



# Standard for Provision of Long -Term Care

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Contact:	Healthcare Payers Sector <a href="mailto:healthsystemfinancing@doh.gov.ae">healthsystemfinancing@doh.gov.ae</a>		

## 1. Standard Scope

### 1. Scope

- 1.1. This standard sets out the criteria for the licensing and provision of Long-Term Care services in the Emirate including:
  - 1.1.1. Definition of Long-Term Care.
  - 1.1.2. Patient eligibility criteria.
  - 1.1.3. Payment for services under the health insurance scheme and the services included in Long-Term Care.
  - 1.1.4. Data reporting and records management requirements.
- 1.2. This standard applies to:
  - 1.2.1. All Healthcare facilities licensed by DOH to provide Long-Term Care and all healthcare professionals employed by these facilities.
  - 1.2.2. All payers and third-party administrators.
- 1.3. This standard **does not apply** to:
  - 1.3.1. Patient staying in Intensive Care Unit (ICU);
  - 1.3.2. Neonatal Intensive Care Unit (NICU) and/or Pediatric Intensive Care Unit (PICU);
  - 1.3.3. Nursing Homes.

## 2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	Long-Term Care (LTC):	is a type of health care service provided to patients with sub-acute or a chronic illness, requiring extended medical and maintenance services, including nursing care for 24 hours a day, 7 days a week and daily physician visits, and that cannot be managed with less intensive care (e.g. Home Health Care). Long-Term Care patient requires prolonged medical needs for an extended period of hospital-level of care, provided by interdisciplinary team including, but not limited to a DOH licensed Specialist/Consultant Physicians, Registered Nurses, Dietitians, Therapists, and Social Workers.
2.2	Referring Physician:	Specialist / Consultant within the scope of specialty related to the patient's medical condition, who will issue a referral letter to transfer the patient to the relevant LTC. The letter should be co-signed by another specialist / consultant with experience in the medical condition necessitating the referral for LTC.
2.3	Treating Physician:	Specialist or Consultant who will define the patient's treatment plan in line with the recommendations from the referring physician. The treating physician will be responsible for the management of the patient within the LTC facility.
2.4	Co-located Unit:	Unit set-up in the same building or an area in another health care facility belonging to the same provider.

### 3. Standard Requirements and Specifications

#### 3.1 Licensing Criteria

Long-Term Care can be provided:

- 3.1.1 In stand-alone facilities licensed as Rehabilitation Facilities or
- 3.1.2 Licensed Long-Term Care units in the acute setting (co-located), i.e. within existing general or specialized hospitals, with dedicated Long-Term Care beds only.

#### 3.2 Eligibility Criteria for the Reimbursement of LTC services

Health care facilities must ensure that patients who are admitted to Long-Term Care fulfill the following eligibility criteria:

- 3.2.1 Patients are stable and do not need continued medical care in an acute care setting.
- 3.2.2 Patient needs cannot be effectively and safely met in a lower level of care (e.g. Home Health Care or Outpatient setting), due to the complexity of the patient's medical condition, including daily visits by a physician and 24-hour nursing care.
- 3.2.3 Patients require extended hospital level of health care including 24 hours of nursing care 7 days a week, daily physician visits and restorative therapies (physical, occupational, speech therapy), as needed. The medical necessity needs to be verified and confirmed by the treating physician.
- 3.2.4 The provided services cannot be performed at an alternative level of healthcare safely and effectively (e.g., at Home Health Care *(as per DOH Standard for Homecare Health Services* or outpatient setting).
- 3.2.5 The principal diagnosis cannot be related to psychiatry.

### 4. Key stakeholder Roles and Responsibilities

#### 4.1 General Duties for Healthcare Providers

All DOH licensed healthcare facilities providing Long-Term Care must:

- 4.1.1 Provide medical services performed by physicians, nurses, and allied healthcare professionals, in accordance with the specifications of this Standard and consistent with DOH policies and UAE laws.
- 4.1.2 Ensure that only licensed and privileged healthcare professionals provide clinical services in accordance with the DOH Standard for Clinical Privileging.
- 4.1.3 Ensure the development and maintenance of clinical practice guidelines for the offered LTC in accordance with the DOH Guidelines for Standard Treatment Guidelines.
- 4.1.4 Report and submit e-Claims data in accordance with the Chapter on Data Management, Healthcare Regulator Manual Version 1.0 and as set out in the DOH Data Standards and Procedures.

