



Pediatric Assessment Tool Home Health Agency Frequently Asked Questions

- 1. What is the Pediatric Assessment Tool (PAT)?**
 - The PAT is an evaluation instrument developed to ensure that services provided through the Home Health Benefit are in (1) accordance with the Benefit standard which can be found [here](#) and (2) are medically necessary.
- 2. When do I need to complete the Pediatric Assessment Tool for my client?**
 - The tool must be completed for all pediatric long-term Home Health Prior Authorization Requests (PARs).
 - After January 1, 2013 all new long-term Home Health clients must have the tool completed for nursing and Certified Nursing Assistant (CNA) prior authorization requests.
 - Existing pediatric long-term Home Health clients must have a completed tool submitted two months before their current PAR ends.
- 3. What clinical information is needed for the PAR review?**
 - The clinical information must include the plan of care (or HCFA-485) and the completed tool. The agency may also submit any clinical, educational or other assessment documentation that illustrates the need for the requested Home Health services.
- 4. Who fills the tool out?**
 - The assessment **must** to be completed by the clinician (RN, therapists, or MD) that assessed the client for Home Health services. Although we encourage the clinician to consult the client's family, this **is not** to be filled out by parent even if the parent is the Home Health nurse, CNA or administrator.
- 5. Can a Medical Social Worker (MSW) complete the pediatric assessment tool?**
 - No, the pediatric assessment tool is a clinical assessment and should be completed by the client's nurse with input from the client and their family.
- 6. What if I don't agree with hours/visits in the tool?**
 - If you disagree with the tool score and associated services, we ask that you, as the Home Health provider, request the amount of services you feel the client's condition warrants and submit all supporting documents at the time the PAR is submitted. Examples of supporting documentation are listed below in Question #13.
 - You can request a consultation with Colorado PAR to discuss the client's case. This is called the Peer-to-Peer Process. This enables the client's physician to discuss the client's needs with a physician at Colorado PAR.
 - You can request a reconsideration by an independent physician.
 - You can work with your client to appeal the reduction.
- 7. What happens to my client when their hours are decreased?**
 - If a PAR is decreased by less 30%, the new service level will start on the day the new PAR goes into effect.
 - If the client's hours are decreased by 30% or more, the Colorado PAR Program will work with the Home Health Agency to create a step-down plan that will allow clients to gradually decrease services over three months.

- Any reductions of Home Health services may be appealed by the client or their authorized representative (family member, caregivers, etc) through the Office of Administrative Courts.

8. What is the Peer-to-Peer process?

- The Peer-to-Peer Process enables the client’s physician/provider to discuss the service plan and PAR with a physician at Colorado PAR when services have been reduced or denied. It occurs when:
 - A request is made by the provider, within five (5) calendar days after a denial decision, for a verbal consultation with a Colorado PAR physician to discuss the reduction or denial determination; or
 - The provider submits additional clinical information for review within the first five (5) calendar days following a reduction or denial decision.

9. What is the reconsideration process?

- The Reconsideration Process is a second review by a non-Colorado PAR physician that must be requested by the client’s provider within ten (10) calendar days of the denial decision. The process proceeds as follows:
 - Review is completed by a physician of the same profession and specialty as the requesting physician;
 - Review will include all information submitted and any additional information the provider wishes to submit;
 - The reviewing physician may overturn or uphold the original denial decision.

10. If I disagree with the pediatric assessment tool score for an existing Long-Term Home Health client, should I request the number of services supported by the tool score, or should I request the number of service that have been previously requested?

- For an existing Long-Term Home Health client, an agency should always request the number of services that the client was receiving. This ensures that 1) the client’s appeal rights are preserved and, 2) if the client is eligible for the step-down process, they will receive the step-down services.

Agencies should include the following language in box 6:

The agency disagrees with the scoring of the pediatric assessment tool (example): “Prior to this PAR, the client was approved to receive 8 hours of service per day. The agency believes documentation in addition to the tool supports 8 hours of service per day, but the tool is currently calculating a reduced number of hours at 6.”

11. If a client reports that they did not receive a letter for the reduction or denial of services, and they want to appeal the change, what should the client do?

- The client does not need to wait for the letter from Medicaid to request an appeal. All they need is to write a brief letter with the client’s name, their Medicaid ID number, the Medicaid Home Health PAR number, a description of the services they believe they should receive and why the services are needed.
- The Home Health PAR information can be obtained by the agency from the provider web portal, or the client/family can obtain this information by calling the Medicaid Home Health Hotline to obtain the PAR information at: 303-866-3447.
- The letter can be sent via regular mail or dropped off in person to:

Office of Administrative Courts
633 17th Street, Suite 1300
Denver, CO 80202



- Or, they may fax the appeal request to the Office of Administrative Courts at 303-866-5909.

