period; and**
- **Be incorporated into the recipient's clinical record within seven calendar days of receipt of the prescribing physician's order.**

The medical director shall review the plans of care in consultation with the PDHC staff and the prescribing physician every 90 days or more frequently as the recipient's condition dictates. Prescribed services and therapies included in the POC shall be adjusted in consultation with the prescribing physician to accommodate the recipient's condition.

PROCEDURE CODES

This section lists the procedure codes and maximum fees that Medicaid reimburses for pediatric day health care (PDHC) services.

Procedure Codes

The procedure codes listed in this manual chapter are Healthcare Common Procedure Coding System (HCPCS) codes, Level II. The codes are part of the standard code set described in the HCPCS Level II book. Please refer to the HCPCS Level II book for complete descriptions of the standard codes. Level II 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), the Medicaid Program will process claims for only the standard code sets allowed in federal legislation.

Diagnosis Codes

Diagnosis codes are found in the International Classification of Diseases, Clinical Modifications, Tenth Edition (ICD-10-CM) or its successor. A diagnosis code is required on the CMS-1500 or managed care organization (MCO) claim. The most specific code, including fourth and fifth digits, when available, must be used.

Units of Service

Medicaid reimburses PDHC services a fixed rate based on the number of hours per day that the recipient attends the PDHC. There are two reimbursement rates, one for a full day, up to 12 hours, and one for a partial-day of services, for six hours or less.

Procedure Code T1025 shall be used for a full day of service and Procedure Code T1026 shall be used for a partial day of service.

If a recipient is approved for full days of PDHC services, Procedure Code T1026 shall be automatically generated with the prior authorization for a percentage of the number of days approved for T1025. This is to be used on days when the child cannot attend for the full day so that providers can bill for the actual service hours of six hours or less. These two procedure codes cannot be billed for the same day.

Procedure Code T2002 shall be used for transportation.

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

OPERATING PROTOCOL:

Systems

- **All authorization requests are documented in the business application system prior authorization module**

Measurement

- **Percent compliance for individual practitioner reviewers and overall Aetna Medicaid for each of the following indicators:**
  - **Use of appropriate medical necessity criteria**

- **Timely decisions**[6]
- **Appropriate documentation**[7]
- **Practitioner reviewers' responsiveness**[8]
- **Appropriate and consistent application of the medical necessity criteria**

Reporting

- **Summary reports are submitted to:**
  - **Aetna Medicaid MM CMO**
  - **Aetna Medicaid senior medical director of Utilization Management**
  - **Aetna Medicaid director of Utilization Management**
  - **Aetna Medicaid Utilization Management Steering Committee**[9]
  - **Aetna NMQM director**

INTER-/INTRA-DEPENDENCIES:

Internal

- **Aetna Medicaid MM chief medical officer**
- **Aetna Medicaid senior director of Utilization Management**
- **Aetna Medicaid director of Utilization Management**
- **Aetna Better Health chief medical officer**
- **Internal and external practitioner reviewers**
- **Medical directors**

External

- **Louisiana Department of Health**
- **Members**
- **Practitioners and providers**

[6] **NCQA HP 2018 /2019 UM5 A-F**
[7] **NCQA HP 2018/2019 UM6**
[8] **NCQA HP 2018/2019 UM7 A, D and G**
[9] **NCQA HP 2018/2019 UM1 B, C**

Aetna Better Health

Richard C. Born
Chief Executive Officer

Madelyn M. Meyn, MD
Chief Medical Officer

Review/Revised History	