## **4.2 Healthcare Professionals**

- 4.2.1 Healthcare professionals offering LTC services must work within their scope of practice and granted privileges.
- 4.2.2 Provide appropriate counseling, complete assessment, and appropriate referral(s) to relevant specialties (when indicated).
- 4.2.3 Deal with all routine aspects of care.
- 4.2.4 Continue to maintain the appropriate skills and knowledge to provide LTC services in accordance with relevant UAE laws and DOH regulations and standards.

## **4.3 Specific Duties**

- 4.3.1 Long-Term Care facilities should perform hospital-level of care that cannot be properly provided at a lower level of care (e.g. Home care). Such in-patient services are performed by a fully employed interdisciplinary team.
- 4.3.2 Long-Term Care should:
  - 4.3.2.1 Ensure that patients' assessment, review, and management is reflected and documented in an individualized care plan that is reviewed, monitored, and updated according to the needs of the patient.
  - 4.3.2.2 Ensure compliance with the eligibility criteria for admission. Continuation of services must be undertaken every 30 days for Long-Term Care, or less if the condition of the patient warrants a more frequent assessment. The evaluation is initiated and conducted by the treating physician.
- 4.3.3 The treating physician should ensure that patients have an individualized and adequate care plan developed and are managed by an interdisciplinary team, tailored to the specific needs of each patient and subject to regular review and evaluation. The care level must be determined by the treating physician with input from the interdisciplinary team in accordance with their job duties and privileges assigned by the provider, and in accordance with the criteria provided in Appendix 1.
- 4.3.4 Patients who do not require 24 hours multidisciplinary care which includes daily evaluation, monitoring and therapeutic services that are frequently supervised by a Specialist / Consultant in an inpatient facility may be considered for alternative level of healthcare (e.g. at home or outpatient setting) in accordance with the DOH Standard for Homecare. The referring physician must document the evidence in support of these referrals.
- 4.3.5 LTC facilities must ensure to provide all range of services required by their patients to ensure quality services.
- 4.3.6 Each staff member receives ongoing in-service and other education and training to maintain or to advance skills and knowledge.

## **4.4 Reimbursement Mechanism**

- 4.4.1 All DOH licensed healthcare facilities providing Long-Term Care must:
  - 4.4.1.1 Comply with the healthcare insurance pre-authorization requirements, where applicable for payment of Long-Term Care in accordance with the patients' health insurance product and the requirements of this Standard.
  - 4.4.1.2 Itemize, code accurately and document the actual services, for each acuity level and for each of the care domains detailed in Appendix 1, supported by the Evaluation and Management Level established in accordance with DOH Coding Manual.

- 4.4.2 For non-self-paying patients, patient eligibility for Long-Term Care shall follow the definition established in Section 2 of this standard and billed accordingly:
- 4.4.2.1 Long-Term Care is billed based on a scoring mechanism with four levels of care, by using per-diem codes.
- 4.4.3 Billing and reimbursement of Long-Term Care shall be in accordance with Standard Provider Contract, DOH Mandatory Tariff and associated Claims and Adjudication Rules, and the Claims and Adjudication Standard. All documents are available from the DOH website: <https://www.doh.gov.ae/shafafiya/>
- 4.4.4 Billing and reimbursement of the Long-Term Care shall commence using:
- 4.4.4.1 Per diem Service Codes as defined in DOH Claims and Adjudication Rules and Mandatory Tariff in effect.
- 4.4.4.2 The level of care (per diem codes) should be in line with the level of intensity of medical condition and the required treatment as determined by the referring physician for initial approval or by the treating physician for renewal, and in accordance with Appendix 1 of this Standard.
- 4.4.5 Required documentation from LTC facilities:
- 4.4.5.1 Pre-authorization request for LTC admission, including the referring letter co-signed by the referring physician and a specialist/consultant with experience in the underlying medical condition necessitating referral, the treatment plan and the requested level of care issued by the referring physician.
- 4.4.5.2 The patients' level of care communicated by the LTC facility should be in accordance with the treatment established by the referring physician.
- 4.4.5.3 Management report issued by the LTC treating physician, upon renewal / extension of the in-patient stay.

