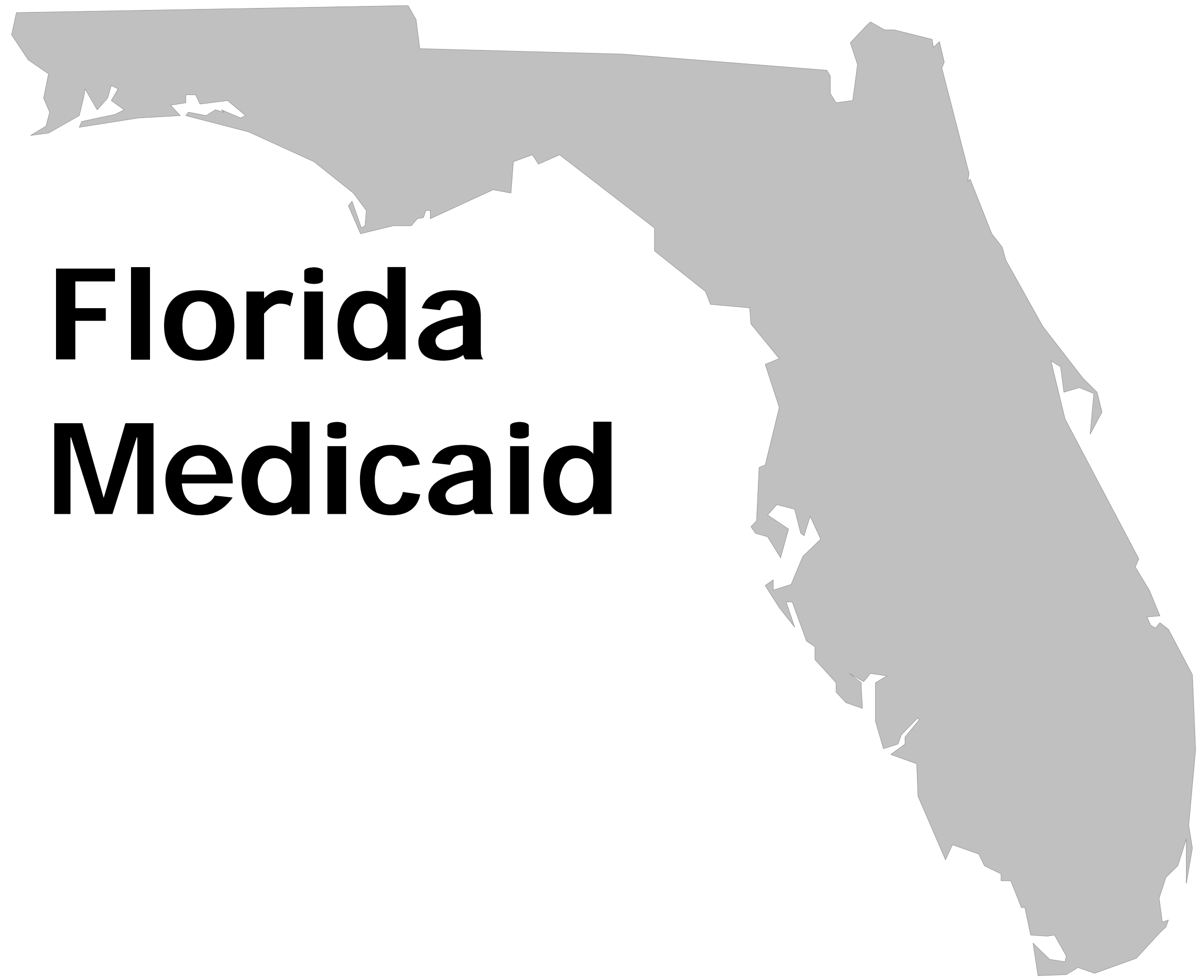

Florida Medicaid

Medicaid Certified School Match Program Coverage and Limitations Handbook

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Agency for Health Care Administration

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FLORIDA MEDICAID

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

October 25, 2005

Dear Medicaid Certified School Match Provider:

Enclosed you will find the Medicaid Certified School Match Services Coverage and Limitations Handbook, which has been reformatted. This handbook is to be used in place of the previous version, which is now obsolete.

The updated handbook material contains new policy for speech therapy services, fee schedule changes, and service reimbursement policy changes.

New Speech Therapy Policy:
Past policy prohibited reimbursement for speech therapy treatment when evaluations were completed by bachelor's level staff and countersigned by master's level speech-language pathologists. The new policy will permit these countersignatures on evaluations completed on and after January 1, 2005. Countersigned evaluations cannot be reimbursed. However, school districts can now submit claims for therapy treatment sessions based on these evaluations.

Fee Schedule Changes:
The present Fee Schedule has been updated to indicate that reimbursement amounts listed may vary from district to district as fees can be based on cost for individual school districts. School districts may elect to complete cost reports to determine their fees instead of using the fees in the handbook fee schedule. Once these fees are calculated, submitted to the Agency for Health Care Administration and approved, the rates calculated for each district will be submitted to the Medicaid fiscal agent so the needed changes can be made to pay the new fees. The new district specific fees will be effective for service dates on July 1, 2005, or later.

Service Reimbursement Policy:
Appendix B of this handbook has been completely revised to reflect current service reimbursement requirements.

Miscellaneous:
You will note as you review your handbook in its entirety that there are a few minor changes to previous language; the purpose of these changes is to further clarify existing policy.

If you have any questions please contact your area Medicaid school services representative. Your services to children in this state are greatly appreciated.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid

Enclosure

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308

Visit AHCA online at
http://ahca.myflorida.com

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UPDATE LOG
MEDICAID CERTIFIED SCHOOL MATCH COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.

2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
Aug1999—Replacement Pages	August 1999
May2000—Replacement Pages	May 2000
Aug2000—Replacement Pages	August 2000
Jul2002—Replacement Pages	July 2002
Oct2003—Replacement Pages	October 2003
Jan2005—Revised Handbook	January 2005

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MEDICAID CERTIFIED SCHOOL MATCH PROGRAM COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an “Update No.” and the “Effective Date”.

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

Paragraph with new material.

CHAPTER 1
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PURPOSE, BACKGROUND AND PROGRAM SPECIFIC INFORMATION

Overview

Introduction

This handbook describes the Medicaid certified school match program, services reimbursed under the program, provider qualifications, Medicaid-eligible student qualifications, and the general service requirements.

Legal Authority

School district provider eligibility and services are governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 440.110 and 440.130, respectively. The program was implemented through Sections 409.9071 and 1011.70, Florida Statutes, and Chapter 59G, Florida Administrative Code.

In This Chapter

This Chapter contains:

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Purpose and Background

Medicaid Provider Handbooks

This handbook is intended for use by school district providers who are enrolled in Medicaid under the certified school match program. Specific policies for each certified school match service reimbursed by Medicaid are contained in service-specific chapters in this handbook. The chapters may be separated and forwarded to staff assigned to the appropriate service area. Chapter 1 must be provided to all staff.

The handbook must be used in conjunction with the Florida Medicaid Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general.

Purpose

The purpose of the Medicaid certified school match program is to provide reimbursement for medically necessary services provided by or arranged by a school district for Medicaid-eligible students.

Background

There are 67 public school districts in Florida. Each school district is responsible for ensuring that students with disabilities receive health care.

Options for Financing Health Care

School districts have several options available for financing health care for Medicaid-eligible students, including:

- The school district may use Medicaid providers in the community to serve Medicaid-eligible students. The community provider bills Medicaid directly for the Medicaid-eligible students' care, and the school district finances the non-Medicaid students' care.
- The school district may use county health departments or other public health agencies to serve Medicaid-eligible students. The county health department bills Medicaid directly for the Medicaid-eligible students' care and the county health department or school district finances the non-Medicaid students' care.
- The school district may enroll as a Medicaid provider to serve Medicaid-eligible students. The school district bills Medicaid to finance care rendered by a school district, health-care employee or by contracted health staff for Medicaid-eligible students' care.

School districts may use one or a combination of these options to finance health care services for Medicaid-eligible students. If a school district chooses to enroll as a Medicaid provider for any of the services included in this handbook, it must be reimbursed under the policies for the certified school match program. School districts interested in becoming providers for services other than those in this handbook such as physician, hearing or vision, should contact the Medicaid fiscal agent for an enrollment application.

School District Provider Qualifications

Qualified School District Providers

School districts that are part of the public education system are eligible to participate in the certified school match program. This includes the Florida School for the Deaf and Blind, which is considered a school district for Medicaid purposes. Also, charter schools and lab schools (also known as developmental research schools) may participate in the program if their contracts with their school districts indicate such. The school district submits Medicaid claims for services provided by or through the charter or lab schools, as done for public schools. Private schools are not eligible to participate in this program.

Enrollment Process

In order to bill Medicaid under the certified match program, each school district must be enrolled as a provider by applying for enrollment to the Medicaid fiscal agent. A separate Medicaid provider agreement must be submitted for each type of service for which the school district will bill Medicaid.

Note: See Chapter 2 in the Medicaid Provider General Handbook for general enrollment requirements.

School District Staff Qualifications

The school district must employ or contract with staff who meet the Medicaid provider qualifications to provide the specific services for which the school district will bill Medicaid. The school district must sign an agreement with Medicaid attesting that staff providing health related services for which the school district will bill meet the Medicaid provider qualifications.

There are no specific Medicaid provider qualifications for transportation services beyond the requirements for transportation in Chapter 1006, Florida Statutes (F.S.), and Chapter 63-A, Florida Administrative Code (F.A.C.).

Note: See Appendix A in Chapter 1 of this handbook for the agreements that the school district must sign attesting that its staff (including contracted staff) providing health care services meet Medicaid provider qualifications.

Note: See the service-specific chapters in this handbook for the individual provider qualifications for specific services.

FDLE Background Check

School districts are not required to submit Florida Department of Law Enforcement (FDLE) background checks or fingerprints to enroll as Medicaid providers.

Ownership Disclosure

School districts are not required to disclose ownership to enroll as Medicaid providers since the school districts are publicly financed.

Certified Match Reimbursement

Introduction

Medicaid is financed by state and federal public funds. The state and federal shares of these funds are set each federal fiscal year by the federal government. Although the federal share varies, it averages about 55 percent in Florida.

School districts participating in Medicaid as providers (see "Qualified School District Providers" above) "certify" quarterly that they have used non-federal education funds for health care services as the state share. Medicaid then reimburses the school district provider the federal share of its payment for the health care service. This unique reimbursement method is termed "certified match reimbursement."

Certified Match Reimbursement Procedures

See Appendix B in Chapter 1 of this handbook for the certified match service reimbursement procedures and form.

Rates for transportation services are developed as described in Chapter 5 of this handbook.

Student Qualifications

Students Qualified for Certified School Match

To be qualified under the Medicaid certified school match program described in this handbook, a Medicaid-eligible student must meet all the following criteria:

- Be Medicaid eligible on the date of service;
- Be under age 21;
- Be considered disabled under the State Board of Education Rule definitions;
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA), Part B or Part C;
- Have Medicaid reimbursable services referenced in his Individual Educational Plan (IEP) or Family Support Plan (FSP); and
- Have Medicaid reimbursable services recommended by school district employees or contract staff meeting the requirements in this handbook.

Medicaid Criteria

Section 409.907(l), F.S., defines children qualified for certified school match reimbursement as "children with specified disabilities who are eligible for both Medicaid and Part B or Part C of IDEA or the exceptional student education program or who have an individualized educational plan." However, due to federal regulations, Medicaid cannot reimburse for services rendered to these students unless they also meet the criteria listed above in "Students Qualified for Certified School Match."

General Service Requirements

Medical Need for Services

Medicaid reimbursement is available only for services recommended by health care practitioners as defined in each service-specific chapter in this handbook.

Free Health Care

School districts may not bill Medicaid for health care services that they provide free of charge to non-Medicaid students, unless the exception below is met. If a school district establishes a fee schedule for billing families for health care services, the services are not considered to be free and Medicaid may be billed.

