

PARTNERS FOR CHILDREN
A PEDIATRIC PALLIATIVE CARE WAIVER PROGRAM

AGENCY PROVIDER MANUAL

For more information on Partners for Children or this Provider Manual,
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To all of the people who worked tirelessly to develop the waiver and create
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Florida Waiver Staff

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Section 1 - How to Use This Manual

How to Use This Manual

This Partners for Children (PFC) Agency Provider Manual was developed to provide you, a PFC Agency provider, with the information and tools you need to participate in this program.

Why You Need this Manual

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

Delivery of PFC 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 PFC services to the participants and families enrolled in PFC.

A California Children's Services Nurse Liaison (CCSNL) in your participating county CCS Program is available to answer questions and provide consultation and technical assistance. Another resource for you is through the State Children's Medical Service Branch staff that will provide technical assistance and consultation for unresolved issues. Contact information for both the County offices and the State can be found on the Pediatric Palliative Care section of the CMS website.

<http://www.dhcs.ca.gov/services/ppc>

How the Manual is Organized

Section 2 provides a Partners for Children program overview and background information on the PFC Waiver.

Section 3 provides a summary of the CCS program.

Section 4 provides PFC provider staff requirements for participation and the roles and responsibilities of the Care Coordinator.

Section 5 provides information on PFC participation expectations on an Agency administrator level.

Section 6 provides information on Provider enrollment and disenrollment.

Section 7 provides a description of the participant enrollment process done at the county level.

Section 8 provides a description of the Family-Centered Action Plan (F-CAP). The F-CAP form and full instructions for completing the form are attachments to this manual.

Section 1 - How to Use This Manual

Section 9 provides a list and description of each PFC service including applicable codes and offers guidelines on authorization and reimbursement.

Section 10 provides a description of the health and welfare standards required of a PFC agency.

Section 11 provides a description of the protection of personal health information and privacy standards required of a PFC agency.

Section 12 provides a list of PFC provider expectations regarding documentation and record keeping.

Section 13 provides a list of acronyms and definitions commonly used in PFC materials.

Section 14 provides a list of attachments. These are separate documents.

Section 2 - Program Overview and Background Information

Partners for Children

Partners for Children (PFC) is a pediatric palliative care program made possible through a 1915(c) (home and community based services or HCBS) waiver approved by the Centers for Medicare and Medicaid Services for use in California.

The impetus behind Partners for Children was the Nick Snow Children’s Hospice and Palliative Care Act of 2006 (Assembly Bill 1745) and encouragement from multiple stakeholders. This led to the release of a numbered letter describing palliative care benefits currently available within the state Medi-Cal plan (NL 04-0207). It was recognized, however, that palliative care services could not be delivered by Hospice Agencies at the time a child might also wish to continue medical treatment of the condition. Also, some services were not available through the state plan by any provider. In response, the waiver was developed to allow for this set of hospice-like services to be delivered by either Hospice or Home Health agencies, concurrently with medical treatment.

The purpose of PFC is to provide family-centered pediatric palliative care services that allow children and their families the benefits of hospice-like care, in addition to ongoing Medi-Cal services during the course of an illness, even if the child does not have a life expectancy of six months or less. Eligible children include those who have a California Children’s Services (CCS) eligible medical condition with a complex set of needs, have full scope, no share of cost Medi-Cal, are under 21 years of age, and live in a participating county.

PFC 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 participant (child or teen) and Family Unit (siblings, parent/legal guardian, and significant others) in the local community. PFC will start with a small number of counties participating in the first three years.

Participating Counties		
Year 1	Year 2	Year 3
Alameda Monterey San Diego Santa Clara Santa Cruz	Year 1 counties plus Marin Orange San Francisco Sonoma	Year 1 & 2 counties plus Fresno Los Angeles

Section 2 - Program Overview and Background Information

Individual Participation

Participation in PFC is accomplished by referring a child/teen residing in one of the participating counties to the CCS program where the CCS Nurse Liaison (CCSNL) will determine if the applicant meets PFC criteria and level of care, based upon the information provided by the referring physician. Once enrolled, the participant will choose a Care Coordinator at a local participating agency. The participant and family will then meet with their Care Coordinator.

The Care Coordinator will work with the family to complete the care plan, the Family-Centered Action Plan. This plan will identify the needs, goals and services requested through the state Medi-Cal plan, PFC, and in the community.

Services provided through Partners for Children will be:

- Comprehensive Care Coordination
- Respite Care (in-home and out-of-home)
- Expressive Therapies: art, music massage and play therapy
- Family Training, including but not limited to: education and instruction on palliative care principles, care needs, treatment regimes, and use of equipment
- Family Bereavement Counseling for members of the Family Unit and other caregivers, as applicable
- Pain and Symptom Management

Future access to PFC will be based on a statewide independent evaluation of the pediatric palliative care benefit. The evaluation will allow California to assess the potential applicability of a statewide pediatric palliative care benefit, including cost neutrality and how the program services lead to improved quality of life for the participating children and families. The evaluation will be done by UCLA Center for Health Policy Research over a four year period.

For more information visit: <http://www.dhcs.ca.gov/services/ppc>

Section 3 - Overview of the CCS Program

California Children's Services (CCS)

CCS is a statewide program that arranges, directs, and pays for medical care, equipment, and rehabilitation when medically necessary and prior authorized by the program. Services can be authorized for children and young adults under 21 years of age who have CCS-eligible medical conditions and whose families are unable to pay for all or part of their care. CCS selects the most qualified professionals to treat the child's CCS-eligible condition. CCS children are followed by a CCS-paneled physician or one who works in conjunction with a CCS-approved Special Care Center located at a tertiary hospital. It is important to know that CCS is not a health insurance program and will not meet or pay for all of a child's health care needs. CCS covers only those health care needs related to a child's CCS-eligible medical condition.

CCS provides treatment, such as doctor services, hospital and surgical care, some home care, physical and/or occupational therapy, laboratory tests, X-rays, orthopedic appliances, and medical equipment as needed for a child's CCS-eligible medical condition. CCS may also provide help for a child to see physician specialists who will care for the child when medically necessary. The CCS program can make referrals to other agencies, including public health nursing, regional centers, or to the Medical Therapy Program (MTP), which can provide physical and/or occupational therapy in some public schools for children who are medically eligible for these special services. CCS does not cover hospice or long term care.

Anyone can make a referral to CCS (i.e., doctor, teacher, family member, neighbor) if they think the child may have a medical condition that is CCS eligible. The CCS program may pay for or provide a medical evaluation to find out if a child's medical condition is covered.

The California Department of Health Care Services, Children's Medical Services Branch, manages the CCS program. In larger counties with populations greater than 200,000, the local county health department staff carries out all program activities. Smaller counties with populations under 200,000 share the operation of their program with the State CCS regional offices. There is a CCS office in every California county health department.

State and county CCS programs share in the cost of providing specialized medical care and rehabilitation to physically handicapped children through allocations of State General Fund and county monies. The amount of State money available for the CCS program is determined annually through the Budget Act.

For more information visit: <http://www.dhcs.ca.gov/services/ccs>

Section 4 - PFC Agency Staff Provider Requirements

PFC Agency Staff

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

- Comprehensive Care Coordination
- In-Home Respite Care and coordination of Out-of-Home Respite Care
- Expressive Therapies including Art, Music, Massage, and Child Life
- Family Training including but not limited to: education and instruction on palliative care principles, care needs, treatment regimens, and use of equipment
- Family Bereavement Counseling for family and other primary caregivers, as applicable

Care Coordination

Registered Nurse or Medical Social Worker (with at least a Master's degree) employed by PFC Agency who meets the ***Pediatric experience and education standard*** of:

- A minimum of three years clinical pediatric experience
- A minimum of one year clinical End of Life Care experience
 - End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years

In Home Respite Care

PFC Agency Employed/Contracted: Registered Nurse, Licensed Vocational Nurse, or Certified Home Health Aide

- Respite care will be provided by a service provider who meets the *Pediatric experience and education standard* described above or by a service provider who is supervised by another provider who meets the standard.
- Training and expertise provided by Home Health/Hospice Agency

Independent Individual Nurse Providers: *Pediatric experience and education standard* and training and expertise provided by a Hospice Agency (HA)/ Home Health Agency (HHA)

- Registered Nurse or Licensed Vocational Nurse (under supervision of RN) who meets the *Pediatric experience and education standard*. (Individual Medical provider number required)

Section 4 - PFC Agency Staff Provider Requirements

Expressive Therapies

PFC Agency Employed/Contracted: Expressive therapists with experience working with children who have chronic complex conditions

- Child Life Specialist: Certification through Child Life Council
- Art Therapist: Master's degree in art therapy or in art education or psychology with major course work in art therapy, including an approved clinical internship in art therapy. Registered or eligible for registration with the American Art Therapy Association
- Music Therapist: Bachelor's degree in music therapy and registered or eligible for registration with the American Music Therapy Association
- Massage Therapist: Registered

Independent providers will not be allowed to bill individually on a fee-for-service-basis.

Family Training

PFC Agency Employed/Contracted: Registered Nurse meeting *pediatric experience and education standard* or Registered Nurse without pediatric experience and education standard who is supervised by an RN who meets *pediatric experience and education standard*

Individual Nurse Provider RN: *Pediatric experience and education standard* (individual Medi-Cal provider number required)

Individual and Family Bereavement Counseling

PFC Agency Employed/Contracted: Licensed Psychologist, Licensed Clinical Social Worker or Marriage and Family Therapist

Independent providers will not be allowed to bill individually on a fee-for-service basis.

