

A healthcare provider with curly brown hair, wearing a white short-sleeved shirt, is leaning over a young child with blonde hair lying in a hospital bed. The child is smiling and looking up at the provider. A brown teddy bear is positioned between them. The background is softly blurred, showing a hospital room with a window and some flowers.

PEDIATRIC PALLIATIVE CARE PROGRAM

Provider Manual for
Home Health Agencies

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PURPOSE

This Pediatric Palliative Care Program (PPCP) Provider Manual was developed to provide you, a Home Health Agency provider, with the information and tools you need to participate in this program. This manual is supplemental for use in conjunction with the [Department of Vermont Health Access Provider Manual](#)¹.

This manual guides your Home Health Agency through the requirements for participation in the PPCP and ongoing delivery of services required by the Centers for Medicare and Medicaid Services in the approved waiver.

Delivery of PPCP services is a team effort. Use the manual to orient staff members to the program, standards, roles and responsibilities, and involve them in delivery of PPCP services to the participants and families enrolled in PPCP.

As a pediatric palliative care team within your agency, you will work to:

- Coordinate care amongst providers
- Optimize symptom control
- Optimize functional status when appropriate
- Promote the highest quality of life for patient and family
- Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness
- Establish an environment that is comforting and healing
- Plan for transition to the appropriate level of care in a timely manner
- Assist actively dying patients and their families in preparing for and managing life closure
- Serve as educators and mentors for staff
- Promote a system of care that fosters timely access to palliative care services

Section 1: PROGRAM BACKGROUND AND OVERVIEW

The Pediatric Palliative Care Program (PPCP) is for children with Medicaid who are living with serious illness. The PPCP is administered through the Vermont Department of Health Children with Special Health Needs and made possible through Vermont's [1115 Demonstration Waiver](#)². The program offers the following services to children who are Medicaid beneficiaries who are living with a serious life-threatening condition (LTC) from which they are not likely to live in to adulthood (age 21):

1. Care Coordination
2. Family Training
3. Expressive Therapy
4. In-Home Skilled Respite
5. Family Grief Counseling/Bereavement Counseling

¹ The Medicaid/DVHA Provider Manual is available at vtmedicaid.com/Downloads/manuals.html

² The 1115 Global Commitment Demonstration is available at dvha.vermont.gov/administration/2011-global-commitment-to-health-documents.

Over the last decade there has been growing concern that children with LTC do not always receive the care they need to alleviate associated physical, emotional and psychosocial pain. In 2010, the Federal Government amended the Patient Protection and Affordable Care Act (PPACA), adding the Concurrent Care for Children Requirement (CCCR), requiring state Medicaid programs to pay for both curative/life-prolonging treatment and hospice services for children under the age of 21 who qualify. Although this law allows children to receive curative treatments while still electing the hospice benefit, it does not change the traditional hospice eligibility criteria, specifically that a physician certify that the eligible person is within the last 6 months of life, should the disease or condition follow its normal course. Many children living with chronic illness experience an undulating illness pattern during which they have periods of extreme illness followed by months, sometimes years, of being well. Prognosticating life-expectancy in children and adolescents, especially for those with chronic complex conditions is challenging, thus making the determination for hospice life-expectancy often unrealistic.

Recognizing that children living with LTC and their families need additional support, Centers for Medicare and Medicaid (CMS) approved the amended Vermont Medicaid Global Commitment Demonstration in 2011 which allows for pediatric palliative care services for Medicaid children in Vermont who are eligible, without the determination of a 6-month life expectancy or having to forgo life-sustaining treatments.

The PPCP is based on the principle that if curative treatment is provided along with compassionate/palliative care, there can be an effective continuum of care throughout the course of the medical condition. The objective will be to minimize the use of institutions, especially hospitals, and improve the quality of life for the child or adolescent and their family in the local community.

The PPCP was launched in August 2012, starting as a pilot in Chittenden County with strategic roll out in other counties where capacity to provide services already existed, and as agencies were trained and prepared to implement services. As of 2014, the program was available to children and families statewide.