Exception to the Free Health Care Policy

Health care services provided under Part B or Part C of IDEA that are referenced in an IEP or FSP may be billed to Medicaid regardless of whether there is a charge for the service for non-Medicaid students. This includes transportation services that are included in the student's IEP or FSP.

Medicaid Reimbursable Services

It is recognized that many health care services may occur before or after the time an IEP or FSP is developed for a student. Behavioral evaluations are an example. Behavioral evaluations are considered as Medicaid reimbursable services if the need for behavioral services or a behavioral evaluation are referenced in an IEP or FSP or made an attachment or filed with an IEP or FSP. If an evaluation is done for a student and it is determined that he is not entitled to services under Part B or C of IDEA (an IEP or FSP is not completed), Medicaid will not reimburse the school district for the evaluation time.

Place of Service

For Medicaid purposes, services may be provided by school district staff at the school, on a school vehicle, at school activities and programs away from campus (example: community based instruction) or in the Medicaid-eligible student's home. If services are provided in a home, the place of service entered on the claim to Medicaid should be "home." (Place of service codes are contained in the Medicaid Provider Reimbursement Handbook, CMS-1500) The place of service entered on the claim form, other than services provided in the home, should be "school."

General Service Requirements, continued

Service Limitations

Medicaid reimburses only one provider, be it the school district or a community provider, for the same procedure (as determined by the Medicaid automated payment system comparing procedure codes on claims) provided to a student on the same day. There are reimbursement limitations contained in each of the service chapters in this handbook. Exceptions to any of the service limits may be requested by sending the following information to the area Medicaid school services representative:

- Physical or Occupational Therapy or Speech-Language Pathology–
  1. Copy of the plan of care or attachment recommending that the student needs more than four units of service per day or more evaluations than specified;
  2. Completed, paper CMS-1500 claim form(s); and
  3. Cover letter requesting the exception, including the length of time (from month/year to month/year) the additional services are needed. The cover letter should be from the therapist or pathologist.

- Transportation–
  1. Written statement from the Exceptional Student Education director explaining the reason for more than four one-way trips per day including the length of time (from month/year to month/year) the additional trips are needed; and
  2. Completed, paper CMS-1500 claim form(s).

- Behavioral/Nursing Services–
  1. Written statement from the school psychologist/psychologist or registered nurse explaining the reason for more than 32 units of service per day, including the length of time (from month/year to month/year) the additional services are needed; and
  2. Completed, paper CMS-1500 claim form(s).

Exceptions may be requested on a retroactive basis; however, Medicaid will not reimburse claims received more than 12 months from the date of service. Exceptions may also be requested in advance of service delivery. For an advance request, the CMS-1500 claim form is not attached to the above documents. If approved, advance exception requests are valid for one year from the approval date. For advance approvals, paper CMS-1500 claim forms would be sent to the area Medicaid office each month during the approved time period with a copy of the approval document from Medicaid.

The area Medicaid school services representative will forward complete exception packages to the Agency for Health Care Administration central Medicaid office for processing. The area Medicaid office will advise the school district of whether the request was approved and the time period of the approval; or, if denied, the reason for denial.

An exception cannot be made to the general “one provider per day limitation.”

General Service Requirements, continued

Medical Necessity

According to the definition of medical necessity in the Florida Medicaid Provider General Handbook, Appendix D, Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

Parental or Guardian Informing

Informing the Parent about FAPE

Although not a Medicaid requirement, the school district should inform the parent or guardian of the "Free and Appropriate Public Education" (FAPE) provisions of IDEA and the fact that Medicaid will be billed. The need for informing parents or guardians of these facts is important since third party insurance must be considered as a primary payer before Medicaid.

Informing the Parent about Services

Although not a Medicaid requirement, parents or guardians should be informed that Medicaid will only reimburse one provider for the same procedure on the same day.

Audit Requirements

Provider Records

The school district must have on file copies of their employed and contracted staffs' medical licenses, certifications, criminal background check results or other documentation that verifies that the staff meet the Medicaid provider qualifications for the specific services for which the school district bills Medicaid.

Provider records must be retained and presented upon request by an Agency for Health Care Administration (AHCA) or a Centers for Medicare and Medicaid Services (CMS) representative.

Documentation

Effective July 1995

Documentation of medical services rendered must be in the Medicaid-eligible student's record or electronically stored. If electronic documentation and signatures are used, the school district must have security procedures in place to prevent unauthorized use. Each district's security procedures should also be in written form for audit purposes. Also, the school district must assign a unique name or number or both for identifying and tracking user identity.

Service documentation must be retained and presented with the student's record upon request by an Agency for Health Care Administration (AHCA) or a Centers for Medicare and Medicaid Services (CMS) representative.

Note: See the service-specific chapters in this handbook for additional documentation requirements.

Recoupment

Failure to maintain records in accordance with this handbook and the Florida Medicaid Provider General Handbook may result in recoupment of Medicaid reimbursement.

APPENDIX A-1

AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT THERAPY SERVICES PROVIDERS ARE CREDENTIALED

(Physical Therapists, Physical Therapist Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech-Language Pathologists, Speech-Language Pathology Assistants)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Physical Therapists:

Current licensure from the Florida Board of Physical Therapy. All services billed to Medicaid must be within the validity period on the individual's license.

Physical Therapist Assistants:

Current licensure from the Florida Board of Physical Therapy. All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the general supervision of a licensed physical therapist, as required in the Medicaid Certified School Match Program Coverage and Limitations Handbook.

Occupational Therapists:

Current licensure from the Florida Occupational Therapy Council.
All services billed to Medicaid must be within the validity period on the individual's license.

Occupational Therapy Assistants:

Current licensure from the Florida Occupational Therapy Council, Division of Occupational Therapy Assistants. All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the general supervision of a licensed occupational therapist, as required in the Medicaid Certified School Match Program Coverage and Limitations Handbook.

Speech-Language Pathologists:

The requirements contained in federal regulation 42 CFR 440.110 (copy attached) must be met. The federal requirements can be met by the pathologist having any one of the following documents:

- Licensure from the Florida Board of Speech-Language Pathology and Audiology. All services billed to Medicaid must be within the validity period on the individual's license.
- Certification from the Department of Education in the area of Speech-Language Impaired, containing the words "Speech-Language Impaired-Professional." All services billed to Medicaid must be within the validity period on the individual's certification.

Speech-Language Pathologists: (continued)

- A Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA). The date on the CCC must be prior to the date services were rendered if those services will be billed to Medicaid.
- An ASHA membership card stating “Certified Member.” All services billed to Medicaid must be prior to the “Valid Thru” date on the card.
- An ASHA “Certificate Holder” card. All services billed to Medicaid must be prior to the “Valid Thru” date on the card.
- A master’s level degree in speech-language pathology (college transcripts may be necessary if the master’s degree does not show a major and the degree title may show terminology such as “Communication Disorders”).

Speech-Language Pathology Assistants:

Certification from the Florida Board of Speech-Language Pathology and Audiology. All services billed to Medicaid must be within the certification period.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

______________________________________ ____________________
ESE Director Date

____________________ County School District

______________________________________ ____________________
Thomas W. Arnold, Deputy Secretary for Medicaid Date

42 CFR §440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) “Physical therapy” means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A “qualified physical therapist” is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational therapy.* (1) “Occupational therapy” means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A “qualified occupational therapist” is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1) “Services for individuals with speech, hearing, and language disorders” means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

(2) A “speech pathologist or audiologist” is an individual who—

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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APPENDIX A-2
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT NURSING SERVICES PROVIDERS ARE CREDENTIALED
(Registered Nurses, Licensed Practical Nurses)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Registered Nurses:

Current licensure as a registered nurse under Chapter 464, Florida Statutes (F.S.). All services billed to Medicaid must be within the validity period on the individual's license.

Licensed Practical Nurses:

Current licensure as a practical nurse under Chapter 464, Florida Statutes (F.S.). All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the direction of a licensed registered nurse, as governed by the state nurse practice act.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_______________________________________ ______________________

ESE Director Date

______________________ County School District

_______________________________________ ______________________

Thomas W. Arnold, Deputy Secretary for Medicaid Date

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ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT NURSING SERVICES PROVIDERS ARE CREDENTIALED

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for school health aides are met as follows:

School Health Aides

Individuals for whom Medicaid is billed must have completed the following courses/training:

- Cardiopulmonary resuscitation,
- First aid,
- Medication administration, and
- Patient specific training.

The school district further agrees that all other requirements contained in the “Agreement for Assuring that School District Nursing Services Providers are Credentialed” are met as applicable to school health aides.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

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ESE Director Date

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Thomas W. Arnold, Deputy Secretary for Medicaid Date

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APPENDIX A-3
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Psychologists, Certified Behavior Analysts and Social Workers)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Psychologists/School Psychologists:

- Current licensure as a psychologist or school psychologist under Chapter 490, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a certified school psychologist; or
- Holder of a master's, specialist's, or higher degree accumulating the experience for licensure under Chapter 490, Florida Statutes (F.S.), or for DOE certification if services are rendered under the general supervision of a licensed psychologist, school psychologist, or DOE certified school psychologist.
- All services billed to Medicaid must be within the validity period on the individual's license and/or certification.

Certified Behavior Analysts:

Certification by the Department of Children and Families with a master's level degree. All services billed to Medicaid must be within the validity period of the individual's certification.

Social Workers:

- Current licensure as a clinical social worker under Chapter 491, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a social worker with a master's level degree or higher in social work; or
- Graduate of a college or university with a master's degree or higher and working under the supervision of a licensed clinical social worker (or the equivalent as defined in Chapter 491, F.S., in order to obtain the work experience necessary for licensure).
- All services billed to Medicaid must be within the validity period of the individual's license or certification.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

____ _____________________
ESE Director Date

_____________________ County School District

____ _____________________
Thomas W. Arnold, Deputy Secretary for Medicaid Date

ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Bachelor's Degree Level Social Workers, Certified Associate Behavior Analysts, Marriage and Family Therapists, Mental Health Counselors, Guidance Counselors)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Bachelor's Degree Level Social Workers

The individual(s) must be certified by the Department of Education (DOE) as a social worker with a bachelor's level degree in social work and must render services under the supervision (as defined by DOE) of a licensed or DOE certified master's level degree social worker.

Certified Associate Behavior Analysts

The individual(s) must be certified by the Department of Children and Families and must render services under the general supervision of a certified behavior analyst with a master's level degree.

Marriage and Family Therapists

The individual(s) must be currently licensed as a marriage and family therapist under Chapter 491, Florida Statutes (F.S.).

Mental Health Counselors

The individual(s) must be currently licensed as a mental health counselor under Chapter 491, Florida Statutes (F.S.).

Guidance Counselors

The individual(s) must be DOE certified as a guidance counselor and must have a master's level degree or higher.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

____ _______________________

ESE Director Date

_______________________County School District

____ _______________________

Thomas W. Arnold, Deputy Secretary for Medicaid Date

ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Bachelor's Degree Certified Behavior Analysts)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Bachelor's Degree Level Certified Behavior Analysts

The individual(s) must be certified by the Department of Children and Families (DCF) and must render services under the general supervision of a certified behavior analyst with a master's level degree.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

____ _______________________
ESE Director Date

_________________________County School District

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Thomas W. Arnold, Deputy Secretary for Medicaid Date

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ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Provisionally Licensed and Board Registered Interns – Mental Health Counselors and Marriage and Family Therapists)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Mental Health Counselors and Marriage and Family Therapists who are Provisionally Licensed or Board Registered Interns

The individual(s) must hold a provisional license or board registration as an intern under Chapter 491, Florida Statutes (F.S.) and must render services under the supervision of a licensed mental health counselor or marriage and family therapist.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

____________________________________ ____________________
ESE Director Date

____________________County School District

____________________________________ ____________________
Thomas W. Arnold, Deputy Secretary for Medicaid Date

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APPENDIX B
CERTIFIED MATCH SERVICE REIMBURSEMENT

Overview

Reimbursements for services performed by school district providers are based either on their own reasonable and actual cost of providing that service or, if applicable, the established Medicaid rate in Appendix C. Reimbursement for all services listed in this handbook are pursuant to the State Plan Amendment (SPA) 98-08 or SPA 97-10, 409.9071 Florida Statutes and other applicable CMS or Medicaid laws, rules, regulations or policies. OMB Circular A-87 contains accounting principles for the reimbursable cost determinations and reporting requirements that school districts must follow when reimbursement is based on school district cost.