#### **4.5 Duties for Payers and Payer Third Party Administrators (TPAs)**

All payers and TPAs must:

- 4.5.1 Comply with the health insurance pre-authorization requirement (where applicable) for payment for Long-Term Care in accordance with the patients' health insurance product and the provisions as detailed in this Standard.
- 4.5.2 Audit medical records of all Long-Term Care patients as per the specifications of the DOH Standard Provider Contract and consistent with the care domains and acuity levels detailed in Appendix 1 of this Standard.

#### **4.6 DOH Role**

- 4.6.1 Put in place mechanisms to ensure the Implementation and monitoring of these Standards of Care in Abu Dhabi.
- 4.6.2 Update standards periodically and compare with best practices to improve clinical outcomes and patient experience.

## 5. Monitoring and Evaluation

**5.1** The facility should report the data through JAWDA portal for the following measures. (<https://www.doh.gov.ae/en/programs-initiatives/muashir/jawda-indicators-submission-guidelines>):

- 5.1.2 Rate of emergency attendance
- 5.1.3 Rate of Unplanned Hospital Admission
- 5.1.4 Rate of Deep Vein Thrombosis
- 5.1.5 Rate of newly acquired or worsening pressure injury (Stage II and above)
- 5.1.6 VAE (Ventilator associated event)
- 5.1.7 Rate of falls resulting in any injury per 1000 resident days
- 5.1.8 Catheter-associated Symptomatic Urinary Tract Infection (CA-SUTI) per 1000 patient days
- 5.1.9 [Non-catheter associated] Symptomatic Urinary Tract Infection (SUTI) per 1000 resident days.
- 5.1.10 Gastroenteritis cases per 1000 resident days

## 6. Enforcement and Sanctions

- 6.1** Healthcare providers, payers and third-party administrators must comply with the terms and requirements of this Standard, the DOH Standard Contract and the DOH Data Standards and Procedures.
- 6.2** DOH may impose sanctions in relation to any breach of requirements under this Standard in accordance with the disciplinary regulations of the healthcare sector.

## 7. Relevant Reference Documents

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1	2019	Federal Law No. (5) Of 2019 on the Subject of Regulating the Practice of the Profession of Human Medicine	<a href="http://mohap.gov.ae/app_content/legislations/php-law-en-78/mobile/index.html">http://mohap.gov.ae/app_content/legislations/php-law-en-78/mobile/index.html</a>
2	2016	Federal Decree No. (4) Of 2016 on the Subject of Medical Liability	<a href="http://www.dha.gov.ae/uploads/112021/d759f988-571f-43b3-87ab-877e770b31ca.pdf">http://www.dha.gov.ae/uploads/112021/d759f988-571f-43b3-87ab-877e770b31ca.pdf</a>
3	2021	Ministerial Decree No. 14 for 2021 on Charter of Patient's Rights and Responsibilities	<a href="http://mohap.gov.ae/assets/d67042d0/Ministerial%20Resolution%20No.%2014%20of%202021.pdf.aspx">http://mohap.gov.ae/assets/d67042d0/Ministerial%20Resolution%20No.%2014%20of%202021.pdf.aspx</a>
4	2017	DOH Regulator Manual	<a href="http://www.doh.gov.ae/en/resources/policies">http://www.doh.gov.ae/en/resources/policies</a>
5	2017	DOH Policy on Emergency & Disaster Management	<a href="http://www.doh.gov.ae/en/resources/policies">http://www.doh.gov.ae/en/resources/policies</a>
6	2015	DOH Consent Guideline	<a href="http://www.doh.gov.ae/en/resources/guidelines">http://www.doh.gov.ae/en/resources/guidelines</a>
7	2012	DOH Standard for Adverse Events Management & Reporting	<a href="http://www.doh.gov.ae/en/resources/guidelines">http://www.doh.gov.ae/en/resources/guidelines</a>