Pain and Symptom Management

PFC Agency Employed/Contracted: Registered Nurse meeting *pediatric experience and education standard* or Registered Nurse without pediatric experience and education standard who is supervised by an RN who meets *pediatric experience and education standard*.

Independent providers will not be allowed to bill individually on a fee-for-service basis.

Section 4 - PFC Agency Staff Provider Requirements

Care Coordinator Roles and Responsibilities

See Care Coordinator requirements above.

[Patient staffing ratio 1:20-30]

Goals:

- Ensure a family-centered, culturally competent system of care by coordinating all services provided to the PFC participant and Family Unit.
- Achieve integration of participant's and Family Unit's goals and medical objectives to assist the participant in successfully and safely living in the community.
- Assess the PFC participant's home and community environment on an ongoing basis to determine if it is safe and conducive to successful implementation of the PFC program.
- Coordinate providers and organize medical, psychosocial, state plan services and community services.
- Communicate with and coordinate the multidisciplinary team for effective medical and palliative care management of the PFC participant.
- Develop and implement a comprehensive care plan called the Family-Centered Action Plan (F-CAP) that responds to social, emotional, spiritual, physical and economic issues that affect the participant's and Family Unit's health and maximum potential.

Goals achieved as a result of the following activities.

- Optimize care through:
 - Facilitation of access to services and continuity of care
 - Family-centeredness
 - Cultural competence
 - Qualified providers
- Maximize and sustain participant and Family Unit quality of life
- Meet the participant and Family Unit's goals and objectives through:
 - A strong working relationship with the CCS Nurse Liaison (CCSNL)
 - Facilitating effective communication, planning, and implementation
 - A working knowledge of CCS, State, community, and provider resources and limitations
 - Shared decision making
 - A holistic approach to service recommendations and integration

Primary Responsibilities:

- Coordinate all care including: PFC services, state plan services and community resources
- Collaborate with the CCSNL, Family Unit, participant and providers to ensure health, safety, choice, and holistic and seamless care
- Educate and train participants, families and Circle of Support in the concepts of palliative and end of life care and caregiver skills needed for home medical regimens

Section 4 - PFC Agency Staff Provider Requirements

- Develop, implement and revise the Family-Centered Action Plan (F-CAP)
 - Ensure family and client-centered development of goals and objectives of care
 - Monitor F-CAP performance against expectations of the participant and Family Unit goals and objectives
- Conduct home visits to monitor health, safety and welfare, including home safety
- Formulate back-up plans to ensure seamless care
- Accompany participant and Family Unit to appointments as necessary
- Maintain records of all correspondence with and about each participant, including but not limited to, calls for nursing triage or assistance and interpreter services needed and used.
- Conduct monthly interdisciplinary team meetings about the participant
 - The team must consist of:
 - At least one nurse, meeting PFC qualifications, who provides care to the participant
 - One social worker, meeting PFC qualifications, who provides care to participant
 - The participant's CCSNL (face-to-face or by telephone)
 - Other professionals involved in the PFC-related care of the child
 - The physician providing primary care for the child (may be by telephone)
 - The participant or a family member if they choose to participate

Collaboration with the CCS Program

The Care Coordinator will be required to maintain on-going communication with the county CCS Nurse Liaison (CCSNL) to:

- Receive information about new participants/families as the CCSNL enrolls them
- Review the F-CAP (initial and updates)
- Request authorization of all waiver services specified on the F-CAP
- Coordinate for needed state plan and community services specified on the F-CAP
- Report all health and welfare incidents to the appropriate authority. See Section 10 - Health and Welfare
- Update records for changes in staffing (submit new copies of the staff pages of the application)
- Report issues/concerns about the PFC program

The county CCSNL responsibilities:

- Provide ongoing technical assistance to the Agencies providing PFC services
- Collaborate with the Agency to find all community resources
- Determine applicant eligibility for PFC program
- Maintain county waiting list and communicate with state for statewide waiting list
- Enroll all new participants
- Refer participants to the chosen agency/Care Coordinator
- Authorize all appropriate services

Section 4 - PFC Agency Staff Provider Requirements

- Follow up on any health and welfare incidents reported: with family, providers, state staff, etc.
- Contact the family/participant to assess satisfaction with services
- Participate in monthly interdisciplinary team meetings

Section 5 - Agency Level Provider Participation

Required Policies and Procedures

Partners for Children (PFC) Agency Providers are defined as Hospice Agencies (HA) (22 CCR sec. 51180.1-51180.7 and 22 CCR Sec. 51250.) and Home Health Agencies (HHA) (22 CCR Sec. 74659 et seq.)

A Participating PFC Home Health Agency or Hospice must:

- Be a Medi-Cal provider delivering services to children residing in one of the participating PFC counties
- Have successfully completed the PFC provider application
- Have completed PFC agency provider training before providing services
- Make available phone consultation on a 24 hour basis, 7 days a week by a Registered Nurse with pediatric experience, training and expertise provided by the Home Health or Hospice Agency.
- Provide interpreter services for the participant and family, if needed
- Maintain documentation related to services provided to all PFC participants for review by the Department of Health Care Services, California Children's Services (CCS) or the California Department of Public Health
- Collaborate with the CCS program to coordinate the care of all PFC participants
 - Primary communication will take place between the Agency Care Coordinator and the county CCS Nurse Liaison (CCSNL)

All Partners for Children Agencies must develop and implement policies and procedures to include the following:

1. **24/7 Access:** There shall be nursing services available at all times to provide advice and assistance to PFC participants/families (who are assigned to the agency) by phone, and by visits to the home to alleviate pain or other symptoms when indicated. The on-call staff must be a registered nurse, with pediatric experience preferred.
2. **Health and Welfare:** The Agency shall adhere to the following practices with personnel and services appropriate for PFC participants.
 - A. Child abuse and neglect: Ensure compliance with laws and regulations pertaining to the identification and reporting of known or suspected child abuse or neglect and to enhance participant safety.
 - B. Confidentiality: All information about participants shall be held in the strictest confidence as required by law.
 - C. Documentation: Keep record of reported incidents in the participant's chart including:
 1. Subjective data including the participant/caregiver's description of the incident or other subjective data which may be indicative of child abuse/neglect
 2. Objective findings of the physical assessment

Section 5 - Agency Level Provider Participation

3. Observed behavior of the participant/caregiver which may be indicative of abuse or neglect
4. Assessment of the immediate safety of the participant in the home environment including the plan for accessing necessary safety and community resources
5. Name of CPS staff to whom the case was reported and the reference number
6. Case disposition
7. Police involvement

3. Documentation/Centralized Chart: Reports and notes shall be recorded in the participant's chart and be readily available to other PFC team members.

- A. Written assessments, diagnosis, evaluation and a plan for intervention by PFC team must be documented in the participant's chart within 24 hours and signed by the service providers
 1. All documentation shall be accompanied by name, date, time, and signature including professional identification.
- B. The CCS county program shall have access to participant charts in order to authorize services.
- C. Progress notes shall be kept in centralized chart.
- D. Records of all 24/7 triage nurse calls need to be included. These shall include participant's name, date, time, issue, resolution (including advice given, redirection, or other) and Nurse's name.

4. Communication: There will be a policy for effective communication using all necessary vehicles in order to exchange information, thoughts or ideas with participants and their families, PFC team members, county CCS staff, medical staff, and outside agencies.

- A. A systematic approach to communicate respectfully with people in difficult situations will be developed and maintained.
- B. The agency will use its professional presence and principles of Family-Centered care to ensure that information sharing is open and objective.

5. New Participant Procedure:

- A. Planning: When a participant is assigned to the agency, the Care Coordinator is responsible for coordination of the multidisciplinary team and will work with the participant, family and each of the service providers to develop a care plan called the Family-Centered Action Plan (F-CAP) that will best fit the participant's needs and available resources.
- C. Health and Safety: The Care Coordinator reviews with the participant/family information on health and safety and personal health protections as described in Section 10.
- D. Implementation: Action must be taken by all members of the team to put the F-CAP into effect on a timely basis.
- E. Documentation: Notations of team meetings and F-CAP will be recorded in the central chart within 24 hours.

Section 5 - Agency Level Provider Participation

6. Participation in Federal Assurances:

Medi-Cal supervises the performance of the waiver and establishes and/or approves policies that affect the Assurances. In partnership with the State CMS Branch, the County CCS Offices and PFC Agency are responsible for assuring the quality of the program. The PFC Agency will be responsible for observing and reporting in the following areas:

- Quality Assurance
 - Health and Safety
 - Environmental assessment
 - Family-centered development of F-CAP
- Quality Improvement
 - Satisfaction
 - Resolution of Incidents and Complaints
 - Identified improvement opportunities

Section 6 - Provider Enrollment Process

The Application package includes:

- Instructions
- Application [page 1] also used as Change of Information Form
- Application [page 2] Expectations/Agreement Signature Page
- Attachment 1: Agency Staff Participation Form
- Attachment 2: Standards and Requirements of Participation
- Attachment 3: Care Coordinator Roles and Responsibilities

Application Process:

- Read and meet standards of participation (provided with the application as well as in the Standards section of this manual)
 - Individual services available
 - Qualified staff
 - Agency requirements
- Read and understand the roles and responsibilities (provided with the application as well as in the Standards section of this manual)
 - Expectations of the Care Coordinator
 - Explanation of the CCSNL role
- Fill out all agency information on the application form
- Sign agreement of expectations and authority to participate
- Document all staff who will be serving waiver children
- Document all outside agencies/persons contracted to provide waiver services (i.e. out of home respite)
- Provide explanation, if services/staff are not in place at the time of application, of how these will be in place by the time participants are served

Out-of-Home Respite Providers

Any providers that will be providing out-of-home respite care as a PFC service for a participant assigned to your agency will need to fill out and submit both pages of the Application but none of the attachments.