Fee Schedule, Appendix C

Appendix C contains all current procedure codes with their applicable fee. It should be noted that actual reimbursement that a billing school district receives is only for the federal share of that fee for each allowable unit of service.

There are two bases for the fee schedule:

- Therapies
  Currently, Occupational Therapists, Physical Therapists and Speech-Language Pathologists are reimbursed at the same current single statewide rate as Florida's regular Medicaid community based therapy providers. However, the statewide rate has been reviewed by CMS as being equal to or less than the submitted individual average costs for providing therapies from the initial school districts.

- Behavioral, Augmentative and Communication, and Nursing service providers are paid at a single statewide average cost. These listed fees were calculated in accordance with cost determination principles contained in the OMB Circular A-87. These fees were established at the beginning of the program with actual costs obtained from records from the Florida Department of Education. Allowable average costs from each school district in Florida for employees that possessed the required certifications for each provider type allowed in this handbook, were averaged with all other school districts with similar costs. The resultant fees for these services contained in Appendix C are an equitable averaged single statewide rate for each provider type and procedure code.

Cost Reports

As provided for in SPA 98-08 and SPA 97-10, providers may elect to submit cost reports that reflect their actual current reimbursable costs for providing the services described in the handbook. These costs must be reasonable and be determined by the principles contained in the OMB Circular A-87.

- Cost report basis:

  Cost determinations should be made with pertinent allowable annual costs contained in the school districts' annual financial reports. Audited costs from the school districts' annual financial reports do not have to be used. However, if the subsequent audit uncovers errors, omissions or unallowable accounting practices that directly affect the costs that were used to calculate rates, a school district must resubmit it's cost data with the corrected amounts for rate revisions.

  Costs used for rate calculation and reimbursement must eventually come from the school district's General Fund expenditures. This fund is also the basis for the school district's certification of nonfederal expenditures required for the matching requirement.

- Cost reporting format:

  There is no specific format for the cost report. Technical assistance is available for the submission of cost reports. Contact information is noted below.

- Units of service:

  The units of service used to calculate the unit costs must be identified. The unit will normally be the same as the units (minutes or hours) for all the procedure codes listed for each service in Appendix C. The most common units will be expressed in time (minutes or hours), applications, fittings, miles or trips.

- Cost reporting for indirect costs:

  School districts that submit cost reports may include indirect costs for reimbursement purposes. Indirect costs may only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. For this handbook, the cognizant agency is the U.S. Department of Education. Specifically, the current approved IDEA indirect cost percent will be used.

- Consultant/Billing agent costs:

  Consultants who assist the school districts in any aspect of Medicaid billing activities are considered billing agents. Costs for billing agent services based on amounts billed to or reimbursed by Medicaid (an example would be percentage payments to agents based on Medicaid reimbursement billed or received) are not allowable per Florida Statutes. School districts that submit cost determinations that include valid billing agent fees, such as a flat fee per Medicaid claim, must send a copy of the contract with the cost report.

- Depreciation and use allowance:

  Depreciation or a use allowance for buildings and equipment are allowable costs per OMB Circular A-87. To ensure these costs comply with the guidelines, a separate schedule must be included that identifies method and asset life if depreciation is claimed as a program cost. Acquisition costs of assets must relate back to financial statements and be net of federally purchased items. There will be a need to certify that the asset basis used for the calculation of depreciation or use allowance for program costs is net of any source of federal funds used for acquisition. The allocation basis for each service provided must be shown.

- Cost report approval:

  Each cost report submitted to the Agency for the purpose of changing a particular existing rate must be approved by the Agency. The Agency, at its discretion, will seek CMS approval for submitted cost determination methods that it considers non-compliant with the principles allowed in OMB Circular A-87.

- Effective date:

  The school district cost report containing the relevant costs and other statistical determinations must come from the district's annual costs and records for the fiscal year ending June 30. Normally, the approved rate changes based upon the submitted cost report by the district would be effective for dates of service on July 1, which would be the first day of the reporting period immediately succeeding the submitted cost report. Or, the district could request the effective date to be for dates of service on the first day of the first quarter after the quarter in which the cost report is received and approved. For example, if a district submits a cost report received and approved in October based on district costs and other pertinent data from their fiscal year ending June 30 of that year, the effective

date would be for dates of service on July 1. However, at district discretion, that same cost report received and approved in October, could be effective for dates of service on January 1, the following year. Claims that are paid after either effective dates of service but before a newer rate is placed on the charge file will not automatically be adjusted. However, a school district may choose to manually adjust those claims.

Local Match Certifications

School districts that provide Medicaid services that utilize local match for the nonfederal share of expenditures are required to submit an annual certification. This certification is necessary to ensure that the school district has expended nonfederal money for the matching requirement. Certifications will be for services rendered for one-year with dates of service between July 1st and June 30th. Certifications will be due by September 30th of each year. These certifications will be sent to the same address as the cost reports as shown below. The form in Attachment I of this Appendix may be used for this purpose. A school district form containing the same information shown on the form in Attachment I may be used, if desired.

Technical Support and Report Submission

Cost reports and quarterly certifications should be sent to the following address:

Agency for Health Care Administration
Office of Medicaid Program Analysis
Attention: School Based Program
2727 Mahan Drive, Mail Stop 21
Tallahassee, Florida 32308-5403

Technical assistance is offered either by writing to the above address or by the following:

Telephone: (850) 414-7563 or SunCom 994-7563

Fax: (850) 922-5172 or SunCom 292-5172

Email: robinsoj@ahca.myflorida.com

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Attachment I
Annual Certification of State Expenditures By School Districts

Agency for Health Care Administration
Medicaid Program Analysis
2727 Mahan Drive, Mail Stop 21
Tallahassee, Florida 32308-5403
Attn.: School Based Programs

Dear Sirs:

I, as financial officer or other responsible school district employee of

____
(Name of School District or Special School)

am charged with the duties of supervising the administration of the provision and billing for services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school or school district has expended the state share of public, nonfederal funds needed to match the federal share of medical claims billed to the state Medicaid agency for

________________________________ services provided to eligible Medicaid students during the
(Type of Service Provided)

fiscal year ending ________________________.
(Month/Year Certified)

I also certify that the school or school district's certified expenditures were incurred in accordance with provisions of Florida's policies for the services. These certified expenditures are separately identified and supported in our accounting system.

____
Name (please print)

____
Signature

____
Title

____
Date

Instructions for Completing Form

The form, or the school district's equivalent form, is due to the Agency for Health Care Administration, Medicaid Program Analysis within 15 days after each quarter ends. The form may be photocopied from this handbook for the school districts' use.

A separate form must be completed for each service type billed to Medicaid. Each service type is defined as: Therapies, Behavioral, Nursing, Transportation and Augmentative Services.

Item Instructions

(1) Enter the name of the school district or special school.
(2) Type of service provided. For example: Therapies
(3) Fiscal year certified. For example: FYE 6/30/2006

APPENDIX C
PROCEDURE CODES AND FEE SCHEDULE

Procedure Code	Modifier	Description of Service	Fee*
		PHYSICAL THERAPY	
97001		Physical Therapy Evaluation by a Physical Therapist	$48.50
97110		Physical Therapy Individual Session by a Physical Therapist	$16.97 (per 15-minute unit)
97110	HM	Physical Therapy Individual Session by a Physical Therapist Assistant	$13.58 (per 15-minute unit)
97150		Physical Therapy Group Session by a Physical Therapist	$3.30 (per Medicaid-eligible student per 15-minute unit)
97150	HM	Physical Therapy Group Session by a Physical Therapist Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)
		OCCUPATIONAL THERAPY	
97003		Occupational Therapy Evaluation by an Occupational Therapist	$48.50
97530		Occupational Therapy Individual Session by an Occupational Therapist	$16.97 (per 15-minute unit)
97530	HM	Occupational Therapy Individual Session by an Occupational Therapy Assistant	$13.58 (per 15-minute unit)
97150	GO	Occupational Therapy Group Session by an Occupational Therapist	$3.30 (per Medicaid-eligible student per 15-minute unit)
97150	UC	Occupational Therapy Group Session by an Occupational Therapy Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)

*School Districts are not reimbursed the full amount – Reimbursement is the Federal Share of these fees. Fees shown in this appendix were derived from an initial statewide average; however, reimbursement fees can be based on an individual school district's cost and may vary from school district to school district.

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
		SPEECH-LANGUAGE PATHOLOGY	
92506		Speech-Language Pathology Evaluation by a Speech-Language Pathologist	$48.50
92507		Speech-Language Pathology Individual Session by a Speech-Language Pathologist	$16.97 (per 15-minute unit)
92507	HM	Speech-Language Pathology Individual Session by a Speech-Language Pathology Assistant	$13.58 (per 15-minute unit)
92508		Speech-Language Pathology Group Session by a Speech-Language Pathologist	$3.30 (per Medicaid-eligible student per 15-minute unit)
92508	HM	Speech-Language Pathology Group Session by a Speech-Language Pathology Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)
		APPLIANCES AND EQUIPMENT	
29799	HA	Application of Cast or Splint	$18.58
97001	TG	Wheelchair Evaluation and Fitting-PT	$48.50
97003	TG	Wheelchair Evaluation and Fitting-OT	$48.50

TRANSPORTATION

Transportation fees vary for each school district. They are not included in this appendix, instead each district is notified of its fee.

Procedure Code	Modifier	Description of Service	Fee*
		BEHAVIORAL SERVICES	
96150	AH	Psychologist-Individual Service-Evaluation	$9.66 (per 15-minute unit)
96152	AH	Psychologist-Individual Service-All Else	$9.66 (per 15-minute unit)
96153	AH	Psychologist-Group Service	$4.95 (per Medicaid-eligible student per 15-minute unit)
96150		Certified Behavior Analyst-Individual Service-Evaluation	$8.00 (per 15-minute unit)
96152		Certified Behavior Analyst-Individual Service-All Else	$8.00 (per 15-minute unit)
96153		Certified Behavior Analyst-Group Service	$4.00 (per Medicaid-eligible student per 15-minute unit)

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
		BEHAVIORAL SERVICES, continued	
96150	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Individual Service-Evaluation	$6.70 (per 15-minute unit)
96152	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Individual Service-All Else	$6.70 (per 15-minute unit)
96153	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Group Service	$3.35 (per Medicaid-eligible student per 15-minute unit)
96150	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Individual Service-Evaluation	$8.97 (per 15-minute unit)
96152	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Individual Service-All Else	$8.97 (per 15-minute unit)
96153	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Group Service	$4.25 (per Medicaid-eligible student per 15-minute unit)
96150	UD	Social Worker (Bachelor's Level)-Individual Service-Evaluation	$7.17 (per 15-minute unit)
96152	UD	Social Worker (Bachelor's Level)-Individual Service-All Else	$7.17 (per 15-minute unit)
96153	UD	Social Worker (Bachelor's Level)-Group Service	$3.40 (per Medicaid-eligible student per 15-minute unit)

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) SERVICES			
92597		AAC Initial Evaluation by a Speech-Language Pathologist	$97.50
92597	GP	AAC Initial Evaluation by a Physical Therapist	$97.50
92597	GO	AAC Initial Evaluation by an Occupational Therapist	$97.50
92597	GN	AAC Re-Evaluation by a Speech-Language Pathologist	$50.00
92609		AAC Fitting, Adjustment and Training Visit	$40.00
NURSING SERVICES			
T1002		Nursing Service-Registered Nurse	$6.20 (per 15-minute unit)
T1003		Nursing Service-Licensed Practical Nurse	$4.80 (per 15-minute unit)
T1004		Nursing Service-School Health Aide	$3.80 (per 15-minute unit)
T1002	KO	Medication Administration-Registered Nurse	$2.07 (per dose)
T1003	KO	Medication Administration-Licensed Practical Nurse	$1.06 (per dose)
T1004	KO	Medication Administration-School Health Aide	$.80 (per dose)

CHAPTER 2
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PHYSICAL THERAPY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for physical therapy services, the requirements for service provision, the service limitations, and service exclusions.