8	2007	Policy for Infection Control in HCFs	<a href="http://www.doh.gov.ae/en/resources/standards">http://www.doh.gov.ae/en/resources/standards</a>
9	2021	DOH Standard for Homecare Health Services in the Emirate of Abu Dhabi	<a href="http://www.doh.gov.ae/en/resources/standards">http://www.doh.gov.ae/en/resources/standards</a>
10	2017	Ministerial Resolution 1448 of 2017 concerning the Code of Ethics and Professional Conduct for Health Professionals.	<a href="http://www.mohap.gov.ae">http://www.mohap.gov.ae</a>
11	2020	Weaning from Mechanical Ventilator in a Long-term Acute Care Hospital: A Retrospective Analysis	<a href="http://openrespiratorymedicinejournal.com/VOLUME/14/PAGE/62/">http://openrespiratorymedicinejournal.com/VOLUME/14/PAGE/62/</a>
12	2021	Long-term care hospital services	<a href="http://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch10_sec.pdf">http://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch10_sec.pdf</a>
13	2006	Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Annual Payment Rate Updates, Policy Changes, and Clarification	<a href="http://www.federalregister.gov/documents/2006/05/12/06-4240/medicare-program-prospective-payment-system-for-long-term-care-hospitals-ry-2007-annual-payment-rate">http://www.federalregister.gov/documents/2006/05/12/06-4240/medicare-program-prospective-payment-system-for-long-term-care-hospitals-ry-2007-annual-payment-rate</a>
14	2022	Long-Term Acute Care Hospitals: An Overview and Discussion of the Goals of Care	<a href="http://info.mcg.com/rs/658-WJS-398/images/MCG-White-Paper-LTACH-2022.pdf">http://info.mcg.com/rs/658-WJS-398/images/MCG-White-Paper-LTACH-2022.pdf</a>
15	2006	Development of a short version of the motor FIM for use in long-term care settings	<a href="http://pubmed.ncbi.nlm.nih.gov/16548088/#:~:text=Conclusion%3A%20The%20short%20version%20of,the%20recovery%20phase%20rehabilitation%20settings.">http://pubmed.ncbi.nlm.nih.gov/16548088/#:~:text=Conclusion%3A%20The%20short%20version%20of,the%20recovery%20phase%20rehabilitation%20settings.</a>

16	2002	A prospective evaluation of the Charlson Comorbidity Index for use in long-term care patients	<a href="http://pubmed.ncbi.nlm.nih.gov/11982678/">http://pubmed.ncbi.nlm.nih.gov/11982678/</a>
17	2023	DOH Shafafiya	<a href="http://www.doh.gov.ae/shafafiya/">http://www.doh.gov.ae/shafafiya/</a>
18	2023	DOH Jawda Indicators	<a href="http://www.doh.gov.ae/en/programs-initiatives/muashir/jawda-indicators-submission-guidelines">http://www.doh.gov.ae/en/programs-initiatives/muashir/jawda-indicators-submission-guidelines</a>

## 8. Appendices

### Appendix 1: Determination of the level of Treatment and Care required using Care Domains and Intensity Criteria, for patients requiring Long-Term Care

- This section describes the care domains and level of acuity of care and support to assist referring and treating physicians to:
  - Assess the level of care required for patients admitted for LTC and
  - Determine the re-imburement rate for LTC patients (per diem service code).
- Determination of intensity of care will require accurate completion and submission of Table 1 for LTC patients. All submissions (including step up and step-down care) must be accompanied by supporting documentation.

**Table 1.** Scoring mechanism to determine intensity of care for **Long Term Care (Adult)**

Mobility & Safety Risk Score		MV Care		Level of Care		Charlson Index Score	
1	R1	1	V1	1	1 - 4	1	0 – 8
2	R2	2	V2	2	5 - 7	2	9 – 12
3	R3	3	V3	3	8 - 10	3	13 – 15
4	R4	5	V4	4	> 10	4	> 15

Intensity of Care	Simple 17-13	Intermediate 17-14	Intensive 17-15	Severe 17-16
<b>Total Score</b>	<b>1 – 4</b>	<b>5 - 6</b>	<b>7 – 8</b>	<b>&gt; 8</b>

- Reimbursement of the Long-Term Care will commence using Per Diem Service Codes as defined in DOH Claims and Adjudication rules and Mandatory Tariff in effect. The selection of the Service Codes (payment levels) must be commensurate with the level of intensity and complexity of treatment and care determined by the referring or treating physician and in accordance with **Table 2 and 3**.