Staff/Agency Updates:

Use the Application/ Change of Information form for any subsequent informational updates and the Agency Staff Participation Form (Attachment 1 of the Application) for any subsequent staff or contracting updates.

Disenrollment:

If an Agency chooses to discontinue participation in the PFC program contact the State CMS Branch. At least 30 days notice will be required before an agency can discontinue services so that other arrangements can be made for the participants.

Section 7 - Participant Enrollment Process

PFC Referral

A child (age 0 through 20) may be referred to Partners for Children (PFC) from a variety of sources, including but not limited to, the Special Care Center team or primary care physician providing medical care to the child, family members, or the child him or herself. For physicians, a Physician Referral Checklist and Physician Referral Form will be available online and from the county CCS office. If a PFC Agency provider identifies a child who may benefit from hospice-like care while continuing to receive curative treatment and may meet the following eligibility criteria, the agency should refer the child to the PFC CCS Nurse Liaison (CCSNL) in the nearest participating county CCS office.

A PFC referral may be initiated using any of the following formats:

- A PFC Referral Form along with any medical documentation that the CCS program has not already received that describes the applicant's waiver eligible medical condition.
- Written request by a parent or legal guardian
- Information provided by telephone or in person at a participating CCS county office

If the referral is submitted by a non-physician, the CCSNL will contact the child's primary physician to request that a signed referral form be returned to the CCS county office.

Eligibility

The CCSNL is responsible for determining eligibility for PFC, including verifying a level of care determination. The CCSNL will use the criteria below to determine whether each child meets the eligibility requirements.

Eligibility is determined based on five broad criteria, the child must:

- Live in a participating county
- Be eligible for full scope, no share of cost Medi-Cal
- Be 20 years of age or younger
- Have a eligible medical condition (below)
- Meet Level of Care (LOC)

Eligible Medical Conditions:

The child has one of the following CCS-eligible medical conditions:

- Neoplasms
 - Not responding to conventional protocols; or
 - Diagnosed with an advanced solid tumor, stages 3 or 4
- Cystic Fibrosis
 - End stage lung disease; or
 - Dependent on ventilatory assistance; or
 - On transplant list
- CNS injury/hypoxic ischemic encephalopathy/neurological condition with severe co-morbidities:
 - Intractable seizures; or

Section 7 - Participant Enrollment Process

- Pulmonary compromise; or
- Recurrent and frequent hospitalizations
- Spinal muscular atrophy, Type I or II, requiring ventilatory support
- Duchennes muscular dystrophy, requiring ventilatory support
- Short gut syndrome either
 - Dependent on Total Parenteral Nutrition (TPN); or
 - Awaiting small bowel and/or liver transplant
- Chronic intestinal failure dependent on TPN
- Liver failure from biliary atresia awaiting transplant
- Heart failure, either
 - Awaiting transplant (heart or heart/lung); or
 - Requiring continuous medication infusions
- Congenital anomalies of the heart
 - Hypoplastic left heart syndrome; or
 - Total anomalous venous drainage with residual pulmonary vein stenosis
- Pulmonary hypertension
- Chronic respiratory failure requiring continuous ventilatory assistance
- Post organ transplant
 - Bone marrow
 - Lung
 - Heart
 - Liver
 - Small bowel
- Leukodystrophies

Level of Care:

The child is at risk of hospitalization for at least 30 days in the following year but for the availability of waiver services, according to the child's physician and documented on the PFC Referral Form.

Enrollment

If the child is eligible and interested, they and their family will meet with the CCSNL to complete the enrollment process. The CCSNL will explain the program including available services, provider choices available, confidentiality of protected health information (PHI), and health and safety safeguards. The CCSNL will determine if the child is in another 1915c waiver, in which case the family will decide which waiver is best for the child, as it is not permitted to be enrolled in more than one 1915c waiver at a time. If the child and family decide to participate in PFC, they will sign the Freedom of Choice form and the Participant Agreement form. The Freedom of Choice form includes the selection of an agency for providing PFC services. When all documents are signed and an agency chosen, the CCSNL will contact the agency to connect the participant/family with their Care Coordinator. The CCSNL is the CCS point of contact for the agency in all matters related to the PFC services for the individual enrolled in the program.

For a list of participating counties and contact numbers visit our website.

<http://www.dhcs.ca.gov/services/ppc>

Section 7 - Participant Enrollment Process

Disenrollment

A participant may be disenrolled for any of the following reasons:

- There is a significant positive change in health status (no longer meets Level of Care).
- The participant has moved to a county not participating in this waiver.
- The participant/family does not want to participate any longer, for any reason.
- The participant has been hospitalized for more than 30 straight days.
- The participant is no longer eligible for full scope, no share of cost Medi-Cal.
- The participant/family/home environment poses a health and safety risk to the Partners for Children agency providers and attempts at remediation have not been successful over a 30 day period.
- The participant/family misses three scheduled and confirmed PFC appointments despite efforts of the Care Coordinator and CCSNL to accommodate the family's needs.
- The participant enrolls in another 1915(c) Home and Community Based Waiver.
- The participant ages out - reaches his/her 21st birthday.
- The participant dies.

When a child is identified for possible disenrollment, the CCSNL will discuss the reasons with the Care Coordinator, and multi-disciplinary team if necessary, to determine if the child needs to be disenrolled. If the identified reason for disenrollment is verified, the CCSNL will discuss with the family and disenroll the child. Once disenrolled, the child/family will need to go through the entire enrollment process again if they wish to re-enroll.

Section 8 - Family-Centered Action Plan (F-CAP)

The comprehensive care plan/service plan for Partners for Children is called the Family-Centered Action Plan (F-CAP). This standardized assessment and planning tool was developed in collaboration with pediatric palliative care stakeholders and Children's Medical Services Branch staff. The purpose of the F-CAP is to integrate the participant/family needs and goals to ensure that the participant can successfully and safely live in the community. It will assist the Care Coordinator and CCSNL in tracking the goals and services as well as maintaining consistent care. The State CMS Branch will use data from the F-CAP to meet the federal assurances required for the program in the waiver.

The F-CAP can be developed using the electronic form or handwritten. If it is initially handwritten, it needs to be entered into the electronic form before submitting to the CCSNL for approval.

The F-CAP is based on the Partners for Children principle that if curative treatment is provided along with pediatric palliative care services there can be an effective continuum of care throughout the course of the medical condition. The F-CAP is a family-centered document designed to assist in achieving the goals of minimizing the use of institutions (especially hospitals), and improving the quality of life for the participant and Family Unit (siblings, parent/legal guardian and significant others). In addition, the F-CAP allows the Care Coordinator to assume a large part of the burden of responsibility otherwise placed on the parent for coordinating, organizing, facilitating access to care and providing critical information to multiple providers relating to the care necessary for effective medical management.

The F-CAP identifies the social, emotional, spiritual, physical, and economic issues effecting the participant and Family Unit's health and maximum potential.

The Care Coordinator works directly with the participant and Family Unit to develop the F-CAP. The participant and Family Unit are also encouraged to invite individuals of their choice (Circle of Support) to actively participate in the F-CAP development. The participant has the authority to determine who is included in the process. The participant's selection of their Circle of Support in this process will be determined by the concurrence of the participant and parent/legal guardian in compliance with state and federal laws regarding capacity and authority to consent to medical treatment and privacy.

The development of the F-CAP requires the coordination of multiple processes, individuals and providers. The F-CAP identifies the following:

- Current medical treatment plan with each participating provider
- Treatment or disparities in medical care among multiple providers and environments
- Qualified local service providers that meet the participant and Family Unit care needs
- Issues that interfere with family functioning and dynamics.

Section 8 - Family-Centered Action Plan (F-CAP)

It is anticipated that completion of the F-CAP will be accomplished with more than one visit. The Care Coordinator has the flexibility to gain information and insights through conversations, observations, appropriate timing and sensitivity with the participant and Family Unit. The initial development of the F-CAP will begin within 48 hours of the agency accepting the new participant. The F-CAP is completed by the Care Coordinator. If the Care Coordinator is a Registered Nurse, the Social Worker may also address and complete areas of the F-CAP. If the Care Coordinator is a Social Worker the physical assessment sections need to be completed by a Registered Nurse.

Once the initial (and each updated) F-CAP is completed the Care Coordinator is responsible for obtaining the treating physician signature and sending the F-CAP to the CCSNL for approval. Once approved by the CCSNL, the Care Coordinator gives a copy to the participant/Family Unit and sends one to the treating physician. The CCSNL will keep a copy in the participant's CCS Partners for Children file.