MISSION

To provide comprehensive interdisciplinary care to children and their families by addressing their physical, emotional, spiritual, and cultural needs while helping them to maintain their goals and hope as the driving force to achieve the best quality of life during living, dying, and grieving.

Section 2: DEFINITIONS AND ACRONYMS

World Health Organization (WHO) Definition of Palliative Care for Children: Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care:

- Is the active total care of the child's body, mind and spirit, and also involves giving support to the family
- Begins when illness is diagnosed, and continues regardless of whether or not a child receives treatments directed at the disease
- Demands that health providers evaluate and alleviate a child's physical, psychological, and social distress
- Requires a broad interdisciplinary approach
- Includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited
- Can be provided in tertiary care facilities, in community health and hospice centers, in children's homes
- Should be developmentally appropriate and in accordance with family values

This document uses the following definitions:

Adulthood: People who are 21 years of age or greater.

Agency: A Medicaid-approved Home Health Agency that is contracted with DVHA to provide direct care services to the child and family, and that subcontracts with the necessary service providers to ensure the care plan objectives are met.

Care Plan: A family-centered written plan that is developed by the Care Coordinator with input from the interdisciplinary team with the child and family's involvement that addresses all relevant aspects of a child's health and socialization needs. It is based on the findings of the child and family's assessments and defines specific service and treatment goals and objectives; proposed interventions; and the measurable outcomes to be achieved.

Curative Treatment: Care intended to eliminate the disease and promote recovery.

Family Unit: Refers to the child and the family. Family is defined as the people who provide physical, psychological, spiritual, and social comfort to the child, regardless of genetic relationship. Families may include, but are not limited to, parents, step-parents, siblings, legal guardians, grandparents, relatives, household members, and friends providing care for the child, and other people considered "family" by the child.

Intake and Needs Assessment: A comprehensive assessment/screening for services conducted by a trained nurse or social worker, with input from the child and family to determine the child's level of functioning, current resources, and additional services needed.

Interdisciplinary: An integrative model wherein people from multiple disciplines work together in addressing a common challenge. This model can be seen as overlapping circles (as in a Venn diagram) where each specialty maintains its own identity while also sharing some common methodologies and assumptions with other disciplines in the web.

Life-Threatening Conditions (LTC): A medical condition that, in the opinion of the child's primary treating health care provider, carries a prognosis of death that is highly probable to be before the child reaches age 21.

Medical Necessity: Care and services as defined in the [Social Security Act Section 1905\(a\)](#)³.

Notice of Decision: A notification automatically generated and mailed to the beneficiary and referring physician by the contracted entity 1 day following authorization (or denial) of services as entered into the system.

Pediatric/Child: A child or youth less than 21 years of age.

Prior Authorization: Process of clinical review for specific services by Medicaid prior to their being approved and implemented.

Program Coordinator: A registered nurse, employed by the State of Vermont/Children with Special Health Needs, who provides oversight of the program, and technical assistance to delivering agencies.

Service Provider: A person or agency that provides a service specific to this program, i.e., Care Coordination, Expressive Therapy, Respite, Family Training, and/or Bereavement Counseling.

This document uses the following acronyms:

CMS – Center for Medicare and Medicaid
CSHN – Children with Special Health Needs
DVHA – Department of Vermont Health Access
IDT – Interdisciplinary Care Team
IFS – Integrated Family Services
LTC – Life-threatening Condition
NOD – Notice of Decision
PPCP – Pediatric Palliative Care Program

³ Definition of Medical Assistance is available at ssa.gov/OP_Home/ssact/title19/1905.htm

Section 3: PARTICIPATING AGENCY REQUIREMENTS

Participating agencies are contracted Medicaid providers, with training in pediatric palliative care, and capable of providing the broad scope of services to support the PPCP including:

- Delivery of services to children in their homes residing in Vermont
- Phone consultation with a nurse or physician available 24 hours/day, 7 days/week
- Interpreter services in person or telephonic for the participant and family, if needed
- Maintenance of current list of Agency employed/contracted persons who deliver services to PPCP beneficiaries including appropriate credentials as defined in this manual
- Responsibility for employees and contracted service providers
- Encourage and support direct care staff in pediatric palliative care educational opportunities
- Supervision and training to staff with limited pediatric palliative care experience

1. Pediatric Palliative Care Competencies

All Agency staff providing direct care will complete pediatric palliative care education within their first year of providing services. Examples of competencies include:

- Complete Pediatric End-of-Life Nursing Education Consortium (ELNEC) curriculum, or equivalent training, prior to caring for children enrolled
- Attend PPCP-endorsed trainings and continuing educational opportunities, online or in-person, to enhance knowledge in the field

2. Medical Record Maintenance

The beneficiary's central chart should include documentation of:

- The Family-Centered Care Plan per Agency standards and Medicaid Rule⁴
- Services including goals, frequency, interventions, and outcomes
- 24/7 triage nurse calls, including beneficiary's name, date, time, issue, resolution (including advice given, redirection, or other) and answering nurse's name
- Confidential information in compliance with Agency standard policies, state and federal laws and regulations, including HIPAA requirements

3. Service Utilization Documentation

- Documentation of PPCP services should be integrated within the agency's current system in order to maximize continuity of care with all other services being provided
- PPCP specific services should be uniquely identified within charting for audit purposes
- CSHN will regularly review documentation of service utilization review
- Specific documentation requirements pertain to certain services (i.e. Skilled Respite and Bereavement Counseling)
- Claims and reimbursement data will be obtained monthly by CSHN

4. Collaboration with CSHN Program Coordinator

⁴ Medicaid Rule is available at <http://humanservices.vermont.gov/on-line-rules/dvha>

- Ensures timely communication with newly enrolled beneficiaries as well as implementation of PPCP services
- Identifies need for additional training, support, education to PPCP in timely manner and problem solve collaboratively
- Includes submission of Monthly Service Reports (Appendix C)

5. Participation in Quality Improvement

Families will be offered multiple opportunities to participate in surveys that will both collect data for palliative care research as well as provide direct feedback regarding their satisfaction with the program. These surveys will be administered and analyzed by CSHN.

1. Family Satisfaction Survey
2. Bereaved Family Satisfaction Survey

6. Agency-Based Interdisciplinary Team (IDT) Meetings

- Conducted and documented every 30 days
- Includes at least 2 members of the IDT caring for each child
- Addresses the care of children enrolled in the PPCP as well as program operations
- Includes the PPCP Coordinator as needed to provide support, resources, and/or education

7. Physician/Clinical Provider Orders for PPCP Services

- *With the exception of In-Home Skilled Respite*, no other PPCP services require a physician order as they are not skilled nursing or rehabilitation services
- If a skilled need (nursing, rehab, teaching, etc.) is identified, it is the responsibility of the Agency to obtain an order from the appropriate provider
- Orders should be ordered on a 485 Form or other comparable documentation per Home Health Agency protocol

Section 4: SERVICE DESCRIPTIONS AND SERVICE PROVIDER QUALIFICATIONS

The Agency must provide all of the following services using either employees or contractors of the Agency:

- Comprehensive care coordination by a nurse trained in palliative care
- Family Training to address those teaching, educational, and support needs identified with the family
- In-Home Respite Care and coordination of Out-of-Home Respite Care (if prior approved and available)
- Expressive Therapies including Art, Music, Play, Dance Movement, OR Child Life
- Family Grief Counseling/Bereavement Counseling for family and other primary caregivers, as applicable
- **Independent providers outside of the Home Health Agency will not be allowed to bill individually on a fee-for-service basis.**

Care Coordination

Care coordination allows for coordinated services and community supports to work with the child and family towards better health outcomes and to prevent unnecessary hospitalization. By acting as the “key person” for the family unit and maintaining communication among the interdisciplinary team, the palliative nurse care coordinator can facilitate and guide appropriate service coordination on behalf of the child and family.