In This Chapter

This chapter contains:

TOPIC	PAGE
Definition	2-1
Provider Qualifications	2-2
Physical Therapy Evaluations	2-2
Plan of Care	2-3
Physical Therapy Sessions	2-5
Splints and Casts	2-7
Wheelchair Evaluations and Fittings	2-7
Therapy Audit Requirements	2-9

Definition

Introduction

Medicaid reimburses school district providers for the physical therapy services described in this handbook.

Physical Therapy

Physical therapy is a specific program to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Activities can include rehabilitation through exercise, massage, and the use of equipment through therapeutic activities.

Provider Qualifications

Physical Therapist Provider Qualifications

To render services in the Medicaid certified school match program a physical therapist must be currently licensed as a physical therapist under Chapter 486, Florida Statutes, (F.S.).

Physical Therapist Assistant Provider Qualifications

To render services in the Medicaid certified school match program, a physical therapist assistant must be currently licensed as a physical therapist assistant under Chapter 486, F.S. Temporary licenses are not acceptable for Medicaid purposes.

Medicaid will reimburse a school district for a physical therapy assistant's services if the services are rendered under the supervision of a licensed physical therapist.

Physical Therapy Evaluations

Physical Therapy Evaluation (97001)

Evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits and limitations.

Service Requirements

To be reimbursed by Medicaid, the evaluation must be conducted by a licensed physical therapist. It must be based on the physical therapist's professional judgment and the specific needs of the student. A physical therapist assistant may not perform an evaluation.

Required Components

To be reimbursed by Medicaid, an evaluation must include the following components:

- Student's name;
- Diagnostic testing and assessment; and
- A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have to be a "stand alone" document. It may be a part of the plan of care or IEP or FSP.

Physical Therapy Evaluations, continued

Reimbursement Limitations

Although it is up to the physical therapist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one physical therapy evaluation per student, per school district provider, every six months.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the evaluation procedure code and fee.

Plan of Care

Plan of Care Requirement and Recommendation for Services

If an evaluation indicates that physical therapy is warranted, the physical therapist must develop and maintain a plan of care.

The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care provided the IEP or FSP contains the required components as described below, or the information can be included in both documents.

The plan of care or signed attachment (see section below on "Plan of Care Approval") may serve as the recommendation for services described in Chapter 1.

Provider Requirement

Only a licensed physical therapist may initiate, develop, submit, or change a plan of care. A physical therapist assistant may not initiate, develop, submit or change a plan of care.

Plan of Care Components

The plan of care must include the following information:

- Student's name;
- Description of the student's medical condition;
- Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of physical therapy activities the student will need; and
- Frequency and estimated length of treatments (may be total minutes per week) and the duration of treatment. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care, continued

Plan of Care Approval

The plan of care must be signed, titled and dated by a physical therapist. Also, a physician, advanced registered nurse practitioner (ARNP), or physician assistant (PA) must sign, title and date the plan of care if:

- Treatments for a student will be required beyond 21 days, and
- The student's condition has not been previously assessed by a physician, ARNP or PA.

An attachment may be used for the signature of a physician, ARNP or PA. A student is considered to have had a previous assessment if a prescription or a referral from a physician, ARNP or PA is present in school district records. A prescription or referral is only needed once unless the medical condition requiring the student's therapy significantly changes.

All required signatures on the plan of care must be legible and must be affixed to the plan before the school district may bill Medicaid for services. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document.

The plan of care must be retained in the student's record. Prescriptions as required by the Department of Education should also be retained in the student's record.

Plan of Care Review

A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. It is not necessary to obtain a physician's, ARNP's or PA's signature on annual plans of care subsequent to initial plans of care. A copy of annual plans of care should be sent to each Medicaid eligible student's physician for information to facilitate continuity of care.

The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care.

In the event that services are discontinued, the physical therapist must indicate the reason for discontinuing treatment in the student's record.

Reimbursement Limitations

Medicaid does not reimburse separately for developing the plan of care.

Physical Therapy Sessions

Introduction

In order to receive Medicaid reimbursement, physical therapy sessions can include rehabilitation through exercise, massage, and the use of equipment through therapeutic activities.

Provider Requirements

Medicaid reimburses for physical therapy sessions provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

Individual Sessions by a Physical Therapist (97110)

Medicaid reimburses for individual physical therapy sessions performed by a licensed physical therapist.

Individual Sessions by a Physical Therapist Assistant (97110 HM)

Medicaid reimburses for individual physical therapy sessions performed by a physical therapist assistant under the supervision of a licensed physical therapist.

Group Sessions by a Physical Therapist (97150)

Medicaid reimburses for group physical therapy sessions performed by a licensed physical therapist.

Group Sessions by a Physical Therapist Assistant (97150 HM)

Medicaid reimburses for group physical therapy sessions performed by a physical therapist assistant working under the supervision of a licensed physical therapist.

Physical Therapy Sessions, continued

Service Requirement

Individual physical therapy sessions must consist of a minimum of 15 minutes of direct contact between the physical therapist or physical therapist assistant and the student.

Group physical therapy sessions must consist of a minimum 15 minutes of direct contact between the physical therapist or physical therapist assistant and the students. Group sessions are limited to a maximum of four students. There is no requirement that all the members of the group be eligible for Medicaid.

An evaluation (even if it was not reimbursed by Medicaid) and a plan of care must have been completed for a student by a licensed physical therapist prior to billing Medicaid for sessions with the student.

Individual and group sessions do not include wheelchair evaluations and fittings or casts and splints.

Note: See "Wheelchair Evaluations and Fittings" and "Casts and Splints" in this chapter for information on those services.

Supervision of Physical Therapist Assistants

Medicaid reimburses for sessions performed by a physical therapist assistant if the services are rendered under the supervision of a licensed physical therapist, pursuant to Chapter 486, F.S.

A licensed physical therapist must have examined and evaluated the student and completed a plan of care before a physical therapist assistant can render services.

Supervision does not have to be on-site; however, the physical therapist must be accessible at all times by two-way communication, which enables the physical therapist to respond to an inquiry and to be readily available for consultation during the delivery of care.

Reimbursement Limitations

Medicaid reimburses for a maximum total of four 15-minute physical therapy sessions per day, per student. The total of four sessions may be a combination of both individual and group sessions.

Service Exclusions

Medicaid reimbursement for physical therapy sessions does not include telephone responses to questions, conferences with the student's parent or guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the physical therapy session procedure codes and fee schedule.

Splints and Casts

Splints and Casts (29799 HA)	Medicaid reimburses for applying splints and casts by a licensed physical therapist that are needed for a Medicaid-eligible student's therapy.
Provider Requirements	To be reimbursed by Medicaid, the splint or cast service must be rendered by a licensed physical therapist.
Service Requirements	To be reimbursed by Medicaid, the splint or cast service must be: • Prescribed by a licensed physician, ARNP, or PA; and • Included in the student's plan of care.
Reimbursement Limitations	Medicaid reimburses for a maximum of two cast and splint applications per day, per student. This is a combined total and is per student, not per therapist. For example, one cast and one splint may be reimbursed or two casts or two splints, per day, per student, regardless of the number of therapists applying the casts and splints.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the splint and cast procedure codes and fee schedule.

Wheelchair Evaluations and Fittings

Wheelchair Evaluations and Fittings (97001 TG)	Medicaid reimburses for an initial evaluation of a Medicaid-eligible student's need for a wheelchair by a licensed physical therapist. Medicaid reimburses for a follow-up evaluation by a licensed physical therapist after the wheelchair is delivered to make adjustments and to properly fit the wheelchair to the student. Medicaid reimburses for wheelchair evaluations and fittings regardless of whether Medicaid purchased the student's wheelchair or if the evaluation indicates that a wheelchair is not needed. Note: Wheelchairs are purchased through the Medicaid Durable Medical Equipment (DME) program.

Wheelchair Evaluations and Fittings, continued

Provider Requirements

To be reimbursed by Medicaid, wheelchair evaluations must be performed by licensed physical therapists.

The physical therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider who is supplying the wheelchair; and
- Perform the follow-up evaluation(s) to make adjustments and properly fit the chair to the student.

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Student's name;
- Identification of the student's physical conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the student's capacity and medical condition;
- Justification of all accessories and add-on components based on the student's medical needs; and
- An explanation of the medical or health-related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the physical disability of the student justifies the inclusion of the item.

Finalization of the Wheelchair Evaluation Report

The wheelchair evaluation report must meet the following criteria:

- The physical therapist must complete, sign, title and date the report documenting the student's need for a wheelchair and the specific type of wheelchair needed; and
- The report must be filed in the student's record.

Wheelchair Evaluations and Fittings, continued

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per student, per wheelchair except that an occupational therapist may also be reimbursed for the evaluation of the student;
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the student (an occupational therapist may also be reimbursed); and
- One additional follow-up evaluation six months after the wheelchair is delivered (an occupational therapist may also be reimbursed).

Wheelchair Follow-up Evaluation Report

The wheelchair follow-up evaluation report must contain the following information:

- Student's name; and
- Description of adjustments and fittings made.

The physical therapist must complete, sign, title and date the report.

The report must be filed in the student's record.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, a wheelchair evaluation that is sent to a wheelchair manufacturer or a plan of care sent to a physician should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation or plan of care. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's records should include the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Therapy Audit Requirements, continued

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist, or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, OTA, 10/20/98; Mary Smith, PT, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation, unless they meet all of the service documentation requirements above.

CHAPTER 3
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
OCCUPATIONAL THERAPY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for occupational therapy services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

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Definition

Introduction

Medicaid reimburses school district providers for the occupational therapy services described in this handbook.

Occupational Therapy

Occupational therapy is a specific service to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior and sensory, motor, postural development, and emotional deficits that have been limited by a physical injury, illness or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Provider Qualifications

Occupational Therapist Provider Qualifications

To render services in the Medicaid certified school match program an occupational therapist must be currently licensed as an occupational therapist under Chapter 468, Florida Statutes, (F.S.). Individuals with temporary licenses can render reimbursable services if done under the supervision of an actively licensed occupational therapist.

Occupational Therapy Assistant Provider Qualifications

To render services in the Medicaid certified school match program, an occupational therapy assistant must be currently licensed as an occupational therapy assistant under Chapter 468, F.S. Temporary licenses are not acceptable for Medicaid purposes.

Medicaid will reimburse a school district for an occupational therapy assistant's services if the services are rendered under the supervision of a licensed occupational therapist.

Occupational Therapy Evaluations

Occupational Therapy Evaluation (97003)

Evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits, and limitations.

Service Requirements

To be reimbursed by Medicaid, the evaluation must be conducted by a licensed occupational therapist. It must be based on the occupational therapist's professional judgment and the specific needs of the student. An occupational therapy assistant may not perform an evaluation.

Required Components

To be reimbursed by Medicaid, an evaluation must include the following components:

- Student's name;
- Diagnostic testing and assessment; and
- A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have be a "stand alone" document. It may be a part of the plan of care or IEP or FSP.

Occupational Therapy Evaluations, continued

Reimbursement Limitations

Although it is up to the occupational therapist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one occupational therapy evaluation per student, per school district provider, every six months.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the evaluation procedure code and fee.

Plan of Care

Plan of Care Requirements and Recommendation for Services

If an evaluation indicates that occupational therapy is warranted, the occupational therapist must develop and maintain a plan of care.

The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care provided the IEP or FSP contains the required components as described below, or the information can be included in both documents.

The plan of care will serve as the recommendation for services described in Chapter 1.

Provider Requirement

Only a licensed occupational therapist may initiate, develop, submit or change a plan of care. An occupational therapy assistant may not initiate, develop, submit or change a plan of care.

Plan of Care Components

The plan of care must include the following information:

- Student's name;
- Description of the student's medical condition;
- Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of occupational therapy activities the student will need; and
- Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care, continued

Plan of Care Approval

The plan of care must be signed, titled and dated by an occupational therapist prior to billing Medicaid for services.