The F-CAP needs to be updated every 60 days, and more often if the condition of the participant or needs change. Following each evaluation visit the Care Coordinator updates the F-CAP based on the assessment of the status of the participant and evaluation of the effectiveness of the services provided. The Care Coordinator is responsible for assuring that the services are provided in accordance with the F-CAP. If it is determined that the existing F-CAP no longer meets the participant's needs, the Care Coordinator, consulting with the treating physician, must submit an updated physician approved F-CAP to the CCSNL.

A Spanish translation of the F-CAP is attached and should be used as a reference document along with the completed English version of the F-CAP for Spanish speaking families. The whole Spanish version does NOT need to be filled out and updated every 60 days.

Also attached is a Spanish translation of the last two sections (IX and X) of the F-CAP. These pages do need to be filled out and kept up to date for Spanish speaking families.

Section 8 - Family-Centered Action Plan (F-CAP)

Structure and Content of the F-CAP

See the F-CAP instructions for details on completing the form.

The F-CAP is divided into the following sections:

- Section I. Patient Information
 - A. Identifying Information
 - B. Diagnosis / Providers
- Section II. Health & Symptom Assessments
 - A. Communication / History
 - B-D. Physical Assessment (completed by and RN)
 - E. Pain Assessment Tool (completed by and RN)
 - F. Nutritional Risk Screen (completed by and RN)
- Section III. Family / Social Information
- Section IV. Health and Safety Assessments
 - A. Risk / Home Environment
 - B. Home Environment assessment continued
- Section V. Perception of Illness / Health Care Goals
 - A. Patient
 - B-E. Family
 - F-H. Siblings
 - I. Decisions
- Section VI. Patient, Family and Circle of Support Desires
 - A. Patient
 - B. Family
 - C. Circle of Support
- Section VII. Care Goals by Care Coordinator
 - A. Goals documented from Sections I-III
 - B. Goals documented from Section IV
 - C. Goals documented from Section V and others
- Section VIII. Integration of ALL Goals
- Section IX. Services
 - A. Current services receiving
 - B. Services requested, including extension of previous servicesSignatures of Care Coordinator, physician, patient (if applicable), parent or legal guardian and CCSNL
- Section X. Additional Resources
 - A. Goals Summary
 - B. Family Phone Sheet

Goals identified for Sections I - V are all also compiled in *Section VII. Care Goals by Care Coordinator*.

Section 8 - Family-Centered Action Plan (F-CAP)

Section I. Patient Information. This section contains demographic information, identification of family members including contact information, diagnosis, primary care and other physicians, Special Care Center following the participant, hospital palliative care team involvement, and other agencies and business providing services to the participant.

Section II. Health & Symptom Assessments. The assessments in Sections II and IV are expected to include multiple visits to the home by the Care Coordinator who may be a nurse or social worker, and at least one visit by a nurse and one by a social worker.

The nursing assessment is to assess the medical fragility and impact of illness on the participant. It will provide baseline information which assists in identifying the participant's care needs, developing the rest of the F-CAP and coordination of services. It will serve as a starting point for evaluating changes in the participant's condition. It will assist with the care coordination and case management to facilitate access for Partners for Children services, State Plan services (Medi-Cal services) and community services.

Section II also gathers information on the participant's communication ability, medical history, current treatments, medications, allergies, and durable medical equipment. The physical assessments are completed by a Registered Nurse and include mental status, pain and symptom management, functional and activity limitations, and rehabilitation potential. The assessment of systems begins with height and weight, which can be answered by the parent or legal guardian, and continues with assessment of eyes, ears, nose, throat, head, neck, respiratory, cardiac, neurological, gastrointestinal, urinary, musculoskeletal, skin integrity, pain assessment, and ending with nutritional risk screen. Assessment of vital signs and any component of the physical examination deemed necessary by the nurse to complete the assessment of the client should be performed in accordance with the Nursing Practice Act.

Section III. Family / Social Information. This section gathers family social information such as the names, ages and relationships of individuals living in the home with the participant. In addition, spiritual beliefs, religious affiliations, traditional health belief systems, contextual and cultural issues are addressed.

Section IV. Health and Safety Assessments. The assessments in Sections II and IV are expected to include multiple visits to the home by the Care Coordinator who may be a nurse or social worker, and at least one visit by a nurse and one by a social worker.

The purpose of the health and safety assessment is to evaluate for health and safety risk, as well as risk of abuse, neglect, exploitation, and potential for violence in the home environment. The Care Coordinator will document all reported or observed critical events or incidents that may affect the health, safety

Section 8 - Family-Centered Action Plan (F-CAP)

and welfare of the participant. Examples of critical events or incidents include: participant abuse (verbal, sexual, physical, or mental) or neglect; incidents posing an imminent danger to the participant; fraud or exploitation (including misuse of participant's funds and/or property); or an unsafe living environment.

Home environment assessment - The purpose of the home environment assessment is to assure a safe environment that meets the needs of the participant and family. It will assure that participant care areas can facilitate and accommodate everything necessary to provide care in the home that is comfortable and safe. This includes the use, maintenance and cleaning of all medical devices, equipment, and stored supplies. All medical equipment must be in working order at all times. The assessment will also assure that safety and preventative measures are in place. All other services and supports need to be in place, or have been ordered and will be in place, at the time the participant is placed in the home, or at the start of care. This included documentation that the care givers have been trained to support the care needs of the patient.

Mitigation of any environment risk factors identified during the assessment will include referral to Child/Adult protective services, other appropriate agencies or community resources. In addition, risk evaluation and proposed intervention is needed to alleviate risk thus enabling the participant to safely receive services at home or in the community.

Section V. Perception of Illness / Health Care Goals. The purpose of this section is to gather information from the participant and the family, including siblings, to understand their perceptions and understanding of the participant's illness, prognosis, trajectory of illness, coping mechanisms, if they worry about self and others, and includes psychosocial and behavior indicators.

An initial psychosocial assessment is done to assess the psychosocial impact of the illness on the participant and family, and to identify the need for services, in particular counseling for family members or participant which is available through the state plan for Medi-Cal beneficiaries, support through any appropriate community agencies, and bereavement counseling for family members available through the PFC program.

In addition, the psychosocial impact of the participant's illness and the risk for anticipatory grief, isolation from peers, depression and parental distress and burnout. The Health Care Goals portion captures the desires for quality of life, how information would like to be received and if comfortable talking about end of life issues.

The last portion of this section addresses the decisions for life sustaining or prolonging treatment and identifies if there is a desire for attempt at resuscitation, if a POLST (Physician Order for Life Sustaining Treatment), advanced directive or equivalent document is completed, or to capture if this conversation has not

Section 8 - Family-Centered Action Plan (F-CAP)

taken place. In addition, this section captures the name of a chosen funeral home or mortuary (and contact person) if applicable.

Section VI. Patient, Family and Circle of Support Desires. This section is designed to document the desires, goals and plans of the participant, family and Circle of Support in each domain including control of pain, physical challenges, emotional and spiritual needs, and academic, social, and end-of-life goals as applicable. The desire for anticipatory grief services and/or bereavement services is captured in this section. For each plan, the desired outcome and follow-up plan are included and services necessary to achieve the plan are identified. This section repeats the same desires for participant as seen from the family and Circle of Support perspectives.

Section VII. Care Goals by Care Coordinator. This section is designed to capture all plans and goals identified in the previous Sections I through V of the F-CAP.

This may include a transition plan. A transition plan is indicated when a participant nears the age of 20, and will require coordination into adult care or when transitioning off of the Partners for Children program for any reason.

Section VIII. Integration of All Goals. The purpose of this section is to bring together the multidisciplinary team members to discuss all the goals and the plans to achieve the goals thus far identified in the F-CAP. It is also where these goals and plans should be integrated into a comprehensive plan for the participant and family. This includes identifying and resolving any conflicting goals or any differences or overlap in the plan and goals. The Care Coordinator also must determine if the care coordination anticipated will be high complexity, high risk or support and management only.

Family members, Circle of Support, and community support members who participated in the Multidisciplinary Team conference are listed in this area.

Section IX. Services. The purpose of this section is to capture all the services the participant is currently receiving including Early Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT-SS) private duty or in-home nursing services, state plan (regular Medi-Cal) services and any community services.

The second part of this section acts as a PFC Services Authorization Request. This is where the services requested are documented including procedure code, service, From and To dates of services, the frequency and duration of the service, the number of units requested, the provider name and NPI number. Community services requested are also captured here. However, the CCSNL is not responsible for authorizing these services. The Care Coordinator is responsible for arranging the community services.

Section 8 - Family-Centered Action Plan (F-CAP)

Section X. Additional Resources. The purpose of this section is to provide an additional place to briefly summarize the identified goals if this would be helpful as a resource page for the participant and Family Unit. This is designed to be kept in the PFC home binder, refrigerator or an easily retrievable place.

The Family Phone Sheet is a resource page for the participant and Family Unit. This provides contact information, the 24 hour agency call line number and complaint/grievance contact information. This sheet lists the names and telephone numbers of the Care Coordinator, CCS Nurse Liaison, therapists and other contact information.

Section 9 - PFC Services, Authorization and Billing

PFC Waiver Authorization Service Request

The CCS program requires authorization for PFC waiver services related to a client's CCS-eligible medical condition. Participating PFC providers must submit a Family-Centered Action Plan (F-CAP) to the CCS county program in which the participant resides (refer to the *CCS Program County Directory* at <http://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx> for information regarding the local CCS program). Only approved PFC providers may receive authorization to provide waiver services.