Qualifications

Agency employed/contracted registered nurse, experienced in working with children living with chronic illness, and who has completed a Pediatric Palliative Care Education Curriculum recommended and/or approved by the PPCP Program (i.e. ELNEC) in person or on-line.

Goals

- Ensure a family-centered, culturally competent system of care by coordinating services provided to the child and family
- Achieve integration of the child and family’s goals and medical objectives to assist the participant in successfully and safely living in the community
- Assess the child’s home and community environment on an ongoing basis to determine if it is safe and conducive to successful implementation of the PPCP
- Collaborate and coordinate with medical, psychosocial, state plan, and community services
- Communicate with and coordinate the multidisciplinary team for effective medical and palliative care management of the child
- Develop and implement a comprehensive care plan that responds to social, emotional, spiritual, physical and economic issues that affect the child and family’s health and maximum potential

Responsibilities

- Conduct first face-to-face visit within 7 days of Home Health Agency receiving intake (exceptions may be made to accommodate the child and family's request)
- Coordinate palliative care services (i.e. Family Training, Expressive Therapy, etc.) and ensure services are implemented as authorized
- Develop a written care plan incorporating the key elements related to palliative care (Appendix B)
- Visit the home monthly to evaluate progress towards meeting the goals established in the Care Plan
 - Telephonic monthly management may be considered if a child has been stable with no changes for 90 days and mutually agreed upon by the family and Care Coordinator, but with a minimum of in-person home visits at least once every 90 days
- Anticipate *on average* up to 4 hours per month of care coordination dependent on diagnosis, needs, acuity, etc. (although time may be flexed from month to month in order to meet family's needs)
- Review Care Plan regularly per [Medicaid Rule 7401](#)⁵ or more often as indicated by a change in the participant's condition
- Coordinate care conferences collaboratively with the child's primary care pediatrician/lead physician as needed to ensure goals of care and continuity are being maintained
 - Communicate with all medical care providers and the family unit to achieve integration of needs and medical treatment goals
 - If appropriate, accompany family unit to appointments, as necessary to facilitate communication and support goals
- Coordinate care during transition periods, such as hospitalization, discharge, rehabilitation, out of state visits, etc.
- Assist the family unit in understanding recommended changes to the medical regimen as they occur and continuously review and update the goals of care as needed
- Create written after hours action plan (who to call) with family and ensure they have an accessible copy
- Collaborate with additional service providers (i.e. CSHN, CIS, school) involved in the child's care when necessary to ensure goals of care are optimized across the care continuum

Communication with PPCP Coordinator

- Act as primary communicator between the Agency and PPCP Coordinator at CSHN
- Communicate challenges in family engagement, changes in health status, etc. in a timely manner
- Submit a Monthly Service Report (Appendix C) and copy of the care plan to the PPCP Nurse Case Manager
- Ensure no lapse in services by communicating child's status prior to services authorization end date

⁵ <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>

Expressive Therapy

Therapeutic interventions are aimed at assisting children and thereby their families meet the challenges of their experience through professionally led creative and kinesthetic treatment modalities. Therapeutic and age-appropriate communications may be used to:

- Promote optimal development
- Present information
- Plan and rehearse useful coping strategies for medical events
- Work through feelings about past or impending experiences
- Support development of therapeutic relationships between children and parents to support family involvement in each child's care

Qualifications

Agency employed/contracted credentialed professional, experienced in working with children living with chronic illness, who has completed a Pediatric Palliative Care Education Curriculum recommended and/or approved by the PPCP Program (i.e. ELNEC) in person or on-line.

See *Appendix D: Approved Expressive Therapy Providers* for a complete list of accepted credentials.

Family Training

Training and instruction for family members and caregivers by a nurse to best support and empower families with skills and knowledge so they can be more self-sufficient and confident in caring for their child. This training will likely be provided by the Palliative Nurse Care Coordinator, but additional training by a provider with specialized expertise may be necessary in some situations.

