Title 23: Division of Medicaid

Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services

Rule 3.1: Definitions

The Division of Medicaid defines:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries as beneficiaries who qualify for the federally mandated EPSDT program according to 42 U.S.C. § 1396d and 42 C.F.R. Part 441.

B. Prescribed pediatric extended care (PPEC) services as medically necessary skilled nursing services and therapeutic interventions for EPSDT eligible, medically complex beneficiaries who:

   1. Are medically or technologically dependent, and

   2. Require continual care.

C. PPEC center as any building or buildings, or other place, whether operated for profit or non-profit, which undertakes through its ownership or management to provide basic nonresidential services to three (3) or more medically dependent or technologically dependent children who are not related to the owner or operator by blood, marriage or adoption and who require such services.

D. Medically or technologically dependent as requiring on-going, physician prescribed, technologically-based skilled nursing supervision and/or requiring routine use of a medical device to compensate for the deficit of life-sustaining body function due to a medical condition/disability whether acute, chronic or intermittent in nature.

E. Medically complex as a medical condition that requires continual care as prescribed by the child's attending physician.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. §§ 41-125-3, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.2: Provider Requirements

A. Prescribed pediatric extended care (PPEC) providers, including out-of-state providers, must satisfy all requirements set forth in Miss. Admin Code Title 23, Part 200, Rule 4.8 in addition to the following provider type specific requirements:

1. National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES).

2. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

3. A copy of the provider's current Medicare certification or Tie-In Notice from the Medicare Administrative Contractor. An Explanation of Medicare Benefits (EOMB) is not acceptable.

4. A copy of License from the Mississippi State Department of Health, Health Facilities Licensure and Certification. If parent entity is an out-of-state facility with a servicing location in Mississippi, a copy of the respective State's license is required.

B. PPEC providers must adhere to the Mississippi State Department of Health Minimum Standards of Operation of PPEC Centers, as required for Licensure.

C. PPEC providers must development, implement and monitor the comprehensive plan of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.3: Covered Services

A. The Division of Medicaid covers up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee:

a) Prior authorizations must be submitted every six (6) months, and

b) The ordering physician must perform an in-person evaluation of the beneficiary a minimum of every six (6) months to review and update the plan of care (POC) as necessary.

B. PPEC services include, but are not limited to:

1. Nursing services,

2. Respiratory therapy,

3. Developmental services,

4. Nutrition services,

5. Social services,

6. Physical therapy, occupational therapy and/or speech-language pathology,

7. Durable medical equipment and medical supplies as required by the Mississippi Department of Health (MSDH), and

8. Transportation to and from the PPEC facility unless the beneficiary's parent and/or legal guardian chooses for the beneficiary to be transported by a family member or friend.

C. All PPEC services must meet the MSDH's minimum standards in order to be covered.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.4: Non-covered Services

The Division of Medicaid does not cover the following as prescribed pediatric extended care (PPEC) services:

A. Services that are not part of a written plan of care,

B. Services that have not been ordered by a physician,

C. Educational services,

D. Services provided to beneficiaries that are related to the owner or operator by blood, marriage or adoption, and

E. Services that do not meet the Mississippi Department of Health's (MSDH's) minimum standards.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.5: Reimbursement

A. The Division of Medicaid reimburses up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee every six (6) months.

B. The Division of Medicaid reimburses the lesser of the provider's usual and customary charge or:

1. An hourly rate for each complete hour of PPEC services for the first six (6) complete hours of PPEC services,

2. A daily rate for over six (6) hours of PPEC services, and

3. A daily rate for transportation to and from the PPEC center when provided by the PPEC.

C. The following items and services are not included in the hourly or daily rates for PPEC services and must be billed separately by the rendering provider:

1. Occupational therapy,

2. Physical therapy, and

3. Speech-language pathology.

4. Baby food or formula,

5. Total parenteral and enteral nutrition,

6. Mental health and/or psychiatric services, and

7. Durable medical equipment (DME) and medical supplies.

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: New rule eff. 11/01/19.

Rule 3.6: Documentation

A. Providers must maintain required documentation in accordance with Miss. Admin. Code Part 200, Rule 1.3, and must maintain auditable records to substantiate claims submitted to the Division of Medicaid or designated entity.

B. Documentation must include, but is not limited to:

1. The physician's orders and any changes in physician orders,
2. Progress notes,
3. Prior authorization,
4. The plan of care and quarterly updates,
5. Immunization records,
6. Dates and times of all services provided including, but not limited to:
    a) Medication administration record,
    b) Treatment administration record, and
    c) Respiratory treatment record
7. Dates and times of educational services,
8. Dietary orders,
9. Pick-up and drop-off times,
10. Accident reports,
11. Incident Reports, and
12. Emergency contact information.

C. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Part 200, Rule 1.3]

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Title 23: Division of Medicaid

Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services

Rule 3.1: Definitions

The Division of Medicaid defines:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries as beneficiaries who qualify for the federally mandated EPSDT program according to 42 U.S.C. §1396d and 42 C.F.R. Part 441.

B. Prescribed pediatric extended care (PPEC) services as medically necessary skilled nursing services and therapeutic interventions for EPSDT eligible, medically complex beneficiaries who:

1. Are medically or technologically dependent, and

2. Require continual care.

C. PPEC center as any building or buildings, or other place, whether operated for profit or non-profit, which undertakes through its ownership or management to provide basic nonresidential services to three (3) or more medically dependent or technologically dependent children who are not related to the owner or operator by blood, marriage or adoption and who require such services.

D. Medically or technologically dependent as requiring on-going, physician prescribed, technologically-based skilled nursing supervision and/or requiring routine use of a medical device to compensate for the deficit of life-sustaining body function due to a medical condition/disability whether acute, chronic or intermittent in nature.

E. Medically complex as a medical condition that requires continual care as prescribed by the child's attending physician.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. §§ 41-125-3, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.2: Provider Requirements

A. Prescribed pediatric extended care (PPEC) providers, including out-of-state providers, must satisfy all requirements set forth in Miss. Admin Code Title 23, Part 200, Rule 4.8 in addition to the following provider type specific requirements:

1. National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES).

2. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

3. A copy of the provider's current Medicare certification or Tie-In Notice from the Medicare Administrative Contractor. An Explanation of Medicare Benefits (EOMB) is not acceptable.

4. A copy of License from the Mississippi State Department of Health, Health Facilities Licensure and Certification. If parent entity is an out-of-state facility with a servicing location in Mississippi, a copy of the respective State's license is required.

B. PPEC providers must adhere to the Mississippi State Department of Health Minimum Standards of Operation of PPEC Centers, as required for Licensure.

C. PPEC providers must develop, implement and monitor the comprehensive plan of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.3: Covered Services

A. The Division of Medicaid covers up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee:

a) Prior authorizations must be submitted every six (6) months, and

b) The ordering physician must perform an in-person evaluation of the beneficiary a minimum of every six (6) months to review and update the plan of care (POC) as necessary.

B. PPEC services include, but are not limited to:

1. Nursing services,

2. Respiratory therapy,

3. Developmental services,

4. Nutrition services,

5. Social services,

6. Physical therapy, occupational therapy and/or speech-language pathology,

7. Durable medical equipment and medical supplies as required by the Mississippi Department of Health (MSDH), and

8. Transportation to and from the PPEC facility unless the beneficiary's parent and/or legal guardian chooses for the beneficiary to be transported by a family member or friend.

C. All PPEC services must meet the MSDH's minimum standards in order to be covered.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.4: Non-covered Services

The Division of Medicaid does not cover the following as prescribed pediatric extended care (PPEC) services:

A. Services that are not part of a written plan of care,

B. Services that have not been ordered by a physician,

C. Educational services,

D. Services provided to beneficiaries that are related to the owner or operator by blood, marriage or adoption, and

E. Services that do not meet the Mississippi Department of Health's (MSDH's) minimum standards.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.

Rule 3.5: Reimbursement

A. The Division of Medicaid reimburses up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee every six (6) months.

B. The Division of Medicaid reimburses the lesser of the provider's usual and customary charge or:

1. An hourly rate for each complete hour of PPEC services for the first six (6) complete hours of PPEC services,

2. A daily rate for over six (6) hours of PPEC services, and

3. A daily rate for transportation to and from the PPEC center when provided by the PPEC.

C. The following items and services are not included in the hourly or daily rates for PPEC services and must be billed separately by the rendering provider:

1. Occupational therapy,

2. Physical therapy, and

3. Speech-language pathology.

4. Baby food or formula,

5. Total parenteral and enteral nutrition,

6. Mental health and/or psychiatric services, and

7. Durable medical equipment (DME) and medical supplies.

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: New rule eff. 11/01/19.

Rule 3.6: Documentation

A. Providers must maintain required documentation in accordance with Miss. Admin. Code Part 200, Rule 1.3, and must maintain auditable records to substantiate claims submitted to the Division of Medicaid or designated entity.

B. Documentation must include, but is not limited to:

1. The physician's orders and any changes in physician orders,

2. Progress notes,

3. Prior authorization,

4. The plan of care and quarterly updates,

5. Immunization records,

6. Dates and times of all services provided including, but not limited to:

a) Medication administration record,

b) Treatment administration record, and

c) Respiratory treatment record

7. Dates and times of educational services,

8. Dietary orders,

9. Pick-up and drop-off times,

10. Accident reports,

11. Incident Reports, and

12. Emergency contact information.

C. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Part 200, Rule 1.3]

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 10/01/19), eff. 11/01/2019.