**Table 2: Mobility & Safety Risk Score and Mechanical Ventilation (MV) care**

Domain	Definition
<b>Mobility &amp; Safety Risk Score</b>	
R1	Completely dependent/Immobile.
R2	Medium Risk: Mobile & requires beyond standard observation with extra safety measures within a structured environment.
R3	High Risk: Mobile & need frequent observations even within a highly structured environment i.e., half-hourly check.
R4	Very High-Risk: Mobile & requires constant 24 hours 1:1 supervision and additional security measures or/and BMI=> 40
<b>Mechanical Ventilation Care</b>	
V1	Dependent on intermittent invasive MV ≤ 8hrs per day.
V2	Completely dependent on invasive MV: GCS=3 or 2T
V3	Completely dependent on invasive MV: >8hrs, GCS>3 or 2T
V4	Intermittent invasive mechanical as part of ventilator liberation protocol*.

\* Maximum 60 days trial allowing 2 trials depending on the patient’s state supported by clinical rationale on the Ventilator Liberation Protocol  
 (The MV Care matrix is designed based on the inputs received from the Clinical experts practicing in the Emirate)

**Table 3: Level of Care**

Level of Care	1	2	3
<b>Pharmaceutical Therapies</b>	Has a drug regime prescribed by licensed physician; that includes regular IM, IV or SC pharmaceutical therapy, such as insulin; (Statutory dose IM, IV or SC not included.)	Administration of medications that exceed AED 500 in cumulative cost per day.	Administration of medication that exceed AED 2,000 in cumulative cost per day.
<b>Feeding</b>	Patient is dependent on continuous feeding devices (NGT or PEG).	Adult special feeding program indicated for patients with specific medical needs or conditions, such as diabetes management, food allergies, etc., requiring individualized nutrition, and recommended by the treating specialist physician and periodically assessed by the dietitian.	Completely dependent on Total Parenteral Nutrition (TPN) and Partial Parenteral Nutrition (PPN)
<b>Functional Status</b>	Patient is dependent and requires skilled intervention for safe ADL.	Slow stream Rehabilitation program including at least 2 rehabilitation disciplines, at least 1 to 1.5 hours 3 times a week.	N/A
<b>Incontinence &amp; Renal Insufficiency</b>	Sterile Intermittent catheterization. Or catheter that requires daily bladder flushing or complicated supra pubic catheter with infected stomas.	Dialysis**	N/A

Level of Care	1	2	3
<i>Skin Integrity</i>	Stage 3 solitary pressure sore or multiple ( $\geq 2$ ) stage 2 in various areas/ body parts.	Wound management for multiple ( $\geq 2$ ) stage 3 in various areas/ body parts	Stage 4/4 pressure ulcers/ wounds (deep infected wounds) requiring debridement and/or continuous monitoring and/or frequent daily dressing.
<i>Breathing</i>	Non- invasive Respiratory care that includes: <ul style="list-style-type: none"> <li>▪ Continuous Daily O2 therapy. Or</li> <li>▪ Use of CPAP, BiPAP Or</li> <li>▪ Tracheostomy care</li> </ul>	Non- invasive Respiratory care that requires: <ul style="list-style-type: none"> <li>▪ O2 therapy with frequent Tracheostomy suctioning. Or</li> <li>▪ Dual therapy of CPAP, BiPAP and continuous O2.</li> <li>▪ High flow nasal oxygen</li> </ul>	Invasive MV care
<i>Cognition and behavior</i>	Patient diagnosed with intermediate Cognitive impairment that requires frequent supervision, prompting and assistance with daily living activities. The individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, (impaired ability to self-determine) which consequently puts them at some risk of harm, neglect, or health deterioration.	Patient diagnosed with extensive cognitive impairment and complete disorientation to time, place and person that requires supervision, prompting and assistance with daily living activities.  AND  1. Requires continuous monitoring (not necessarily bedside); and 2. Assessment, regular review and management by a DOH licensed specialist/consultant neurologist/ geriatrician, psychiatrist or physiatrist.	a) Patient diagnosed with severe cognition impairment conditions associated with serious threats to health or personal safety or behaviors placing patient at high risk of harm to self or others.  OR b) Patient Glasgow Coma (GCS) < 8 with a severe reduction in consciousness rendering patient unlikely to be able to maintain their airway spontaneously.  AND 1. Requires continuous bedside monitoring and 1:1; 2. Assessment and management by a DOH licensed specialist/consultant neurologist/geriatrician, psychiatrist  Note: 1 and 2 are required for any of the above i.e. a) or b) based on the applicability
<i>Palliative Care</i>	Patient with end stage disease* that requires continuous bedside monitoring and symptomatic management.	Terminal illness* that requires symptomatic management includes the use of narcotic medication.  <i>*(Patient with end stage heart, lung, or liver disease, etc.)</i>	N/A