The signature on the plan of care must be legible. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document.

The plan of care must be retained in the student's record.

Plan of Care Review

A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this chapter.

The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care.

In the event that services are discontinued, the occupational therapist must indicate the reason for discontinuing treatment in the student's record.

Reimbursement Limitations

Medicaid does not reimburse separately for developing the plan of care.

Occupational Therapy Sessions

Introduction

In order to receive Medicaid reimbursement, occupational therapy sessions can include perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment, and other techniques related to improving motor development.

Provider Requirements

Medicaid reimburses for occupational therapy sessions provided by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

Occupational Therapy Sessions, continued

Individual Session by an Occupational Therapist (97530)	Medicaid reimburses for individual occupational therapy sessions performed by a licensed occupational therapist.
Individual Session by an Occupational Therapy Assistant (97530 HM)	Medicaid reimburses for individual occupational therapy sessions performed by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.
Group Session by an Occupational Therapist (97150 GO)	Medicaid reimburses for group occupational therapy sessions performed by a licensed occupational therapist.
Group Session by an Occupational Therapy Assistant (97150 UC)	Medicaid reimburses for group occupational therapy sessions performed by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.
Service Requirements	Individual occupational therapy sessions must consist of a minimum 15 minutes of direct contact between the licensed occupational therapist or occupational therapy assistant and the student. Group occupational therapy sessions must consist of a minimum 15 minutes of direct contact between the licensed occupational therapist or occupational therapy assistant and the students. Group size is limited to a maximum of four students. There is no requirement that all the members of the group be eligible for Medicaid. An evaluation (even if it was not reimbursed by Medicaid) and plan of care must have been completed for a student by an occupational therapist prior to billing Medicaid for sessions with the student. Individual and group sessions do not include wheelchair evaluations and fittings or casts and splints. Note: See “Wheelchair Evaluations and Fittings” and “Casts and Splints” in this chapter for information on those services.

Occupational Therapy Sessions, continued

Supervision of Occupational Therapy Assistants

Medicaid reimburses for sessions performed by a licensed occupational therapy assistant if the services are rendered under the supervision of a licensed occupational therapist, pursuant to Chapter 468, F.S.

A licensed occupational therapist must have examined and evaluated the student and completed a plan of care before an occupational therapy assistant can render services.

Supervision does not have to be on-site; however, the supervising occupational therapist must be available to the assistant for consultation.

Reimbursement Limitations

Medicaid reimburses for a maximum total of four 15-minute occupational therapy sessions per day, per student. The total of four sessions may be a combination of both individual and group sessions.

Service Exclusions

Medicaid reimbursement for occupational therapy sessions does not include telephone responses to questions, conferences with the student's parent, guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the occupational therapy session procedure codes and fee schedule.

Splints and Casts

Splints and Casts (29799 HA)

Medicaid reimburses for applying splints and casts by a licensed occupational therapist that are needed for a Medicaid-eligible student's therapy.

Provider Requirements

To be reimbursed by Medicaid, the splint or cast service must be rendered by a licensed occupational therapist.

Service Requirements

To be reimbursed by Medicaid, the splint or cast service must be:

- Prescribed by a licensed physician, ARNP, or PA; and
- Included in the student's plan of care.

Splints and Casts, continued

Reimbursement Limitations

Medicaid reimburses for a maximum of two cast and splint applications per day, per student. This is a combined total and is per student, not per therapist. For example, one cast and one splint may be reimbursed or two casts or two splints, per day, per student, regardless of the number of therapists applying the casts and splints.

Codes and Fees

See Appendix C in Chapter 1 in this handbook for the splint and cast procedure codes and fee schedule.

Wheelchair Evaluations and Fittings

Wheelchair Evaluations and Fittings (97003 TG)

Medicaid reimburses for an initial evaluation of a Medicaid-eligible student's need for a wheelchair by a licensed occupational therapist. Medicaid reimburses for a follow-up evaluation by a licensed occupational therapist after the wheelchair is delivered to make adjustments and to properly fit the wheelchair to the student.

Medicaid reimburses for wheelchair evaluations and fittings regardless of whether the student's wheelchair was purchased by Medicaid or if the evaluation indicates that a wheelchair is not needed.

Note: Wheelchairs are purchased through the Medicaid Durable Medical Equipment (DME) program. See the DME handbook for further information on equipment purchasing policies.

Provider Requirements

To be reimbursed by Medicaid, wheelchair evaluations must be performed by licensed occupational therapists.

The occupational therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider who is supplying the wheelchair; and
- Perform the follow-up evaluation to make adjustments and properly fit the chair to the student.

Wheelchair Evaluations and Fittings, continued

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Student's name;
- Identification of the student's occupational conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the student's capacity and medical condition;
- Justification of all accessories and add-on components based on the student's medical needs; and
- An explanation of the medical or health-related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the occupational disability of the student justifies the inclusion of the item.

Finalization of the Wheelchair Evaluation Report

The wheelchair evaluation report must meet the following criteria:

- The occupational therapist must complete, sign and date the report documenting the student's need for a wheelchair and the specific type of wheelchair needed; and
- The report must be filed in the student's record.

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per student, per wheelchair except that a physical therapist may also be reimbursed for an evaluation of the student;
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the student (a physical therapist may also be reimbursed); and
- One additional follow-up evaluation six months after the wheelchair is delivered (a physical therapist may also be reimbursed).

Wheelchair Follow-up Evaluation Report

The wheelchair follow-up evaluation report must contain the following information:

- Student's name; and
- Description of adjustments and fittings made.

The occupational therapist must complete, sign, title and date the report. The report must be filed in the student's record.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, a wheelchair evaluation that is sent to a wheelchair manufacturer should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.
Each Medicaid-eligible student's records should include, at a minimum, the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, OTA, 10/20/98; Mary Smith, OT, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation unless they meet all of the service documentation requirements above.

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CHAPTER 4
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
SPEECH-LANGUAGE PATHOLOGY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for speech-language pathology services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

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Provider Qualifications	4-2
Speech-Language Pathology Evaluations	4-2
Plan of Care	4-4
Speech-Language Pathology Sessions	4-5
Therapy Audit Requirements	4-7

Definition

Introduction

Medicaid reimburses school district providers for the speech-language pathology services described in this handbook.

Speech-Language Pathology

Speech-language pathology services involve the evaluation and treatment of speech and language disorders. Services include evaluating and treating disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory or visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the student's communication needs, when appropriate. Speech-language pathology services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Provider Qualifications

Speech-Language Pathologist Provider Qualifications

To bill Medicaid for services in the Medicaid certified school match program, a school district must have one of the following forms of credentials for speech-language pathologists:

- Current license as a speech-language pathologist under Chapter 468, Florida Statutes. Individuals with provisional licenses may render reimbursable services if done under the supervision of an actively licensed speech-language pathologist;
- Department of Education Certification in the area of Speech-Language Impaired, containing the words “Speech-Language Impaired-Professional”;
- Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
- ASHA membership card stating “Certified Member”;
- ASHA Certificate Holder card; or
- Master’s level degree in speech-language pathology (the degree title may show terminology such as “Communication Disorders”).

Speech-Language Pathology Assistant Provider Qualifications

To render services in the Medicaid certified school match program, a speech-language pathology assistant must be currently certified as a speech-language pathology assistant under Chapter 468, F.S.

Medicaid will reimburse a school district for a speech-language pathology assistant’s services if the services are rendered under the supervision of a licensed speech-language pathologist.

Speech-Language Pathology Evaluations

Speech-Language Pathology Evaluation (92506)

Evaluations determine the Medicaid-eligible student’s level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student’s functional abilities, capabilities, activities performance, deficits and limitations.

Speech-Language Pathology Evaluations, continued

Service Requirements

To be reimbursed by Medicaid, the evaluation must be conducted by a speech-language pathologist. It must be based on the speech-language pathologist's professional judgment and the specific needs of the student. A speech-language pathology assistant may not perform an evaluation.

Required Components

To be reimbursed by Medicaid, an evaluation must include the following components:

- Student's name;
- Diagnostic testing and assessment; and
- A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have to be a "stand alone" document. It may be a part of the plan of care, IEP or FSP.

Reimbursement Limitations

Although it is up to the speech-language pathologist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one speech-language pathology evaluation per student, per school district provider, every six months.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the speech-language pathology evaluation procedure code and fee.

Plan of Care

Plan of Care Requirements and Recommendation for Services

If an evaluation indicates that speech-language pathology treatment is warranted, the speech-language pathologist must develop and maintain a plan of care.

The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care as long as the IEP or FSP contains the required components as described below.

The plan of care may serve as the recommendation for services described in Chapter 1.

Provider Requirement

Only a speech-language pathologist may initiate, develop, submit or change a plan of care. A speech-language pathology assistant may not initiate, develop, submit or change a plan of care.

Plan of Care Components

The plan of care must include the following information:

- Student's name;
- Description of the student's medical condition;
- Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of speech-language pathology activities the student will need; and
- Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment necessary. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care Approval

The plan of care must be signed, titled and dated by a speech-language pathologist prior to billing Medicaid for services.

The signature on the plan of care must be legible. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document.

The plan of care must be retained in the student's record.

Plan of Care, continued

Plan of Care Review

A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this chapter.

The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care.

In the event that services are discontinued, the speech-language pathologist must indicate the reason for discontinuing treatment in the student's record.

Reimbursement Limitations

Medicaid does not reimburse separately for developing the plan of care.

Speech-Language Pathology Sessions

Introduction

In order to receive Medicaid reimbursement, speech-language pathology sessions should include procedures to maximize the student's oral functions.

Provider Requirements

Medicaid reimburses for speech-language pathology sessions provided by a credentialed speech-language pathologist or a certified speech-language pathology assistant under the supervision of a licensed speech-language pathologist.

Individual Session by a Speech-Language Pathologist (92507)

Medicaid reimburses for individual speech-language pathology sessions performed by a speech-language pathologist.

Individual Session by a Speech-Language Pathology Assistant (92507 HM)

Medicaid reimburses for individual speech-language pathology sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist.

Speech-Language Pathology Sessions, continued

Group Session by a Speech-Language Pathologist (92508)	Medicaid reimburses for group speech-language pathology sessions performed by a speech-language pathologist.
Group Session by a Speech-Language Pathology Assistant (92508 HM)	Medicaid reimburses for group speech-language pathology sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist.
Service Requirement	Individual speech-language pathology sessions must consist of a minimum of 15 minutes of direct contact between the speech-language pathologist or speech-language pathology assistant and the student. Group speech-language pathology sessions must consist of a minimum 15 minutes of direct contact between the speech-language pathologist or speech-language pathology assistant and the students. Group size is limited to a maximum of eight students. There is no requirement that all the members of the group be eligible for Medicaid. An evaluation (even if it was not reimbursed by Medicaid) and plan of care must be: • Completed by a licensed or DOE-certified or ASHA-certified or master's degree level speech-language pathologist; or • The document must be countersigned by a master's level speech-language pathologist prior to billing Medicaid for sessions with the student.
Supervision of Speech-Language Pathology Assistants	Medicaid reimburses for sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist, pursuant to Chapter 468, F.S. A speech-language pathologist must have examined and evaluated the student and completed a plan of care before a speech-language pathology assistant can render services. The speech-language pathologist must be physically present in the same facility in order to be available for consultation and direction.
Reimbursement Limitations	Medicaid reimburses for a maximum total of four 15-minute speech-language pathology sessions per student, per day. The total of four sessions may be a combination of both individual and group sessions.

Speech-Language Pathology Sessions, continued

Service Exclusions

Medicaid will not reimburse for assisting foreign speaking students in comprehending or speaking English or for interpreter's services.

Medicaid reimbursement for speech-language pathology sessions does not include telephone responses to questions, conferences with the student's parent, guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.

Medicaid will not provide reimbursement for treatment based on evaluations completed by a bachelor's speech-language pathologist unless one of the following conditions exists:

- A master's level speech-language pathologist has interpreted and countersigned if the testing documents from the evaluation are available and current; or
- A statement is written by the master's level speech-language pathologist after reviewing the student's IEP and the evaluation report, indicating that the master's level speech-language pathologist concurs with the findings.