- Educational/counseling needs are routinely assessed and reassessed throughout care and treatment
- When educational needs are identified, they are incorporated into the plan of care
- Age-, language- and educationally appropriate educational materials (written, Internet, oral) will be provided to meet the needs identified in the assessment process

The following is a list of common issues to be addressed, depending on the patient's unique clinical circumstances:

- Pain and symptom management, including side-effect management
- Advance care planning and advance directives
- Anticipated future medical needs
- Home or institutional support options (e.g., home hospice services)
- What to expect in the normal course of the disease
- Signs/symptoms of approaching death
- Community services (e.g., bereavement, counseling)
- Whom to call for routine and emergency needs

Qualifications

Agency employed nurse, experienced in working with children living with chronic illness.

- Strongly recommend completion of a Pediatric Palliative Care Education Curriculum recommended and/or approved by the PPCP Program (i.e. ELNEC) in person or on-line.

Family Grief/Bereavement Counseling

Anticipatory counseling is offered to the child and/or family by a certified or licensed professional trained in grief counseling. Counselors take care to address the physical, psychological and spiritual issues associated with the child's complex picture for which curative treatment may fail, is not possible, or because an early death is likely.

Service Specifics and Requirements

- Services prior to the child's death are fee-for-service
- Formal counseling may continue up to 6 months after the child's death providing services are started prior to child's death
- Up to 6 units of service may be billed on final claim to cover services during bereavement period
- If 6 units of service are not remaining at the time of death, it is the Care Coordinator's responsibility to communicate with the PPCP Coordinator at CSHN to ensure adequate units of services are authorized and available to the family
- Bereavement Service Log will be maintained and submitted to DVHA 7 months after the death of the child

Qualifications

Agency employed/contracted mental health counseling professional who meets qualifications as stated in [Department of Mental Health Medicaid Manual](#)⁶ with experience in grief and bereavement counseling.

- Strongly recommend completion of a Pediatric Palliative Care Education Curriculum recommended and/or approved by the PPCP Program (i.e. ELNEC)

Preferred Providers include:

- Certified Hospice and Palliative Social Worker (CHP-SW)
- Advanced Certified Hospice and Palliative Social Worker (ACHP-SW)

Or those listed in the Department of Mental Health Medicaid Manual (Effective Jan. 2004):

- Licensed psychiatrist in Vermont
- Licensed psychologist in Vermont
- A professional nurse holding a M.S. in Psychiatric/Mental Health Nursing from a university with an accredited nursing program, licensed in Vermont.
- Licensed Clinical Social Worker in Vermont
- Licensed Mental Health Counselor in Vermont
- Persons with a minimum of a Master's level degree in a human services field approved by the clinical or medical and executive director as qualified to provide clinical assessment services.

⁶ Department of Mental Health Medicaid Manual is available at http://mentalhealth.vermont.gov/sites/dmh/files/policies/DMH-Medicaid_Manual.pdf

Bereavement Service Documentation

- Documentation of all Bereavement Services rendered to the family after the child's death must be maintained in a Bereavement Log and submitted to the PPCP Nurse Case Manager upon completion of the service (approximately 7 months after the child's death)
- Agencies will create an internal tracking Bereavement service system that produces a file by child

In-Home Skilled Respite Care

Respite is intended to provide short-term relief for family members from the demanding responsibilities of caring for a child with a complex medical condition, or for the family to attend to personal or other family needs. Skilled respite provides an alternative to hospitalization. Clinically eligible children may qualify for up to 5 days of respite per 6 months.

All of the following care requirements must be present to meet the medical eligibility requirement:

1. At least 8 hours of primary nursing care within a 12 hour period are required to maintain the child or adolescent at home;
2. Significant deterioration in health status;
3. Continued use of medical technology, complex medical equipment or invasive techniques;
and
4. Without the support of skilled nursing services, hospitalization would be required due to the complexity or intensity of medical needs.