Upon F-CAP approval, the CCS program will generate a Service Authorization Request (SAR) for PFC services only. Other CCS authorized services will be authorized on a separate SAR.

PFC Services, Procedure Codes and Rates

Refer to section 4 of this manual for a description of the service providers that may perform the following services.

Care Coordination

Care Coordination codes represent an array of services that will enable the participant to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. A key function of care coordination is for a Care Coordinator to assume a large part of the burden of responsibility, otherwise placed on the parents. Critical information that is related to care and necessary for effective medical management will be organized by the Care Coordinator for the provider.

Care Coordination codes:

Procedure Code	Description	Rate	Limits
G9001	Coordinated care fee, initial rate. To be used for at least 22 hours of initial assessment services	\$1,000	One time payment
T2022	Monthly case management. 1 Unit = 4-12 hours per month of required care coordination services, per child	\$229.17 per month	12 units per year
G9012	Other specified case management. Supplemental hourly care coordination rate to be utilized after monthly maximum of 12 hours has been exhausted	\$45.43 per hour	60 hours every 90 days

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Expressive Therapies

The Expressive Therapy code was designed to allow children to creatively express their understanding and reaction to their illness by utilizing creative activity to improve the capacity of the body and mind to heal. This code permits a certified music therapist, massage therapist, child life specialist or art therapist to provide therapy to PFC participants.

Expressive Therapies code:

Procedure Code	Description	Rate	Limits
G0176	Activity therapy, 45 minutes or more per session Includes art, music, child life, and massage therapy	\$35.00	Limit: Three units per day; up to 60 hours every 90 days

Family Training

The Family Training code permits a registered nurse to instruct caregivers about end of life care, palliative care principles, care needs, medical treatment regimen, use of medical equipment, and how to provide in-home medical care to meet the needs of the participant.

Family Training code:

Procedure Code	Description	Rate	Limits
S5110	Home care training, family; per 15 minute unit.	\$11.36 per unit (RN employed by HHA/HA) \$8.94 per unit (Individual Nurse Practitioner billing independently)	Limit: 12 units per day 100 hours per year, per child

Section 9 - PFC Services, Authorization and Billing

Respite Care

PFC provides for both in-home and out-of-home respite. In-home respite will be provided in the participant's residence and may require different provider skill levels to meet the individual needs of the participant.

In-home Respite Care code:

Procedure Code	Description	Rate	Modifier	Limits
T1005	Respite care services, in 15 minute increments. Intermittent or regularly scheduled temporary care and supervision.	\$10.14 (RN employed by HA/HHA)	TD	Maximum of 96 units (at 15 minutes) per day, 30 days per year in combination with out-of-home respite (code H0045).
		\$7.35 (LVN employed by HA/HHA)	TE	
		\$4.72 (Certified Home Health Aide employed by HA/HHA)	None	
		\$7.98 (Individual RN)	TD	
		\$6.10 (Individual LVN)	TE	

Out-of-Home respite, as a waiver service, will be provided outside the home in an approved Congregate Living Health Facility, and will be furnished on a short-term basis. Services provided in an approved out-of-home location will include appropriate care and supervision to ensure the participant's safety and care which meets the participant's medical needs.

Out-of-Home Respite Care code:

Procedure Code	Description	Rate	Modifier	Limits
H0045	Respite care services, out-of-home. Code developed for use by Congregate Living Health Facility only. Other approved facilities may bill using established Medi-Cal procedure codes and rates.	\$91.28	U1 = Level of care 1. Denotes skilled nursing services A or B level of care.	30 days of respite care per year, combined with in-home respite services (T1005).
		\$358.97	U2 = Level of care 2. Denotes subacute level of care.	
		\$490.60	U3 = Level of care 3. Denotes acute level of care.	

Section 9 - PFC Services, Authorization and Billing

Family Counseling/Bereavement

As used for PFC, family counseling is designed to allow the participant's family up to 22 units of counseling during any 365 day period. This counseling also includes grief counseling services prior to the death of the participant. **Requests for family counseling/bereavement must be made and services initiated prior to the waiver participant's death.** In return for the one-time payment, the HA/HHA will provide all necessary bereavement counseling identified in the participant's F-CAP.

Family Counseling/Bereavement code:

Procedure Code	Description	Rate	Limits
X9508	Family Counseling (Bereavement), one hour.	\$50.87 per unit (total billable amount \$1,119.14 (22 units x per unit rate))	22 units to be billed at one time. Service is limited to a one-time only payment.

Pain and Symptom Management

Pain and symptom management, as defined for the waiver, is nursing care in the home by a registered nurse to manage the participant's symptoms and pain. Management includes regular and ongoing pain and symptom assessments and as needed visits to provide relief of suffering. During these assessments and visits the efficacy of current pain management is assessed and the regimen is modified if needed.

Pain and Symptom Management code:

Procedure Code	Description	Rate	Modifier	Limits
S9123	Nursing care, in the home; by registered nurse, per hour (use of general nursing care only, not to be used when CPT-4 codes 99500 – 99602 can be used). Individual private duty nursing services	40.57 HHA (14)	None	100 hours per year
		31.94 HCBS RN (67)	None	
		44.63 HHA (14)	TT	

Section 9 - PFC Services, Authorization and Billing

	provided by a registered nurse for individual and shared nursing care.	35.13 HCBS RN (67)	TT	
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Section 9 - PFC Services, Authorization and Billing

PFC Billing

This section provides an overview of the California Children's Services (CCS) program billing guidelines for PFC services.

Billing Overview

Providers must be enrolled in the Medi-Cal program and use their National Provider Identifier (NPI) on all authorized claims for CCS clients. An NPI must be used when billing for PFC services.

Service Authorization Request (SAR) Number

The CCS program will issue providers unique SAR numbers beginning with a prefix of 97 for waiver services authorized by CCS. The SAR number must be included on the claim form in the appropriate authorization field. Claims without a SAR number will be denied.

Claim Submission and Timeliness Requirements

Refer to the *Claim Submission and Timeliness Overview* section of the *Part 1 - Medi-Cal Program and Eligibility* manual (located at www.medi-cal.ca.gov). This section details the claim forms used by various providers and the guidelines for submitting those claim forms.

Original claims must be received by the State's Fiscal Intermediary within six months following the month in which services were rendered. Providers submitting claims as an exception to the six-month billing time limit must include a valid delay reason code with each claim. Refer to the *Submission and Timeliness Instructions* section of the appropriate *Part 2 - Medi-Cal* manual (located at www.medi-cal.ca.gov) for a list of valid delay reason codes.

Payments to providers who submit claims after the six-month billing time limit without the required delay reason code will be reduced in accordance with Medi-Cal policy.

CMC Billing

Computer Media Claims (CMC) submission is the most efficient method of billing. Unlike paper claims, these claims already exist on a computer medium. As a result, manual processing is eliminated. CMC submission offers additional efficiency to providers because these claims are submitted faster, entered into the claims processing system faster, and paid faster. For more information, refer to the CMC section of the *Part 1 - Medi-Cal Program and Eligibility* manual or call the Telephone Service Center (TSC) at 1-800-541-5555.

Section 9 - PFC Services, Authorization and Billing

Claims Completion

The *UB-04* claim form (example below) is used by Hospice and Home Health Agency providers when billing PFC services authorized by the CCS program. All items must be completed unless otherwise noted. For additional billing information or questions about other fields on the claim form, refer to the following sections in the *Part 2 - Medi-Cal* manual (located at www.medi-cal.ca.gov):

- *UB-04 Completion: Outpatient Services*
- *UB-04 Special Billing Instructions for Outpatient Services*
- *UB-04 Tips for Billing: Outpatient Services*

Section 9 - PFC Services, Authorization and Billing

The following item numbers and descriptions correspond to the *UB-04* claim form. Only those fields necessary to complete the *UB-04* for PFC waiver services have been identified.