In either case the signature of the master's level speech-language pathologist must be accompanied by his title, and dated.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the speech-language pathology session procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's records should include the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Therapy Audit Requirements, continued

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, SLPA, 10/20/98; Mary Smith, SLP, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation unless they meet all of the service documentation requirements above.

CHAPTER 5
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
TRANSPORTATION SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for transportation, the eligibility requirements for service provision, how rates are established and claims submitted, and the documentation and record keeping requirements.

In This Chapter

This chapter contains:

TOPIC	PAGE
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Service Requirements	5-2
Reimbursable Transportation Services	5-3
Reimbursement Information	5-4
Trip Logs	5-5

Provider Qualifications

Enrollment Process

To be reimbursed for transportation services under the certified school match program, the school district must enroll as a Medicaid provider and submit a Medicaid provider agreement for transportation services. (The school district must submit a separate provider agreement for each type of service for which it will bill Medicaid.)

Note: See Chapter 1 in this handbook for the general provider qualifications.

Transportation Services Provider Qualifications

There are no specific Medicaid provider qualifications for transportation services beyond the requirements for school bus transportation in Chapter 1006, F.S., and Chapter 6A-3, F.A.C.

Service Requirements

Introduction	To receive Medicaid reimbursement for transportation services, the following requirements must be met.
Non-Emergency	The transportation must be non-emergency.
Two Types of Categories of Specialized Transportation Service	To qualify for Medicaid reimbursement one of the two types of categories of services described below must be met.
Type One: Handicapped Equipped or Adapted Vehicle	The bus or vehicle must be adapted or specially equipped to serve the disabled student.
Type Two: Attendant Required to Accompany Student	When an attendant rides with the student(s) during the transport to assist the student(s) with behavioral or physical disability related needs the trip is defined as type two specialized transportation. The vehicle may be any vehicle used to transport students to school or to a medical appointment to and from school, and may not necessarily be adapted or specially equipped to serve the disabled student.
Recipient Eligibility	The student must meet the criteria for the Exceptional Student Education (ESE) program under the provisions of the Individuals with Disabilities Education Act (IDEA), Part B or Part C.

Service Requirements, continued

Individual Education Plan or Family Support Plan

Transportation can only be reimbursed when a Medicaid-covered service other than transportation is rendered, and when the other medical or behavioral service provided is referenced in the student's IEP or FSP. The services of the attendant under type two specialized transportation cannot satisfy the requirement as the other Medicaid-covered service. For example, if the need for a bus attendant is identified, as a related service on a student's IEP, the service of the attendant cannot be considered the Medicaid-covered service for which the transportation is provided.

The cost of the attendant under type two specialized transportation may be added to the provider's cost base when calculating a new trip rate.

The transportation must be referenced as a service in the student's IEP or FSP as specialized transportation meeting one of the following three criteria for specialized transportation:

- Medical or vehicle adaptive equipment required;
- Medical condition that requires a special transportation environment; or
- Attendant required due to (physical or behavioral) disability and specific needs of student.

(Note of Clarification: The three criteria above are based on the criteria also used by the Department of Education for specialized funding for transportation.)

Reimbursable Transportation Services

Medicaid-Covered Service at the School

Medicaid may reimburse for a trip to and from the school only when a Medicaid-covered service is provided at the school.

Specialized transportation to or from the school must be provided on the same day that the Medicaid-covered service is provided at the school. The services of the attendant under type two specialized transportation cannot satisfy this requirement as the other Medicaid-covered service.

Reimbursable Transportation Services, continued

Medicaid-Covered Service Provided Off Campus

When a Medicaid-covered service is provided off the school campus, Medicaid may reimburse for the trip from the school to the medical service and back.

Medicaid cannot reimburse for a trip from home to the school and back when the only Medicaid-covered medical service is provided at a location off the school campus.

Service Limitations

Medicaid reimbursement for certified school match transportation services is limited to four one-way trips per day, per Medicaid-eligible student. Four trips in one day may only be claimed when a Medicaid-covered service is provided at the school, and a different Medicaid-covered service is provided off campus on the same day.

Reimbursement Information

Reimbursement Rate

Medicaid reimburses the school districts on a per trip basis at a district-specific rate determined by information provided to the Department of Education (DOE) from each school district's annual financial reports and other available sources. Medicaid reimburses only the federal share of the trip rate for specialized transportation. Only type one and type two specialized transportation, as defined above, meet the criteria for specialized transportation; and, only specialized transportation is reimbursable under this program. The district-specific rate is applicable to type one and type two specialized transportation for reimbursement.

Claim Instructions (For Claims Filed Electronically or by Paper)

To receive reimbursement, the school district must submit school-related transportation claims on CMS-1500 claims using the following instructions:

- Enter procedure code T2003 (non-emergency transportation).
- Enter diagnosis code 999.9 for all Medicaid-eligible students.
- Enter keyed claim type 88 in field 19.
- Use a separate claim line for each date of service.
- For units of service, enter the total number of one-way trips that the student was transported to and from Medicaid-covered services for each date of service.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500, for complete information on completing the CMS-1500 claim.

Trip Logs

Introduction

In addition to the audit requirements listed in Chapter 1 of this handbook, and the Medicaid Provider General Handbook, the school district must keep a trip log as described in this section. A school district may submit a proposal to the area Medicaid school services representative for an alternate plan of documentation other than daily trip logs. The area liaison will forward complete descriptive alternate plans of documentation to the Agency for Health Care Administration central Medicaid office for processing. The area Medicaid office will advise the school district of whether the request was approved and the time period of the approval; or, if denied, the reason for denial.

Documentation

To document the provision of transportation to Medicaid services, provided at school or off campus, the school districts must keep dated trip logs that contain the following information:

- Student's name,
- Date the student was transported, and
- Bus or loading dock attendant's or bus driver's daily initials on the date of each trip verifying that the student(s) listed on each trip log actually rode in the vehicle.

The school district may list multiple student names on one trip log. Preprinted trip log forms listing all the students that normally ride a specific route may be used with only one set of initials required per route log indicating which students rode the vehicle for that trip.

Electronic documentation and electronic signatures are allowed but these records must be available upon request, as required in Chapter 1 of this handbook.

Matching Logs to Services

The school district must have the capacity to match the trip logs to health care records to document that a Medicaid-covered service referenced in the student's IEP or FSP was provided to the student on each day for which a claim was submitted for transportation reimbursement.

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CHAPTER 6
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM BEHAVIORAL SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for behavioral services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

TOPIC	PAGE
Definitions	6-1
Provider Qualifications	6-2
Service Requirements	6-4
Individual Behavioral Services	6-6
Group Behavioral Services	6-7
Audit Requirements	6-9

Definitions

Introduction

Medicaid reimburses school districts for the behavioral services described in this handbook.

Behavioral Services

Behavioral services are services which can include:

- Testing, assessment and evaluation that appraise cognitive, developmental, emotional, social and adaptive functioning;
- Interviews, behavioral evaluations and functional assessments, including interpretations of information about the student’s behavior and conditions relating to functioning;
- Development of evaluative reports;
- Consultation and coordination, follow-up referrals with other health care staff, other entities or agencies, parents, teachers, and family during the Individual Educational Plan or Family Support Plan (IEP or FSP) development and review process or at other times deemed appropriate by the school district staff performing behavioral services;

Definitions, continued

Behavioral Services, continued

- Therapy and counseling;
- Behavioral analysis or assessment and treatment or intervention; and
- Unscheduled activities for the purpose of resolving an immediate crisis situation.

Terminology

The term "behavioral" services is used in this chapter as a generic term to cover the many behavioral services (the above list consists of examples) school districts offer to students. Procedure codes have been assigned by type of qualified provider (see Appendix C in Chapter 1 for a list and definition of each code). School district staff members should be aware of the specific services their licenses or certifications allow them to provide and must work within practice parameters allowed.

Provider Qualifications

Provider Types for Behavioral Services

For Medicaid purposes, the following types of employed or contracted school district staff may render reimbursable services:

- School psychologists and psychologists;
- Social workers (master's and bachelor's level degrees);
- Certified behavior analysts (master's and bachelor's level degrees);
- Associate certified behavior analysts;
- Mental health counselors;
- Marriage and family therapists; and
- Guidance counselors.

Unless noted otherwise in this chapter, the various staff above will be referenced as "school district staff." The list of examples of covered services is not intended as a comprehensive or all-inclusive list for every school district staff member.

Provider Qualifications, continued

School Psychologist or Psychologist Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a school psychologist or psychologist must have one of the following:

- Current license as a school psychologist or psychologist under Chapter 490, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a temporary certified school psychologist or as a certified school psychologist; or
- Master's, specialist's, or higher degree and the individual is accumulating the experience for licensure under Chapter 490, F.S., or for DOE certification if services are rendered under the general supervision of a licensed psychologist, school psychologist, or DOE certified school psychologist.

School Social Worker or Social Worker Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a school social worker or a social worker must have one of the following:

- Current license as a clinical social worker under Chapter 491, Florida Statutes, (F.S.);
- Certification by the Department of Education (DOE) as a school social worker with a master's level degree or higher in social work;
- A master's degree or higher from a college or university and working under the supervision of a licensed clinical social worker (or the equivalent as defined in Chapter 491, F.S.) or DOE-certified school social worker with a master's degree or higher in social work in order to obtain the work experience necessary for licensure or certification; or
- Certification by DOE as a school social worker with a bachelor's level degree in social work and working under the supervision of a licensed or DOE-certified master's level degree school social worker.

Temporary licenses are not acceptable for Medicaid purposes.

Certified Behavior Analyst and Associate Certified Behavior Analyst Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a certified behavior analyst must have a bachelor's or master's level degree and be currently certified by the Department of Children and Families. Certified behavior analysts with bachelor's level degrees must be working under the supervision of a master's level degree certified behavior analyst for Medicaid to reimburse the services.

To render reimbursable services in the Medicaid certified school match program, an associate certified behavior analyst must hold current certification issued by the Department of Children and Families and must be working under the supervision of a certified behavior analyst with a master's level degree.

Provider Qualifications, continued

Mental Health Counselor Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a mental health counselor must have one of the following:

- Current license as a mental health counselor under Chapter 491, Florida Statutes, (F.S.); or
- Master's degree and provisional license or board registration as an intern and working under the supervision of a licensed mental health counselor.

Temporary licenses are not acceptable for Medicaid purposes.

Marriage and Family Therapist Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a marriage and family therapist must have one of the following:

- Currently licensed as a marriage and family therapist under Chapter 491, Florida Statutes, (F.S.); or
- Master's degree and provisional license or board registration as an intern and working under the supervision of a licensed marriage and family therapist.

Temporary licenses are not acceptable for Medicaid purposes.

Guidance Counselor Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a guidance counselor must be DOE-certified as a guidance counselor and have a master's level degree or higher.

Service Requirements

Introduction

To receive Medicaid reimbursement for behavioral services, the following requirements must be met.

General Service Requirements

To be reimbursed by Medicaid, the service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services.

If a Medicaid eligible student receives counseling, therapy or behavioral treatments from a school district and a community mental health provider during the same time period, these activities should be coordinated by both providers.

Service Requirements, continued

Individual Educational Plan or Family Support Plan

The need for behavioral services must be referenced in the student's Individual Educational Plan (IEP) or Family Support Plan (FSP).

Recommendation for Services

Except as noted, qualified providers of behavioral services who have master's level or higher degrees and are licensed or certified, must sign, title and date the IEP, FSP or separate document indicating that behavioral services are needed for the Medicaid-eligible student prior to the time any claims for behavioral services are submitted to Medicaid. However, recommendations for behavioral services rendered by guidance counselors must be signed by school psychologists or psychologists or master's level social workers.

Diagnosis Code

Medicaid requires that an ICD-9 diagnosis code be entered on the CMS-1500 claim. The student's diagnosis statement or ICD-9 diagnosis code must be contained in his record.