Qualifications

Agency employed/contracted Registered Nurse, Licensed Practical Nurse, or Licensed Nursing Assistant, experienced in working with children living with chronic illness, and with skills necessary to match the needs of the child in order to maintain their health and safety.

- Strongly recommend completion of a Pediatric Palliative Care Education Curriculum recommended and/or approved by the PPCP Program (i.e. ELNEC)

Rules and Requirements

- Children and adolescents receiving block nursing are not eligible for skilled respite (i.e. private duty nursing, high technology nursing, etc.)
- Prior authorization may occur on an as-needed basis (i.e. family obligation) or in anticipation of need (i.e. near end-of-life) as requested by the Palliative Nurse Care Coordinator to the PPCP Nurse Case Manager
- More than one provider type (RN, LPN, LNA) may provide respite, but not simultaneously
- Children and adolescents receiving skilled nursing services may also receive other authorized PPCP services at the same time (i.e. grief counseling)

- MD orders to support nursing interventions must be submitted to the Home Health Agency as with other skilled service requirements per Regulations for the Designation and Operation of Home Health Agencies⁷.

In-Home Skilled Respite Care Service Documentation

Documentation should be in compliance with Regulations for the Designation and Operation of Home Health Agencies, and may include specifics such as the following:

- Reason for in-home skilled respite care
- Vital signs (as appropriate)
- Observations of the patient's condition
- Interventions used to achieve palliation of physical or emotional symptoms
- Services provided to the patient
- Medications given and the patient's response
- Treatments completed and the patient's response
- Contacts made to the hospice and/or attending physician
- New or changed orders received
- Family response to care (as indicated)
- Detailed plan to return to routine home care when appropriate

⁷ Regulations can be found at <http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/regs-designation-operation-home-health-agencies>

Section 5: PROGRAM OPERATIONS PROCESS

SUMMARY

1. Referral from primary pediatrician or lead clinical provider made to PPCP Coordinator at CSHN
2. Program eligibility determined
3. Referring provider and beneficiary notified by mail
4. Prior authorization completed
5. Referring provider, beneficiary, and delivery home health agency notified by mail
6. Prior authorization renewed every 6 months with annual re-assessment

REFERRAL

- A PPCP-specific Referral Form must be submitted to PPCP Coordinator by the beneficiary's primary care physician or subspecialist over-seeing their care
- Inquiries may be made from other state or community programs, however completion of the Referral Form by a MD/NP/PA regarding clinical diagnosis and medical necessity of services will still be required
- Referring provider will be notified promptly by PPCP Coordinator at CSHN if additional information is needed to complete the program eligibility process
- Although the referral process does not assess for specific program needs, it is intended to screen thoughtfully and thoroughly for children who will require services based on the needs assessment
- The PPCP Referral Guideline provides a guide to highly recommended and suggested referrals

PROGRAM ELIGIBILITY

- Program Eligibility is determined by the PPCP Coordinator at CSHN in consultation with the CSHN Clinical Services Director based on basic eligibility requirements and Level of Care documentation as described on the Referral Form, as well as supporting medical documents that demonstrate medical necessity
- Determination will be made by PPCP Coordinator at CSHN within 14 calendar days of receiving the Referral Form if all necessary information is included
- Family and referring provider will be notified of the child's program eligibility status by receiving a "Letter of Program Eligibility"

AUTHORIZATION OF SERVICES

- Services are authorized at the same time a child is determined program eligible to prevent any delay in provision of services
- Prior Authorization by the PPCP Coordinator at CSHN for each service is required
- Skilled Respite is authorized on an as needed basis to children who are clinically eligible (See Section 4: Service Descriptions and Provider Qualifications)
- A Notice of Decision (NOD) will be sent to the beneficiary, referring physician, and delivering Home Health Agency indicating which services the child is approved for, including the parameters and limits

- Services will be authorized for either a 6 or 12-month period with the understanding that the care plan may be modified at any time if the Agency Care Coordinator or PPCP Coordinator deems such a modification necessary based on family unit need
- Appropriate physician documentation may be required to modify authorized services