Level of Care	1	2	3
	<i>*(Patient with end stage heart, lung, or liver disease, etc.)</i>		

**\*\* Hemodialysis will be reimbursed outside of the service code.**

**Table 4.** Scoring mechanism to determine intensity of care for Long-Term Care (Pediatrics)

Mobility & Safety Risk Score		MV Care		Level of Care		Co-morbidity Index Score	
1	R1	1	V1	1	1 - 4	0	1
2	R2	2	V2	2	5 - 7	1	2
3	R3	3	V3	3	8 - 10	2	3
4	R4	5	V4	4	> 10		

Intensity of Care	Simple 17-13	Intermediate 17-14	Intensive 17-15	Severe 17-16
<b>Total Score</b>	<b>1 – 4</b>	<b>5 - 6</b>	<b>7 – 8</b>	<b>&gt; 8</b>

1. Reimbursement of the Long-Term Care will commence using Per Diem Service Codes as defined in DOH Claims and Adjudication rules and Mandatory Tariff in effect. The selection of the Service Codes (payment levels) must be commensurate with the level of intensity and complexity of treatment and care determined by the referring or treating physician and in accordance with **Table 5 and 6**.

**Table 5: Mobility Risk Score and Mechanical Ventilation (MV) care (Paediatrics)**

Domain	Definition
<b>Mobility &amp; Safety Risk Score</b>	
R1	Completely dependent/Immobile.
R2	Medium Risk: Mobile & requires beyond standard observation with extra safety measures within a structured environment.
R3	High Risk: Mobile & need frequent observations even within a highly structured environment i.e. half-hourly check.
R4	Very High-Risk: Mobile & requires constant 24 hours 1:1 supervision and additional security measures or/and BMI > 95th Percentile
<b>Mechanical Ventilation Care</b>	
V1	Dependent on intermittent invasive MV ≤ 8hrs per day.
V2	Completely dependent on invasive MV: GCS=3 or 2T
V3	Completely dependent on invasive MV: >8hrs, GCS>3 or 2T
V4	Intermittent invasive mechanical as part of ventilator liberation protocol*.

\* Maximum 60 days trial allowing 2 trials depending on the patient's state supported by clinical rationale on the Ventilator Liberation Protocol  
*(The MV Care matrix is designed based on the inputs received from the Clinical experts practicing in the Emirate)*

**Table 6: Level of Care (Paediatrics)**

Level of Care	1	2	3
<b>Pharmaceutical Therapies</b>	Has a drug regime prescribed by licensed physician; that includes regular IM, IV or SC	Administration of medications that exceed AED 500 in cumulative cost per day.	Administration of medication that exceed AED 2000 in cumulative cost per day.

Level of Care	1	2	3
	pharmaceutical therapy, such as insulin; (Statutory dose IM, IV or SC not included.)		
<b>Feeding</b>	Patient is dependent on continuous feeding devices (NGT or PEG).	Pediatric special feeding program indicated for patients with specific medical needs or conditions, such as diabetes management, food allergies, etc., requiring individualized nutrition, and recommended by the treating specialist physician and periodically assessed by the dietitian.	Completely dependent on Total Parenteral Nutrition (TPN) and Partial Parenteral Nutrition (PPN)
<b>Functional Status</b>	Patient is dependent and requires skilled intervention for safe ADL.	Slow stream Rehabilitation program including at least 2 rehabilitation disciplines, at least 1 to 1.5 hours 3 times a week.	N/A
<b>Incontinence &amp; Renal Insufficiency</b>	Sterile Intermittent catheterization. Or catheter that requires daily bladder flushing or complicated supra pubic catheter with infected stomas.	Dialysis**	N/A
<b>Skin Integrity</b>	Stage 3 solitary pressure sore or multiple ( $\geq 2$ ) stage 2 in various areas/ body parts.	Wound management for multiple ( $\geq 2$ ) stage 3 in various areas/ body parts	Stage 4/4 pressure ulcers/ wounds (deep infected wounds) requiring debridement and/or continuous monitoring and/or frequent daily dressing.
<b>Breathing</b>	Non- invasive Respiratory care that includes: <ul style="list-style-type: none"> <li>▪ Continuous Daily O2 therapy. Or</li> <li>▪ Use of CPAP, BiPAP Or</li> <li>▪ Tracheostomy care</li> </ul>	Non- invasive Respiratory care that requires: <ul style="list-style-type: none"> <li>▪ O2 therapy with frequent Tracheostomy suctioning. Or</li> <li>▪ Dual therapy of CPAP, BiPAP and continuous O2.</li> <li>▪ High flow nasal oxygen</li> </ul>	Invasive MV care
<b>Cognition and behavior</b>	Patient diagnosed with intermediate Cognitive impairment that requires frequent supervision, prompting and assistance with daily living activities. The individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, (impaired ability to self-determine) which consequently puts them at some risk of	Patient diagnosed with extensive cognitive impairment and complete disorientation to time, place and person that requires supervision, prompting and assistance with daily living activities.  AND  1. Requires continuous monitoring (not necessarily bedside); and 2. Assessment, regular review, and management by a DOH licensed	a) Patient diagnosed with severe cognition impairment conditions associated with serious threats to health or personal safety or behaviors placing patient at high risk of harm to self or others.  OR b) Patient Glasgow Coma (GCS) $< 8$ with a severe reduction in