Field Number	Description								
1.	<p>Unlabeled (Use for facility information). Enter the facility name. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. A telephone number is optional in this field. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.</p>								
3A.	<p>Patient Control Number. This is an optional field that will help you to easily identify a recipient on Resubmission Turnaround Documents (RTDs) and Remittance Advices (RAs). Enter the patient's financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RTD and RA. Refer to the <i>Remittance Advice Details (RAD) Examples: Outpatient Services</i> section in the appropriate Medi-Cal Part 2 manual for patient control number information.</p>								
3B.	<p>Medical Record Number. Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RTD or RA for recipient clarification. The patient control number (item 3A) will appear on the RTD and RA.</p>								
4.	<p>Type of Bill. Enter the appropriate three-character type of bill code as specified below. The type of bill code includes the two-digit facility type code and one-character claim frequency code. This is a required field when billing Medi-Cal:</p> <p>Use one of the following codes as the first two digits of the three-character type of bill code:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Code</th> <th style="text-align: center;">Facility Type</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">33</td> <td>Home Health – Outpatient</td> </tr> <tr> <td style="text-align: center;">34</td> <td>Home Health – Other (For hospital referenced diagnostic services – Or home health not identified in the plan of treatment.)</td> </tr> <tr> <td style="text-align: center;">81</td> <td>Special Facility – Hospice (non-hospital based)</td> </tr> </tbody> </table>	Code	Facility Type	33	Home Health – Outpatient	34	Home Health – Other (For hospital referenced diagnostic services – Or home health not identified in the plan of treatment.)	81	Special Facility – Hospice (non-hospital based)
Code	Facility Type								
33	Home Health – Outpatient								
34	Home Health – Other (For hospital referenced diagnostic services – Or home health not identified in the plan of treatment.)								
81	Special Facility – Hospice (non-hospital based)								

Section 9 - PFC Services, Authorization and Billing

8B.	<p>Patient Name. Enter the patient’s last name, first name and middle initial (if known). Avoid nicknames or aliases.</p> <p>When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s name in Box 8B. If the infant has not yet been named, write the mother’s last name followed by “Baby Boy” or “Baby Girl.” If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.</p> <p>Enter the infant’s date of birth and sex in Boxes 10 and 11. Enter the mother’s name in Box 58 (Insured’s Name), and enter “03” (Child) in Box 59 (Patient’s Relationship to Insured).</p>
10.	<p>Birthdate. Enter the patient’s date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, June 12, 2007 = 06122007). If the recipient’s full date of birth is not available, enter the year preceded by 0101 (For newborns, see Field 8B).</p>
11.	<p>Sex. Use the capital letter “M” for male or “F” for female. Obtain the sex indicator from the Benefits Identification Card (BIC). For newborns, see Item 8B on a previous page.</p>
18-24.	<p>Condition Codes. Condition codes are used to identify conditions relating to this claim that may affect payer processing.</p> <p>The Medi-Cal claims processing system only recognizes the condition codes on the following pages. The claims processing system ignores all codes not applicable to Medi-Cal.</p> <p>Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, “A2”, “80” and “82”, enter “80” in Box 18, “82” in Box 19 and “A1” in Box 20.</p> <p>Applicable Medi-Cal codes are:</p> <p><u>Other Coverage:</u> Enter code “80” if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered other coverage and is identified separately.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance prior to billing Medi-Cal. For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Medi-Cal Part 1 manual.</p>

Section 9 - PFC Services, Authorization and Billing

Medicare Status: Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the Condition Codes fields blank. The Medicare status codes are:

Code	Description
YO	Under 65, does not have Medicare coverage
Y1*	Benefits Exhausted
Y2*	Utilization committee denial or Physician non-certification
Y3*	No prior hospital stay
Y4*	Facility denial
Y5*	Non-eligible provider
Y6*	Non-eligible recipient
Y7*	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9*	PSRO denial
Z1*	Medi/Medi Charpentier: Benefit Limitations
Z2*	Medi/Medi Charpentier: Rates Limitations
Z3*	Medi/Medi Charpentier: Both Rates and Benefit Limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section in the appropriate Part 2 manual for more information.

25-28. **Condition Codes.** The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18-24.

37. **Unlabeled (use for delay reason codes).** Enter one of the following delay reason codes and include the required documentation if there is an exception to the six-months-from-the-month-of-service billing limit.

Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None*
11	Other (theft, sabotage)	Attachment*
15	Natural disaster	Attachment

Section 9 - PFC Services, Authorization and Billing

	<p>* Documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason “11” without an attachment will either receive reimbursement at a reduced rate or a claim denial. Refer to “Reimbursement Reduced for Late Claims” in the <i>UB-04 Submission and Timeliness Instructions</i> section of the Part 2 Medi-Cal manual (located at www.medi-cal.ca.gov).</p>
42.	<p>Revenue Code. Revenue codes are not required; however, this field is used when recording “Total Charges.” Enter “001” on line 23, and enter the total amount on line 23, field 47.</p>
43.	<p>Description. This field will help you separate and identify the descriptions of each PFC service. The description must identify the particular service code indicated in the <i>HCPCS/Rate/HIPPS Code</i> field (Box 44). This field is optional.</p> <p>Note: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.</p>
44.	<p>HCPCS/RATES/HIPPS Code. Enter the applicable PFC waiver HCPCS procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier must be billed appropriately. All modifiers must be billed immediately following the HCPCS code in the <i>HCPCS/Rate</i> field (Box 44) with no spaces.</p> <p>For a listing of the waiver procedure codes that require a modifier and the applicable modifier, refer to the <i>PFC Services, Procedure Codes and Rates</i> section of this manual.</p> <p>Medicare/Medi-Cal Recipients. If billing for services to a recipient with both Medicare and Medi-Cal, refer to the <i>Medicare Non-Covered Services</i> section in the appropriate Part 2 Outpatient Services Medi-Cal manual (located at www.medi-cal.ca.gov) to check the list of Medicare non-covered service codes. Only those services identified in the <i>Medicare Non-Covered Services</i> section may be billed directly to Medi-Cal. All others must be billed to Medicare first.</p>
45.	<p>Service Date. Enter the date the service was rendered in six-digit, MMDDYY (Month, Day, Year) format, for example, June 12, 2007 = 061207.</p>
46.	<p>Service Units. Enter the actual number of times a single procedure or item was provided for the date of service. Medi-Cal only allows two-digits in this field.</p>
47.	<p>Total Charges. In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100).</p>

Section 9 - PFC Services, Authorization and Billing

	<p>Note: Medi-Cal cannot process credits or adjustments on the <i>UB-04</i> form. Refer to the <i>CIF Completion</i> and <i>CIF Special Billing Instructions for Outpatient Services</i> section in the appropriate Part 2 Medi-Cal manual (located at www.medi-cal.ca.gov) for information regarding claim adjustments.</p> <p>Enter the “Total Charge” for all services on line 23. Enter code 001 in the <i>Revenue Code</i> field (Box 42) to indicate that this is the total charge line (refer to field number 42).</p> <p>Note: Providers may enter up to 22 lines of detail data (fields 42-47). It is also acceptable to skip lines.</p> <p>To delete a line, draw a horizontal line through all fields (42-47) using a blue or black ballpoint pen.</p>
50A-C.	<p>Payer Name. Enter “O/P MEDI-CAL” to indicate the type of claim and payer. Use capital letters only.</p> <p>When completing Boxes 50 – 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B, or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.</p> <p>When billing other insurance, the other insurance is entered on Line A of Box 50, with the amount paid by Other Coverage on Line A of Box 54 (<i>Prior Payments</i>). All information related to the Medi-Cal billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line.</p> <p>If Medi-Cal is the only payer billed, all information in Boxes 50 - 65 (excluding Box 56) should be entered on Line A.</p> <p>Reminder: If the recipient has Other Health Coverage, the insurance carrier must be billed prior to billing Medi-Cal.</p>
54A-B.	<p>Prior Payments (Other Coverage). Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage “payer” (Box 50). Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Leave blank if not applicable.</p> <p>Note: For instructions about completing this field for Medicare/Medi-Cal crossover recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: Outpatient Services</i> section of the appropriate Part 2 Medi-Cal manual (located at www.medi-cal.ca.gov).</p>
55A-C.	<p>Estimated Amount Due (Not amount billed). In full dollar amount, enter the difference between “Total Charges” and any deductions, for example</p>

Section 9 - PFC Services, Authorization and Billing

	Other Coverage. Do not enter a decimal point (.) or dollar sign (\$).
56.	NPI. Enter the National Provider Identifier (NPI).
58A-C.	Insured's Name. If billing for an infant using the mother's ID, enter the Medi-Cal recipient's name here and the patient's relationship to the Medi-Cal recipient in Box 59 (<i>Patient's Relationship to Insured</i>). See Box 8B above for further instruction. This box is not required by Medi-Cal unless an infant is using the mother's ID.
59A-C.	Patient's Relationship to Insured. If billing for an infant using the mother's ID, enter a "03" (child) which indicates the patient's relationship to the Medi-Cal recipient. This box is not required by Medi-Cal unless an infant is using the mother's ID.
60A-C.	Insured's Unique ID. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field.
63A-C.	Treatment Authorization Codes. All PFC services must be prior authorized with a CCS Service Authorization Request (SAR) which includes a unique 11-digit SAR number beginning with a prefix "91" or "97." The SAR number must be entered in this box. It is not necessary to attach a copy of the SAR to the claim. Claims without a SAR number will be denied.
67.	Unlabeled (Use for primary diagnosis code). Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
67A.	Unlabeled (Use for secondary diagnosis code). If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
80.	Remarks. Use this area for procedures that require additional information or justification.

Section 10 - Health and Welfare

The California Department of Health Care Services, Children's Medical Services Branch assures that necessary safeguards have been put in place to protect the health and welfare of persons receiving services under this waiver. We must assure that:

- There are reporting and management processes in place at the individual and provider level to assure that reports are filed and instances are investigated in a timely manner; and
- Incident data is analyzed (i.e. about specific types of incidents, providers, participant characteristics, results of investigations, the timeliness of reports and investigations) in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future.

Policies and Procedures

PFC agency providers must implement and maintain written policies and procedures regarding the handling of instances of abuse, neglect, and exploitation of participants enrolled in the program. In California, all individuals providing or monitoring health care are considered mandated reporters. Areas to address include:

Types of Critical Events and Identifying Incidents.