Abbreviated Title for Psychologists

School psychologists or psychologists may sign IEPs, FSPs or service documentation as follows:

- A licensed psychologist may sign his name and enter degree earned (ex. Ph.D., Ed.D., Psy.D.) or "LP" or "licensed psychologist";
- A licensed school psychologist may sign his name and enter degree earned (ex. M.S., Ph.D.) or "LSP" or "licensed school psychologist";
- A DOE-certified school psychologist may sign his name and enter degree earned (ex. M.S., Ph.D.) or "CSP" or "certified school psychologist" ("NCSP" could be used if the individual holds national certification); or
- An individual with a master's, specialist's or higher degree accumulating the experience necessary to obtain a license should sign his name and enter degree earned (example: M.S., Ed.S., Ph.D.).

Place of Service

Travel time off school campus for the provision of behavioral services is not reimbursable unless reimbursable services are rendered during travel.

Individual Behavioral Services

Individual Behavioral Service-Evaluation (96150 or 96150 followed by AH, HN, HO or UD)

Individual Behavioral Service-All Else (96152 or 96152 followed by AH, HN, HO or UD)

Individual behavioral services as defined in this chapter may be billed to Medicaid when the school district staff are rendering services to or on behalf of a specific Medicaid-eligible student.

Two procedure codes are used for billing individual behavioral services.

- One code, 96150 or 96150 with a modifier, is used to bill for services related to evaluating a student; and
- Another code, 96152 or 96152 with a modifier, is used to bill for all other services rendered to or on behalf of a specific Medicaid-eligible student.

Service Requirements

If services are rendered to or on behalf of an individual Medicaid-eligible student, regardless of which service or combinations of services are being rendered, the school district must bill for individual behavioral services.

When a consultation is performed for one Medicaid-eligible student, the service is considered to be an individual service, regardless of the number of family members, school staff or health care staff present.

Service Reimbursement

Medicaid reimbursement is based on the amount of time spent by the school district staff with or on behalf of each Medicaid-eligible student. One unit of individual behavioral service equals a maximum of 15 minutes.

The total time spent per day providing behavioral services to or on behalf of a Medicaid-eligible student must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, three individual behavioral services of 27 minutes, 8 minutes and 30 minutes equals a daily total of 65 minutes and would be billed to Medicaid as 5 units.

It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Individual Behavioral Services, continued

Reimbursement Limitations	Medicaid reimburses a maximum of 32 units **per school district staff member**, per day. The school may bill for behavioral services provided by the same staff member to multiple Medicaid-eligible students on the same day of service; however, the total individual and group units cannot exceed 32 units. It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the individual behavioral services procedure codes and fees.

Group Behavioral Services

Group Behavioral Service (96153 or 96153 followed by AH, HN, HO or UD)	Group behavioral services as defined in this chapter may be billed to Medicaid when the school district staff are rendering services to or on behalf of a group of students.
Service Requirements	If services are rendered to or on behalf of a group of students, regardless of which service or combinations of services are being rendered, the school district must bill for group behavioral services. For Medicaid to reimburse the service, the group size must be a minimum of two students and must not exceed ten students. It is not required that all the students in a group be eligible for Medicaid.

Group Behavioral Services, continued

Service Reimbursement

Medicaid reimbursement is based on the amount of time spent by school district staff with or on behalf of a group of students. One unit of group behavioral service equals a maximum of 15 minutes.

The total time spent per day providing group behavioral services to or on behalf of a group of students must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, if the school district staff member conducted a 35-minute group counseling session and spent 18 minutes that same day documenting the results of the group session for a daily total of 53 minutes, 4 units of service would be billed to Medicaid. If two of the students in the group were Medicaid-eligible, two claims would be submitted, each showing 4 units of service.

Only one Medicaid claim (or claim line) per day, per Medicaid-eligible student can be reimbursed. This one claim must show the cumulative total units for the Medicaid-eligible student for the day.

It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Reimbursement Limitations

Medicaid reimburses a maximum of 32 units **per school district staff member**, per day. The school may bill for behavioral services provided by the same staff member to multiple Medicaid-eligible students on the same day of service; however, the total individual and group units for the staff member cannot exceed 32 units.

Travel time off school campus for provision of behavioral services is not reimbursable unless reimbursable services are rendered during travel.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the group behavioral services procedure code and fee.

Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of Medicaid reimbursable behavioral services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's record must include, at a minimum, the following:

- Current IEP or FSP indicating the need for behavioral services;
- Test and assessment results; and
- Documentation describing each behavioral service, as listed in the following sections.

Diagnosis Code

A diagnosis statement or ICD-9 diagnosis code must be contained in each Medicaid-eligible student's record.

Documentation Components for Testing, Assessment, Evaluation and Consultative and Referral Activities

Documentation of each behavioral service billed to Medicaid, other than therapy or counseling, must include the following information:

- Student name;
- Date of service;
- Description of tests, assessments or other evaluative methods such as interviews, observations and record reviews, or description of consultative or referral activities;
- Length of time the service was performed;
- The school district staff member's signature, title and date (for example, Susan Jones, CBA, October 2, 1998).

Audit Requirements, continued

Narrative Descriptions or Logs

It is acceptable to use either narrative descriptions or logs as documentation of services if the content meets the above requirements. For example, a school psychologist might enter:

Name	Date	Time	Description of Service
James Doe	10/2/98	90 minutes	AAMD Adaptive Developmental Inventory, observation and interview
James Doe	10/3/98	60 minutes	Compiling evaluative report

If a log-type format is used, the school district staff may either:

- Sign, date, and title the log by each entry on the log; or
- Initial each entry and sign, date and title the log on a weekly basis.

Documentation Components for Treatment Services

Documentation of therapy or counseling sessions billed to Medicaid must include the following information:

- Student name;
- Date of service;
- Description of therapy or counseling session;
- Description of the student's progress toward any established goals, if appropriate (can be weekly);
- Length of time the service was performed;
- Identify if group or individual therapy; and
- School district staff member's signature, title and date (for example, Mike Smith, LCSW, October 18, 1998).

These records may be kept in narrative form or on logs if the above components are present. Daily initials may be used if weekly signatures are present in the manner described on the preceding page.

CHAPTER 7
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for augmentative and alternative communication (AAC) therapy services, the requirements for service provision, the service limitations, and service exclusions.

AAC devices and auxiliary equipment are **not** covered through the certified school match program. AAC devices and auxiliary equipment are covered through the Durable Medical Equipment (DME) and Medical Supply Services program. Some steps in obtaining an AAC system do not require school district involvement, but are included in this chapter so that school districts will have an understanding of the complete process for obtaining AAC systems.

In This Chapter

This chapter contains:

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AAC Fitting, Adjustment and Training Sessions	7-12
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Definitions and Descriptions

Introduction

Medicaid reimburses school district providers for the augmentative and alternative communication (AAC) therapy services described in this handbook.

Augmentative and Alternative Communication (AAC)

AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association, (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments.

Medicaid reimburses only for systems and services that are deemed medically necessary.

Note: For description of medical necessity, refer to Chapter 1 of this handbook.

AAC Therapy Services Covered

AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid certified school match program.

AAC Systems Reimbursement

AAC systems are not reimbursed through the Medicaid certified school match program. AACs are reimbursed through the Medicaid Durable Medical Equipment (DME) and Medical Supply Services program. AAC systems must be prior authorized by the Medicaid consultant (see definition on the next page).

It is important for the family to be involved throughout the process of obtaining an AAC system for a student. The AAC system will be purchased for the Medicaid eligible student (not the school district) and is designed to be used both in home and school settings.

Definitions and Descriptions, continued

Coverage and Limitations

Medicaid reimburses only AAC systems that are dedicated systems as described below.

Medicaid will reimburse for one AAC system every five years per Medicaid-eligible student and a software upgrade every two years, if needed. Modifications, which may be in the form of replacing the AAC system or upgrading the AAC's software, may be reimbursed only if the new technology will improve communication significantly.

Medicaid will reimburse for replacement of devices, components or accessories when there is irreparable failure or damage not caused by willful abuse or neglect.

Dedicated System

A dedicated system is designed specifically for a disabled population. A non-dedicated system is a commercially available device such as a laptop computer with special software.

Medicaid Consultant

A Medicaid consultant is a licensed speech-language pathologist employed with or contracted by the Agency for Health Care Administration with responsibility for reviewing requests for AAC systems.

Service Requirements

Introduction

To receive Medicaid reimbursement for AAC therapy services the following requirements must be met.

General Service Requirements

To be reimbursed by Medicaid, the therapy service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services.

IEP or FSP Requirement

The need for AAC services does not have to be specifically referenced in the student's IEP or FSP if the need for speech-language pathology services is referenced.

Service Requirements, continued

Eligibility for Receiving an AAC

For Medicaid to reimburse a DME provider for an AAC system, the Medicaid-eligible student must have the physical, cognitive and language abilities necessary to use the AAC system.

Interdisciplinary Team

An interdisciplinary team (ID team) must be formed to evaluate the student, recommend an AAC and write an individualized action plan.

The ID team must consist of at least two members and must include a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist and physical therapist. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. If appropriate, the student who will use the AAC should be encouraged to participate on the ID team as well as the student's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

Conflict of Interest

The medical professionals who evaluate the student, serve on the ID team, or prescribe the AAC must not have a financial relationship with or receive any gain from the AAC manufacturer.

Steps for Completion of a Prior Authorization Package

The **DME provider** must submit a prior authorization package to the Medicaid fiscal agent for Medicaid review and approval. For the therapist's information, the following components must be included in the prior authorization package (the DME provider may obtain items 1 through 4 from the school district):

1. The AAC evaluation signed by the ID team members;
2. The individualized action plan;
3. A prescription for the AAC signed and dated by the recipient's physician, advanced registered nurse practitioner, or physician's assistant that includes the provider's name, address, telephone number, and medical license number;
4. The MediPass authorization number if the student is a MediPass participant;
5. A completed Florida Medicaid Prior Authorization form;
6. An itemized invoice listing retail costs for the equipment; and
7. Manufacturer's catalogue information regarding cost and warranty information.

The DME provider is responsible for completing items 5, 6 and 7.

Service Requirements, continued

Medicaid Approval of the AAC

Medicaid's decision for coverage will be based on a medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to a medical need.

Medicaid will not deny an AAC based solely on the fact that the student can communicate in writing.

DME Provider Responsibilities

Prior to billing for an AAC system, the DME provider is responsible to ensure the properly selected system and all components have been delivered to the student and are operational in the student's home.

School District Speech-Language Pathologist Responsibilities

The Medicaid fiscal agent is not responsible for notifying the school district of approval or denial of the AAC systems. The school district should maintain contact with the DME provider to ensure notification of approval or denial of the AAC request.

Each step for which the school district or speech-language pathologist is responsible is described in detail in the following topics.

Initial AAC Evaluations

Initial Evaluation (92597 92597 GP 92597 GO)

The ID team, led by the speech-language pathologist, must perform an initial evaluation on the student for an AAC system, which meets, at a minimum, evaluation requirements that are listed under "Evaluation Documentation Requirements" in this chapter.

Initial AAC Evaluations, continued

Provider Qualifications for Initial Evaluations

Medicaid reimburses school districts for AAC initial evaluations performed by the following types of health care providers through the certified school match program:

- Licensed and provisionally-licensed speech-language pathologists;
- Speech-language pathologists who have a:
  - Department of Education Certification in the area of Speech-Language Impaired, containing the words “Speech-Language Impaired-Professional”;
  - Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
  - ASHA membership card stating “Certified Member”;
  - ASHA Certificate Holder card; or
  - Master’s level degree in speech-language pathology (the degree title may show terminology such as “Communication Disorders”).
- Licensed physical therapists; and
- Licensed occupational therapists.

Provider Exclusions

Medicaid does not reimburse for AAC evaluations performed by bachelor’s degree level speech-language pathologists, speech-language pathology assistants, occupational therapy assistants, or physical therapist assistants.