Level of Care	1	2	3
	harm, neglect, or health deterioration.	specialist/consultant neurologist or psychiatrist.	consciousness rendering patient unlikely to be able to maintain their airway spontaneously. AND 1. Requires continuous bedside monitoring and 1:1 , 2. Assessment and management by a DOH licensed specialist/consultant neurologist or psychiatrist.  Note: 1 and 2 are required for any of the above i.e., a) or b) based on the applicability.
<i>Palliative Care</i>	Patient with end stage disease that requires continuous bed side monitoring and symptomatic management.  <i>*(Patient with end stage heart, lung, or liver disease, etc.)</i>	Terminal illness that requires symptomatic management includes the use of narcotic medication.  <i>*(Patient with end stage heart, lung, or liver disease. Etc.)</i>	N/A

*\*\* Hemodialysis will be reimbursed outside of the service code.*

**Table 7: Co-morbidity Index**

Children with complex chronic disease – 3 points	Conditions examples	Children with Non-Complex Chronic Disease – 2 points	Conditions examples	Children without Chronic Disease-1	Conditions examples
<b>Significant chronic conditions in two or more body systems:</b> <b>Significant chronic condition</b> is defined as a physical, mental, or developmental condition that can be expected to last at least a year, will use health care resources above the level for a healthy child, require treatment for control of the condition, and the condition can be expected to be episodically or	Type 1 diabetes and static encephalopathy; type 1 diabetes and depression; developmental delay and chronic pulmonary conditions	Chronic Conditions that last at least one year: These conditions are commonly lifelong but can be episodic with periods of good health in between episodes. They include physical, developmental, or mental health conditions that may	Type 1 diabetes, atrial septal defect, asthma, depression, ADHD	Acute Non-Chronic Conditions: A physical, developmental, or mental health condition that is not expected to last more than a year. These children may temporarily (for < 1 year) utilize health care	Ear infection, pneumonia, diarrhea and dehydration, bronchiolitis

Children with complex chronic disease – 3 points	Conditions examples	Children with Non-Complex Chronic Disease – 2 points	Conditions examples	Children without Chronic Disease-1	Conditions examples
continuously debilitating. <b>Body systems</b> include: cardiac, craniofacial, dermatologic, endocrinologic, gastrointestinal, genetic, genitourinary, hematologic, immunologic, mental health, metabolic, musculoskeletal, neurologic, ophthalmologic, otologic, pulmonary/respiratory, and renal OR		persist into adulthood but may also resolve either secondary to the natural history of the disease or as a result of surgical intervention. These conditions involve a single body system, are not progressive, can vary widely in severity and result in highly variable health care utilization		resources above the normal level for a healthy child.	
A progressive condition that is associated with deteriorating health with a decreased life expectancy in adulthood OR	Muscular dystrophy, cystic fibrosis, paraplegia, quadriplegia, malignancy				
Continuous dependence on technology for at least six months OR	Tracheostomy +/- ventilator assistance, renal dialysis, gastrostomy tube, CSF shunt				
Malignancies: Progressive or metastatic malignancies that impact life function. Exclude those in remission for more than 5 years.	Lymphoma, leukemia, brain tumor				