Examples include:

- Physical abuse: bodily injury, cuts, bruises, burns, unexplained injuries, physical restraints, evidence of sexual abuse, deprivation of food and water, pushing or hitting, intentional misuse of medications, causing pain.
- Isolation: preventing receipt of mail, phone calls, visitors, or contact with concerned persons.
- Financial: misuse of funds, unusual activity in bank accounts, checks cashed by others, suspicious changes in ownership, unpaid bills, missing belongings, undue influence to change documents, theft, embezzlement, misuse of property.
- Abandonment: individual left alone when unable to provide for own basic necessities of daily living.
- Sexual abuse: sexual assault, inappropriate sexual advances, sexual exploitation, rape.
- Neglect by self or others: inadequate clothing, food, dehydration, untreated medical conditions, misuse of medications, unsafe housing.
- Emotional or verbal abuse: threats, threats of harm or abandonment, isolation, intimidation.

Section 10 - Health and Welfare

Who Must Report

In incidents involving children, mandated child abuse reporters include all those individuals and entities listed in **Penal Code Section 11165.7**.

In incidents involving adults, reporters include community agencies, social workers, nurses, other service providers, relatives, or other concerned individuals.

In California, all individuals providing or monitoring health care are considered mandated reporters and are required to report known or suspected child abuse and dependent adult abuse. "Mandated Reporters" (*Welfare and Institutions Code Section 15630, Section 15610.37 and Section 15610.17*).

When to Report

Whenever, in a professional capacity or with the scope of employment, the mandated reporter:

- observes or has knowledge of an incident that reasonably appears to be abuse
- is told of an incident by the victim
- reasonably suspects abuse

Making a Report

Incidents involving children

- Report to local law enforcement, county probation department, county welfare department, or Child Protective Services.
 - By telephone immediately or as soon as practically possible.
 - By written report sent within 36 hours of receiving the information concerning the suspected incident.

Incidents involving adults (age 18 and over)

- If the occurrence happened in a long term care facility, report to local law enforcement or the Long-term Care Ombudsman.
 - By telephone immediately or as soon as practically possible.
 - By written report sent within two working days to the appropriate agency.
- Report to local law enforcement or Adult Protective Services.
 - By telephone immediately or as soon as practically possible.
 - By written report sent within two working days to the appropriate agency.

Section 10 - Health and Welfare

Additional Information for Mandated Reporters

- All mandated reporters are required to sign statements with their employers or with the State agency issuing their license or certificate, confirming knowledge of the reporting requirements and agreement to comply with the law.
- Reporter may not be subjected to sanctions for making a report.
- Law provides civil and criminal liability protection for anyone who makes a report in good faith.
- Reports made under the law are confidential.
- Whenever two or more mandated reporters have knowledge about a suspected incident, they can agree that one of them will make a report.

Section 11 - Privacy and Protection of PHI

All PFC providers must develop and implement policies and procedures to comply with State law and the Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy and security of Protected Health Information (PHI) for Medi-Cal clients. Except for the Medi-Cal Notice of Privacy Practice (NPP), this document does not address Medi-Cal regulations that apply to all Medi-Cal providers.

All Medi-Cal recipients receive an NPP from Medi-Cal at the time of enrollment. The NPP sent to Medi-Cal beneficiaries is written from the perspective of a health plan. The project director and case managers are to be familiar with the NPP sent to Medi-Cal beneficiaries in case any clients have questions; see Website link:

<http://www.dhcs.ca.gov/formsandpubs/laws/privIPages/NoticeofPrivacyPractices.aspx>

Under HIPAA, PFC providers are health care providers. All health care providers (agencies) must give a separate NPP to all clients receiving health care at the agency. Although the Medi-Cal NPP can be used as a resource, the language must be modified to be appropriate to a provider of health care and not that of a health plan.

All PFC providers must develop and implement policies and procedures to include the following:

- When enrolled, PFC participants receive the PFC agency NPP
- When enrolled, Medi-Cal recipients receive a separate Medi-Cal NPP from Medi-Cal
- The roles and responsibilities and contact information (i.e. name, phone number, and address) of the PFC agency privacy officer
- Permitted uses and disclosures of PHI including availability of information to DHCS and individuals
- Safeguards to protect the confidentiality, integrity, and availability of PHI
- Individual access to PHI
- Reporting and documentation of improper disclosures, and mitigation of harmful effects of improper disclosure
- Amendments to PHI
- Restrictions on use and disclosure
- Provision of staff training for the above policies and procedures according to job responsibilities.

Section 12 - Documentation and Record Keeping

The participant's record must be kept as part of the contractual obligation to the Department of Health Care Services (DHCS) and should follow the accepted guidelines for record handling and documentation practices for health care records.

Reasons for Documenting

- To provide a written record of information necessary for participant care and program decisions
- To make available information about participant assessment, service planning, and implementation to core case management team members within the agency and with the CCS Nurse Liaison (CCSNL) in the county
- To substantiate care decisions made with or on behalf of the participant
- To meet participant service record legal documentation requirements
- To allow an assessment of the efficacy and appropriateness of funded services
- To document the activities of care coordination and other activities in a uniform, comprehensive manner

Documentation Practices

There shall be written policies and procedures that delineate written assessments, diagnosis, evaluation and a plan for intervention by the Palliative Care team. This plan shall be documented in the participant's chart and signed by the appropriate people within 24 hours of the accepted referral from the CCSNL. All documentation shall be accompanied by the name, date, time, and signature, including the professional identification.

- No section of a form should be left blank. If a participant chooses not to provide information or the Care Coordinator feels that a particular area should not be addressed at the time, or if an area was already completed by another team member, the section should be noted with not applicable (N/A) or "Deferred."
- Each participant must have a separate chart. It is optional to assign each participant chart an identification number.
- Observations and conclusions documented should be objective, professional and non-judgmental. They should include the input of all staff participating in care coordination activities as well as summaries of team discussions related to the participant.
- Records should follow a standard format with standardized documents.
- Documentation must be legible, typewritten, computer-generated, or handwritten in ink. It must be dated and signed (with professional title).
- Written policy should assign responsibility for recording documentation with time frames.
- Corrections should be made by drawing a single line through the entry, writing "error" and dating and initiating the entry. The use of "white-out", rewriting pages and destroying the original documentation or other correction methods are not acceptable.

Section 12 - Documentation and Record Keeping

- If choosing to utilize an electronic record keeping system, policies and procedures need to be developed and implemented that include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance. Electronic records that are to be printed and filed in a participant chart must be originally signed by the appropriate Care Coordinator.

Record Handling and Storage

- All documents should be secured in the records and protected from potential damage or loss.
- No forms shall be destroyed or removed from the records once entered into them.
- Records should be available only to the agency staff directly responsible for charting, reviewing and filing, and to State, County, and Federal representatives as required by law and in keeping with their shared responsibility for the participants, except when there is an authorization for release of medical records including the records described. The records should be protected from unauthorized access; computerized or electronic records must be similarly protected and have appropriate safeguards. Participant records must be kept safe in a locked storage area accessible only to the agency staff directly responsible for charting, reviewing, and filing.
- If the progress/case notes are kept in an electronic format, the notes will need to be printed out and placed in participant charts prior to a program compliance review.
- Contractor policy should address the manner and length of time the documents will be stored, as well as removal from storage and destruction of records. A plan must be specified for record storage and retrieval if the organization were to close.

Confidentiality

- Health care providers, contractors and staff must comply with all provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These practices need to be discussed with the participant/family with documentation maintained that this discussion occurred.
- Medical/healthcare information cannot be released verbally, in writing, or copied from records without a written consent for the release of information signed by the participant (or legal representative). This consent must specify the type of information to be released and to whom, and may be revoked at any time by the participant (or legal representative).
- The provider shall have written policies addressing the circumstances and processes by which all or any part of a record may be released and to whom. These policies shall address and assure effective communication in order to facilitate the exchange of information, thoughts or ideas with participants and their families, the Palliative Care team members, County CCS staff, medical

Section 12 - Documentation and Record Keeping

providers, and outside agencies involved in the care of the participant. Original documentation may be released only when required by court subpoena, otherwise photocopies should be provided.

- Current State and Federal law will be followed regarding participant access to records.
- The provider shall maintain signed statements of confidentiality for employees, consultants, and volunteers who have access to participant records.
- The provider will protect participant names and other identifying information. Identifying information may only be used to provide care coordination, management, and other services offered by the provider. When information is sent electronically outside of the agency, it must be encrypted in order to protect the participant.
- The provider will maintain a confidential fax machine. Fax cover sheets should address the intended recipient, what type of information is included, and instructions for unintended recipients.
- When using personal computers or mobile devices, protect participant confidentiality and anonymity by every reasonable means, including all of the following:
 - Use password protection on desktop/laptop computers
 - Use a Local Area Network (LAN) drive that is password protected
 - Use encryption software on all mobile devices such as, but not limited to: laptop, flash drives, and CD ROMS
 - Provide a secure workstation for authorized staff with access to sensitive participant information
 - Notify DHCS staff immediately when a computer is stolen or repaired

Contents of a Participant Chart

There shall be policies and procedures that assure reports and notes shall be recorded in the participant's chart and readily available to other Palliative Care team members, including the authorizing CCS County program.