HOME HEALTH AGENCY ENROLLMENT

- PPCP Coordinator will complete an enrollment request/referral to the intake department of the selected Home Health Agency (if more than one choice is available) immediately upon authorizing services
- PPCP Coordinator will also contact the Agency PPCP Lead to notify them of a newly enrolled beneficiary
- With the exception of Skilled Respite, services do not require a direct referral or order submitted to the Home Health Agency since referral will have been made directly to CSHN for approval

HOME HEALTH AGENCY IMPLEMENTATION OF SERVICES

- The Home Health Agency will make contact with the family within 24-48 hours of receiving the intake information
- Once the Palliative Nurse Care Coordinator is identified, he/she is expected to notify the PPCP Coordinator
- The Palliative Nurse Care Coordinator will visit the child and family within 7 calendar days – document reason in patient’s chart if this does not occur (i.e. family request)
- If the Home Health Agency does not have adequate information based on the intake process to make the initial visit, it is the Home Health Agency’s responsibility to follow up with the PPCP Coordinator immediately
- Hospitalization at the time of enrollment will not be a barrier to admitting a child and initiating *any* PPCP services.

CARE PLAN IMPLEMENTATION

- Developed by the Palliative Nurse Care Coordinator in collaboration with IDT, including but not limited to Medicaid PPCP authorized services
- Reflects services that will be provided, including the anticipated frequency
- Implemented by the Palliative Nurse Care Coordinator in accordance with the scope and frequency approved in the plan based on prior authorization
- Re-evaluated regularly with family input and by the IDT to meet the evolving needs of the child and family

OPERATIONS

- The Nurse Care Coordinator will visit and communicate with the family as described, with intermittent telephonic visits as needed based on the child’s condition
- Agency IDT Meetings and outside Multidisciplinary Team Meetings will be coordinated as defined under the Care Coordinator’s responsibilities

- The “Family Satisfaction Survey” will be provided to the child and family 6 months after enrollment and every 6 months thereafter
- A redetermination of eligibility is completed a minimum every 12 months by the PPCP Coordinator
- A strong line of communication will be maintained between the Care Coordinator and the PPCP Coordinator at CSHN including monthly updates

RE-AUTHORIZATION OF SERVICES

- Services are authorized for 6-12 months at a time
- It is the responsibility of the Care Coordinator to communicate with the PPCP Coordinator at CSHN prior to the authorization end date, as part of the regularly scheduled communication, to ensure services are renewed

DISENROLLMENT

- The child/family is notified of disenrollment by receiving a “Letter of Disenrollment” from the PPCP, explaining the reason for disenrollment (i.e. 21st birthday)
- A child may be disenrolled for any of the following reasons:
 - The parent/guardian requests it;
 - There is a significant positive change in health status/no longer meets Level of Care;
 - When the child turns 21 years old;
 - If the child is no longer eligible for Medicaid;
 - If the participant/family/home environment poses a health and/or safety risk to the providers and attempts at remediation are unsuccessful;
 - If the family leaves the state of Vermont; or
 - If death occurs.
- Children who previously disenrolled may be re-referred by way of the standard procedure

EVALUATION

- Annual Agency meetings will be continued as needed by the Agency and the PPCP Coordinator at CSHN
- The PPCP may participate in both state and national evaluation projects to measure outcomes and family satisfaction

Section 6: BILLING, CODING AND REIMBURSEMENT

- Medicaid is the payer of last resort and requires a denial from the beneficiary’s primary insurer prior to reimbursement for services
- All claim forms **must** include the primary diagnosis ICD-10 code for which the beneficiary qualified for the PPCP in order to be processed
- All services must be billed using the appropriate Revenue Code **and** Procedure Code on a UB-04 form
- See the Medicaid Provider Manual⁸ for additional billing questions
- See Appendix A for Service Reimbursement Rates
- Call HP Enterprise Systems Provider Services for billing questions (800) 925-1706 or (802) 878-7871