12. What additional documentation or information should be sent in to help illustrate the need for more services?

- Home Health Providers should work with families to obtain any additional information that explains the client’s needs and demonstrates the need for Home Health services. These documents include but are not limited to:
 - Plan of Care (HCFA-485)
 - Treatment Plans
 - Individual Educational Plans (IEPs)
 - Therapy Notes (Including Physical Therapy, Occupational Therapy, Speech Therapy)
 - Primary Doctor Notes
 - Consultations or Notes from Specialists
 - Any document from other public health agencies regarding the child’s situation
 - Documentation from the child’s DME provider(s)
 - Letter from child’s caregiver providing additional insight into your child’s case/complexity to Colorado PAR
 - Any other documents that provide additional insight into the client’s needs
 - Documents regarding Developmental Delay treatment and needs (Part C Documents)
 - Documentation/reports from child’s behavioral/psychological provider
 - If letters of medical necessity are requested specifically for the Home Health PAR process, be sure that these avoid generalizations or simple statements such as “the services are medically necessary.” All letters should contain clear and concise reasons and specific needs of skilled Home Health services.

13. Isn’t it illegal for a Medicaid provider to charge a Medicaid client?

- As per [state regulation](#), (10 CCR 2505-10 Section 8.061.9): A client may enter into an agreement with a third party or provider whereby the client agrees to be personally liable for payment of services not covered by Medicaid. The agreement must be signed and dated by both the client and provider prior to providing the service, and the agreement must specify the services that will be provided by the provider and include the approximate cost of services provided and the method of payment by the client.

14. Should the tool be used for clients who are between 18 and 20 years of age? (Since their PAR application is also made through Colorado PAR)

- You will use the tool for all PARs that are sent to the Colorado PAR Program for pediatric long-term home health. If you are submitting a request for an 18-20 year old client for adult long-term home health, then you will use the standard form and submit the PAR to the county SEP or CCB.

15. Will clients who are 18, 19 or 20 years of age have their Home Health requests reviewed as adult Home Health or a pediatric Home Health?

- Clients who are 18, 19 and 20 years of age may receive pediatric or adult Home Health services. If a Home Health request is made for pediatric Home Health, then the agency must complete the pediatric assessment tool and submit the prior authorization request to the Colorado PAR Program.
 - If the client is 18, 19 or 20 years old and on a waiver, the pediatric assessment tool is not required and the agency should submit the prior authorization request to the SEP or CCB.



16. Is a parent CNA considered a working parent?

- Yes, a CNA (parent or other) who is employed by a Home Health agency to provide service to the agency's client is considered to be working.

17. What is the primary diagnosis?

- The client's primary diagnosis on a plan of care should be the diagnosis that is *most related* to the need for Home Health services. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and the one that requires the most intensive services.

18. Can therapy-only requests be requested for 1 full year?

- After January 1, 2013, therapy-only requests may be requested for up to 1 year.

19. Speech & Oral (Verbal) Expression of Language – When is it appropriate to mark two boxes as is mentioned?

- The assessor may select up to 2 options when both options illustrate the client's ability to verbalize ideas, thoughts and needs. If only one response illustrates that client's ability, then only one option should be selected.

20. Toileting Hygiene – Is it appropriate to indicate perineal hygiene assistance levels for those not able to toilet? (Example: For diaper changing and perineum hygiene needed at that time)

- Yes, it is appropriate to document the need for toileting hygiene when a client is incontinent or uses diapers.

21. For those clients requiring water hydration via feeding tube (GT/JT) – is it appropriate to indicate that need?

- Yes, if the client only receives hydration via the feeding tube, then the agency should include the number of times hydration is administered via the feeding tube.

22. Does the Pediatric assessment tool need to be completed for children who only need Syngis injections?

- No; agencies are not required to complete a Pediatric Assessment Tool for clients who only need temporary nursing services for sole purpose of Synagis immunizations.

23. Does an agency need to complete the Pediatric assessment tool for clients who are receiving only Home Health therapies?

- No, the Pediatric assessment tool is only required for Home Health CNA and/or nursing services.

Program Contact:

[Guinevere Blodgett](#) (email link)

303-866-5927