- Informed Consent/Agreement to Participate
- Initial comprehensive participant assessment using Family-Centered Action Plan (F-CAP)
- Ongoing participant reassessment at least every 60 days, or more often as needed
- Progress/case notes, including but not limited the following:
 - Education, counseling, referrals, or other direct services provided to the participant
 - Phone contact with the participant, caregivers, service providers, physicians, CCSNL or other staff
 - Copies of correspondence, medical and provider service notes

Section 12 - Documentation and Record Keeping

- Documentation of the need for the specific services delivered, if not noted in another place such as the F-CAP
- As indicated, documentation related to Child Abuse and Neglect including:
 - Subjective data including the participant/ caregiver's description of the incident or other subjective data which may be indicative of child abuse/neglect
 - Objective findings of the physical assessment
 - Observed behavior of the participant/caregiver which may be indicative of abuse or neglect
 - Assessment of the immediate safety of the participant, including community resources, especially for participants who are not admitted to a hospital
 - Name of Child protective Services (CPS), Adult Protective Services (APS) hotline staff the case was reported to and the reference number
 - Case disposition
 - Police involvement
- Documentation of all services provided for the participant/family, including the date, length and nature of the service, provider name and type, and any additional notes about the service
- Bereavement services documentation which includes the date bereavement services were discussed with an agreement reached, date(s) services were provided and time involved, the name and training of service provider, the length and type of services provided before the death of the participant and the services provided after the death as well as the initial and updated plan for bereavement care to continue after the death of the participant.

Section 13 - Acronyms and Definitions

Acronym	Full Name	Definition
	Aid Codes	A two-digit (alphanumeric or numeric) code that identifies the types of services that Medi-Cal recipients are eligible for. Clients will be assigned one of two PFC unique CCS Aid Codes. If the child participating in the waiver is already a CCS client, the new PFC Aid Code will replace the child's previously assigned CCS Aid Code, as appropriate.
AB 1745	Assembly Bill 1745	California's Partner for Children (PFC) Pediatric Palliative Care waiver implements the Nick Snow Children's Hospice and Palliative Care Act of 2006.
BIC	Benefits Identification Number	Medi-Cal health care number specific for each child
Ca-MMIS	California Medi-Cal Management Information System	Database containing fiscal intermediary claims paid and denied information
CCC	California Civil Code	The code is made up of statutes which govern the general obligations and rights of persons within the jurisdiction of the State of California
CCR	California Code of Regulations	The official compilation and publication of the regulations adopted, amended or repealed by state agencies pursuant to the Administrative Procedure Act (APA).
CCS	California Children's Services	A statewide program that provides diagnostic and treatment services, utilization management, service authorization, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. The CCS program is administered by county health departments or state regional offices. DHCS, Children's Medical Services Branch manages the CCS program.
CCSNL	CCS Nurse Liaison	County CCS nurse Liaison will maintain a collaborative partnership through open communication with the Care Coordinator to ensure a seamless process of care. This will includes effectiveness of the F-CAP. The CCSNL Will is responsible for authorizing all state plan services, and all waiver services needed to implement the F-CAP.
	Circle of Support	Extended family (outside of home) and/or friends who provide emotional support and advice to the participant and family.
	CMSNet	CCS digital case management database/network.

Section 13 - Acronyms and Definitions

Acronym	Full Name	Definition
CDPH	California Department of Public Health	The State's Public Health Department which is responsible for Licensing and Certification.
DHCS	California Department of Health Care Services	The Medicaid agency of the State of California.
DHHS	Department of Health and Human Services	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
ELNEC	End of Life Nursing Education Consortium	Training required for Care Coordinators in PFC, and recommended for other nurses, health care providers and health care professionals who provide end-of-life care. www.aacn.nche.edu/ELNEC Pam Malloy pmalloy@aacn.nche.edu 202-463-6930, Ext. 238
F-CAP	Family-Centered Action Plan	The comprehensive care plan designed to integrate goals and medical objectives of the participant and Family Unit to ensure that the participant can successfully and safely live in the community. The F-CAP will respond to social, emotional, spiritual, physical and environmental issues that affect the participant/Family Unit's health and maximum potential, including but not limited to palliative care.
	Family Unit	Those persons who are living in the home that include the parent/legal guardian(s).
	Centers for Medicare and Medicaid Services	Federal agency responsible for oversight of Medicare and Medicaid programs, including 1915(c) Home and Community Based waivers.
FI	Fiscal Intermediary	Contracted provider who reviews and adjudicates claims for Medi-Cal. Contract currently provided by: Electronic Data Systems (EDS).
FTE	Full-Time Equivalent	Designation of amount of time work in a pay period, such as full time (1 FTE), half time (.5 FTE), quarter time (.25 FTE).
HCBS	Home and Community Based Services	Home and community-based services provide services, beyond those covered by the Medical Assistance program (also referred to as Medicaid), that enable individuals to remain in a community setting rather than being admitted to a Long Term Care Facility (LTCF). The waiver responsible for PFC is a 1915(c) HCBS waiver.

Section 13 - Acronyms and Definitions

Acronym	Full Name	Definition
HA	Hospice Agency	Partners for Children agency providers are defined as Hospice Agencies 22 CCR sec. 51180.1-51180.7 and sec. 51250
HHA	Home Health Agency	Partners for Children agency providers are defined as Home Health Agencies 22 CCR Sec. 74659 et seq.
HIPAA	Health Insurance Portability and Accountability Act	Federal act regarding privacy and security of health information for Medi-Cal clients.
ICD-9 Codes	International Classification of Diseases, 9th Revision	Codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.
LOC	Level of Care	<p>The federally required level of care criteria, as defined by each state requesting a waiver, is used to evaluate and reevaluate whether an individual needs services through the waiver.</p> <p>For the PFC program LOC is defined as follows: PFC will serve Medi-Cal beneficiaries under the age of 21 years who meet waiver eligibility criteria and who would, in the absence of this waiver and as a matter of medical necessity (pursuant to W&I Code §14059.5), be expected to require acute hospital services for at least 30 non-consecutive days during the year.</p>
	Medi-Cal	California's Medicaid program. Medicaid is the federal insurance program for eligible individuals and families with low incomes and resources.
NOA	Notice of Action	Notification of client and/or parent, guardian, legal advisor of action taken to deny, modify or discontinue a service(s).
NPI	National Provider Number	A unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use their NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier.
NPP	Notice of Privacy Practices	Document that provides interested persons a defined opportunity to receive adequate notice of the uses and disclosures of protected health information (PHI) that may be made by the provider; patient rights concerning PHI; and the provider's legal duties pertaining to PHI.

Section 13 - Acronyms and Definitions

Acronym	Full Name	Definition
PFC	Partners for Children	Program to provide family-centered pediatric palliative care services that allow children and their families the benefits of hospice-like care, in addition to ongoing Medi-Cal services during the course of an illness, even if the child does not have a life expectancy of six months or less. It is the California 1915(c) Home and Community Based Waiver program for Pediatric Palliative Care.
	PFC Agency Provider	Hospice or Home Health Agency approved to provide PFC services under the Pediatric Palliative Care Waiver.
POLST	Physician's Orders for Life Sustaining Treatment	An element of transitional care, which uses a standardized medical order form for health care professionals to indicate which types of life-sustaining treatment a seriously ill patient wants or doesn't want if his or her condition worsens.
PHI	Protected Health Information	PHI under HIPAA includes any <i>individually identifiable</i> health information. <i>Identifiable</i> refers not only to data that is explicitly linked to a particular individual (that's <i>identified</i> information). It also includes health information with data items which reasonably could be expected to allow individual identification.
SAR	Service Authorization Request	CCS electronic system for authorizing services. "SAR" can refer to both the request and the authorization itself.
SOC	Share of Cost	The amount of money a Medi-Cal recipient has to pay or agrees to pay each month for medical goods and services before Medi-Cal begins to pay.
SCC	Special Care Center	Special Care Centers are inpatient or outpatient care centers affiliated with CCS approved tertiary hospitals that provide multidisciplinary specialty care for children.
State CMS Branch	Children's Medical Services Branch	Branch of DHCS responsible for the CCS program and oversight of the PFC waiver program.

Section 14 - Attachments List

[Due to the size of the documents they have been kept as separate files from the body of the manual. They are available on the website along with the manual.

<http://www.dhcs.ca.gov/services/ppc/Pages/ProviderManuals.aspx>]

These attachments are provided for your use.

1. F-CAP
 - F-CAP (Spanish)
Used blank as a reference with English version when Spanish speaking families request to see the entire F-CAP
 - F-CAP (Spanish) Family Sections IX & X
Kept complete and updated along with English version for Spanish speaking families
2. F-CAP Instructions
3. Family Counseling/Bereavement Services Tracking Form
4. Agency Application
5. Complaint-Incident Intake Report

6. PFC Family Flyer

These attachments are provided for your information.

The CCSNL will use these documents during the participant enrollment process.

7. Medical Eligibility and LOC Determination Form

These documents will be discussed with the participant/family and copies will be provided for them to take home.

8. Participant Agreement Form and Information Sheet
 - +Spanish Version
9. Freedom of Choice Form and Information Sheet
 - +Spanish Version
- 10a. PFC Services Information Sheet - Parent Version
 - +Spanish Version
- 10b. PFC Services Information Sheet - Participant Version
 - +Spanish Version
- 11a. F-CAP and Circle of Support Information Sheet - Parent Version
 - +Spanish Version
- 11b. F-CAP and Circle of Support Information Sheet - Parent Version
 - +Spanish Version
12. Child Abuse Information
 - +Spanish Version

These attachments were developed for use by the referring physicians.

13. PFC Referral Form
14. Referring Physician Flyer
15. Referral Eligibility Checklist