Service	Revenue Code	Procedure Code	Additional Information
Care Coordination	580 Home Health – Other visits, General	G9006 <i>Coordinated care fee, home monitoring</i>	<ul style="list-style-type: none"> •Based on Needs Assessment and prior auth •HHA expected to bill only for hours used even if authorized maximum number of units
Expressive Therapy	562 Home Health – Medical Social Services, Visit charge	G0176 <i>Activity therapy, such as music, dance, art or play therapies not for recreations, relative to the care and treatment of patient’s disabling mental health problems per session, 45 mins or more</i>	<ul style="list-style-type: none"> •Based on Needs Assessment and prior auth
Skilled In-Home Respite	660 Respite Care, General For RN or LPN	T1005 <i>Respite care services, up to 15 minutes</i>	<ul style="list-style-type: none"> •Based on medical necessity and prior auth •No more than 12 hours (48 units) may be billed in a 24 hour period
	669 Respite Care, Other For HHA/LNA		
Family Training	589 Home Health – Other visits, Visit charge	G0164 <i>Skilled services of an LPN or RN in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes</i>	<ul style="list-style-type: none"> •Based on Needs Assessment and prior auth
Family Grief/Bereavement Counseling	561 Home Health – Medical Social Services, General	99510 <i>Home visits for individual, family, or marriage counseling</i>	<ul style="list-style-type: none"> •Must be initiated prior to beneficiary’s death •Fee-for-service prior to beneficiary’s death •May bill for 6 units of service on final bill to cover services during bereavement period

⁸ The Medicaid/DVHA Provider Manual is available at vtmedicaid.com/Downloads/manuals.html

Section 7: IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

*Vermont Department of Health
Children with Special Health Needs*
108 Cherry Street
Burlington, VT 05402
Voice: 802-863-7200
In Vermont 800-464-4343
Fax: 802-865-7754
TTY/TDD: Dial 711 first

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (802) 879-5900

Vermont Family Network
600 Blair Park Rd, Suite 240
Williston, VT 05495
Phone: (800) 800-4005
Fax: (802) 876-6291

Pediatric Advanced Care Team at Vermont Children's Hospital
Medical Center Campus
111 Colchester Avenue
Burlington, VT 05401
Phone: (802) 847-8888

*After hours, call Provider Services @ FAHC and ask for the Palliative Care Clinician on-call

COMMUNICATION CHEAT SHEET

➤ Please use this as a quick reference only - further details are outlined in the Provider Manual

PURPOSE: To summarize communication expectations thereby preventing gaps in care

OBJECTIVE: Ensure fluid and timely communication between the:

- Home Health Agency and enrolled family
- Home Health Agency and PPCP Coordinator at CSHN

The PPCP Nurse Case Manager is responsible for the following:

- ✓ Processing Provider Referral
- ✓ Determining Program Eligibility
- ✓ Facilitating and/or conducting Needs Assessment for services
- ✓ Completing prior authorization for services
- ✓ Submitting Enrollment Request to HHA Intake Department for enrollment of child
- ✓ Submitting the New Patient Intake Not to the designated Care Coordinator once identified

Once the Intake Department has received the Enrollment Request →

The HHA is responsible for the following:

- ✓ Contacting the child/family within **24-48 hours** to:
 - Acknowledge receipt of information
 - Notify that enrollment within the agency is underway
 - Provide name of child's Palliative Nurse Care Coordinator (if call is not made by himself/herself)
 - Schedule first face-to-face visit within **7 calendar days**
 - ✓ Notifying the PPCP Coordinator at CSHN of the designated Palliative Nurse Care Coordinator
 - ✓ Follow-up with PPCP Coordinator at CSHN after first face-to-face visit
 - ✓ Submitting Monthly Services Reports and care plans to the PPCP Coordinator at CSHN
 - ✓ Review of care plan with PPCP Coordinator at CSHN, including prior to exhaustion of authorized services every 6 months
- When in doubt, call the PPCP Coordinator at CSHN at (802)865-1312