Initial AAC Evaluations, continued

Initial Evaluation Documentation Requirements

Once the ID team has evaluated the student and recommended an AAC, the speech-language pathologist must document the following information in writing (the first three items are obtained from the student's medical record):

- Significant medical diagnosis(es);
- Significant treatment information and medications;
- Medical prognosis (per student records, physician, ARNP, PA, or designee);
- Motor skills, i.e., posture and positioning, selection abilities, range and accuracy of movement, etc.;
- Cognitive skills, i.e., alertness, attention span, vigilance, etc.;
- Sensory or perceptual abilities, i.e., hearing, vision, etc.;
- Language comprehension;
- Expressive language capabilities;
- Oral motor speech status;
- Use of communication and present communication abilities;
- Communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs;
- Writing impairments, if any;
- Environment, i.e., home, work, etc., with a description of communication barriers; and
- AAC recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns.

AAC Selection

The ID team must select an AAC that is based on the recipient's current medical needs and projected changes in the recipient's communication development over at least a 5-year period.

Team Approval of the Evaluation

The evaluation, which includes the individualized action plan (IAP), must be signed, titled (credentials) and dated by all contributing interdisciplinary team members.

Initial AAC Evaluations, continued

Initial Evaluation Reimbursement Limitations

Medicaid reimburses school districts for the initial evaluation services provided by one speech-language pathologist (who meets the provider qualifications for initial evaluations); one licensed occupational therapist; and one licensed physical therapist who are designated members of the interdisciplinary team for an initial evaluation. Medicaid reimburses for one initial evaluation per student, per therapy type.

Additional Evaluation Requested by Medicaid

Florida Medicaid reserves the right to request an AAC evaluation of a student from either another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist, or ophthalmologist.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the procedure codes and fees.

AAC Trial Periods and Rental Systems

Trial Period for AACs

The ID team may recommend that the student have a trial period with the AAC system. The trial period must be prior authorized by the Medicaid consultant. All the steps for completion of a prior authorization package and the components of the prior authorization package must be completed for a trial period to be authorized.

Rental-Only AAC Systems

Medicaid reimburses DME providers for rental-only AAC systems for trial periods. Rental-only reimbursements can continue past the trial period when the ID team recommends and Medicaid approves a continued rental-only situation.

Individualized Action Plan

Individualized Action Plan Requirement

The ID team members, led by the speech-language pathologist, must develop an individualized action plan.

Individualized Action Plan Components

The ID team members, led by the speech-language pathologist, must write the student's individualized action plan. The plan must include the following information:

- An explanation of any AAC system currently being used or owned by the student at home, work or school;
- The current use of the system(s) and its limitations;
- Appropriate long and short-term therapy objectives;
- The recommended AAC(s);
- The recommended length of a trial period, if applicable;
- A description of any AAC systems the student has previously tried;
- The specific benefits of the recommended AAC over other possibilities;
- An established plan for mounting, if necessary; repairing; and maintaining the AAC;
- Name of person responsible for delivering and programming the AAC to operate at the level recommended by the ID team; and
- Name of person(s) who will train the support staff, student and primary caregiver in the proper use and programming of the AAC.

Reimbursement Limitations

Reimbursement for development of the individualized action plan is included in the reimbursement for the AAC evaluation.

AAC System Approval

Physician Approval of AAC System

The school district must send the evaluation, which includes the recommended AAC and the individualized action plan to a physician, ARNP or PA or designated physician specialist. The physician, ARNP or PA or designated physician specialist must review the evaluation and individualized action plan and if he or she concurs, prescribe the AAC.

The prescription must include the physician's, ARNP or PA or designated physician specialist's name; address; telephone number; medical license number; and MediPass authorization number, if applicable. If the student is in MediPass, the student's MediPass primary care provider must authorize the AAC.

The physician, ARNP or PA or designated physician specialist returns the evaluation, individualized action plan and prescription to the school district.

If the MediPass primary care provider does not respond timely, the school district should contact the Medicaid area school services representative. The school services representative will work with the area MediPass liaison to resolve any problems.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500, for information on MediPass.

Referral to the DME Provider

The school district is responsible for submitting the following information to the DME provider:

- The student's evaluation, which is completed, signed, titled (credentials) and dated by the interdisciplinary team members;
- Individualized action plan; and
- The physician, ARNP or PA or designated physician specialist's prescription for the AAC system.

Re-Evaluations

Re-Evaluations (92597 GN)

Medicaid reimburses school districts for re-evaluations performed by speech-language pathologists for students with AACs. Re-evaluations may be scheduled at the discretion of the speech-language pathologist, based on the ongoing needs of each student.

Re-Evaluations, continued

Re-Evaluation Documentation

Documentation for a re-evaluation must describe the session with the student and AAC, and any alterations made to the initial evaluation or the individualized action plan.

Provider Qualifications for Re-Evaluations

Medicaid reimburses school districts for re-evaluations that are performed by:

- Licensed and provisionally-licensed speech-language pathologists;
- Speech-language pathologists who have a:
  - Department of Education Certification in the area of Speech-Language Impaired, containing the words "Speech-Language Impaired-Professional";
  - Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
  - ASHA membership card stating "Certified Member";
  - ASHA Certificate Holder card; or
  - Master's level degree in speech-language pathology (the degree title may show terminology such as "Communication Disorders").

Provider Exclusions

Medicaid does not reimburse school districts for AAC re-evaluations performed by occupational therapists, physical therapists, bachelor's degree level speech-language pathologists or therapy assistants.

Re-Evaluations Reimbursement Limitations

Medicaid reimburses for a maximum of two re-evaluations, per student, per AAC system, per school district, per calendar year.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for procedure codes and fees.

AAC Fitting, Adjustment and Training Sessions

AAC Fitting, Adjustment and Training Sessions (92609)

Medicaid reimburses school districts for AAC fitting, adjustment and training sessions. Treatment sessions for AAC fitting, adjustment and training are face-to-face encounters with a student for the purpose of providing instruction on the use of the AAC device and making minor adjustments on the device as needed.

The sessions must be face-to-face contacts with individual students. Medicaid does not reimburse for group AAC fitting, adjustment and training.

Provider Qualifications for AAC Fitting, Adjustment and Training Sessions

Medicaid reimburses school districts for AAC fitting, adjustment and training sessions performed by speech-language pathologists who meet one of the qualifications listed below:

- Current license as a speech-language pathologist under Chapter 468, Florida Statutes. Individuals with provisional licenses may render reimbursable services if done under the supervision of an actively licensed speech-language pathologist;
- Department of Education Certification in the area of Speech-Language Impaired, containing the words “Speech-Language Impaired-Professional”;
- Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
- ASHA membership card stating “Certified Member”;
- ASHA Certificate Holder card; or
- Master’s level degree in speech-language pathology (the degree title may show terminology such as “Communication Disorders”).

Provider Exclusions

Medicaid does not reimburse school districts for AAC fitting, adjustment and training sessions performed by bachelor’s degree level speech-language pathologists or speech-language pathology assistants.

AAC Sessions Reimbursement Limitations

Medicaid reimburses the school district for up to a maximum of eight 30-minute AAC fitting, adjustment and training sessions, per device.

Medicaid reimbursement for AAC fitting, adjustment and training sessions is based on 30-minute units. There is no daily limit on the number of 30-minute units billed; however, there is a maximum of eight units per device as stated above.

Medicaid reimburses school districts for AAC sessions in addition to regular speech-language pathology sessions (i.e., a school district may be reimbursed by Medicaid for a speech-language pathology treatment session and an AAC session occurring on the same day).

AAC Fitting, Adjustment and Training Sessions, continued

Service Exclusions	Medicaid reimbursement for the AAC fitting, adjustment and training sessions does not include telephone responses to questions, conferences with the student's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.
Documentation for AAC Fitting, Adjustment and Training	The therapist must record on a per treatment basis the services rendered and the progress of the student in the use of the AAC device.
Documentation Components	Documentation of each fitting, adjustment and training session must include the following information: • Student's name; • Date of service; • Length of time the therapy or service was performed (time may be recorded based on start and stop times or length of time spent with the student); • Description of the services provided during the session; and • Dated signature and title (credentials) of the speech-language pathologist providing the service. All documentation must be signed, titled (credentials) and dated by the provider of the services, i.e., Sally Jones, SLP, 3/26/78.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the procedure code and fee.

AAC Services Audit Requirements

Student Records

The school district is required to maintain a record for each Medicaid-eligible student, which includes documentation of all Medicaid reimbursable services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, initial evaluations or individualized action plans sent to a physician, ARNP, PA, physician specialist or DME provider should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation or action plan. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook.

Each Medicaid-eligible student's records must include, at a minimum, the following:

- An individualized action plan, plan of care, IEP or FSP if used as the plan of care, indicating the student's need for services;
- Test results and evaluation reports; and
- Documentation describing each fitting, adjustment and training session as listed in the above applicable section.

Note: See Medicaid Provider Reimbursement Handbook, CMS-1500, for further information.

CHAPTER 8
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
NURSING SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for nursing and medication administration services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

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Definitions

Introduction

Medicaid reimburses school district providers for the nursing and medication administration services described in this handbook.

Nursing Services

Nursing services are services which can include:

- Health assessments;
- Individual student health training and counseling;
- Catheterizations;
- Tube feedings;
- Maintenance of tracheostomies;

Definitions, continued

Nursing Services, continued

- Oxygen administration;
- Specimen collection;
- Ventilator care;
- Health monitoring and management;
- Health care treatments and procedures;
- Management of chronic health care;
- Health care coordination and referrals;
- Crisis intervention (e.g., life-threatening accidents or situations);
- Compilation of health histories;
- Screenings such as scoliosis, dental, vision, hearing, growth and development;
- Emergency health care (e.g., treatment of minor wounds); and
- Consultation and coordination with other health care staff, parents, teachers and family during the Individual Educational Plan (IEP) or Family Support Plan (FSP) development and review process or at other times deemed appropriate by the nurse.

Note: Medication administration is explained below.

Excluded Services

Medicaid cannot reimburse school districts for nursing services provided to a group, such as group education or classroom education. In accordance with Florida Statutes, Medicaid may not reimburse school districts for family planning services, prenatal care or immunizations.

Medication Administration Services

Although medication administration is a nursing service in the context of general nursing activities, Medicaid reimburses separately for medication administration on a fee-per-dose basis. The fee for medication administration includes time spent preparing medication for administration, administering medication and documenting the service.

Nursing time spent observing or treating a student's reaction to medication is considered to be a nursing service, as defined in the above section.

Service Reimbursement

Medicaid will reimburse for nursing services and medication administration provided on the same date of service for the same student.

Provider Qualifications

Registered Nurse Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a registered nurse must be currently licensed under Chapter 464, Florida Statutes.

Licensed Practical Nurse Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a licensed practical nurse must be currently licensed under Chapter 464, Florida Statutes.

School Health Aide Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a school health aide must have completed the following courses or training through or by the school district:

- Cardiopulmonary resuscitation (CPR);
- First aid;
- Medication administration; and
- Patient (i.e., student) specific training.

Student specific training must be face-to-face between the registered nurse and the school health aide.

Records of CPR and first aid training must be retained by the school district indicating that the school health aide did attend and the date of the training. Records attesting to the fact that all school health aides in a school district are given medication administration and student specific training must also be retained. Documentation to this effect should be signed by a registered nurse and must be on file at the school district.

Supervision of Licensed Practical Nurses and School Health Aides

To receive Medicaid reimbursement for services rendered by a licensed practical nurse or school health aide, the services must be performed under the direction of a licensed registered nurse, as governed by the state nurse practice act.

Temporary Licenses

Medicaid cannot reimburse for services provided by nurses with temporary licenses.

Service Requirements

Introduction

To receive Medicaid reimbursement for nursing services, the following requirements must be met.

General Service Requirements

To be reimbursed by Medicaid, the service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services.

Individual Educational Plan or Family Support Plan

The need for nursing services must be referenced in the student's Individual Educational Plan (IEP) or Family Support Plan (FSP). The need for medications does not have to be referenced separately in the IEP or FSP if the student needs nursing services. If a student needs only medication but no other nursing services, an entry indicating either nursing services or medication administration must be referenced in the IEP or FSP. A preprinted statement attesting to the fact that the student needs nursing services is acceptable.

Recommendation for Services

The IEP, FSP or separate document indicating that nursing services are needed must be signed, titled and dated by a registered nurse, an advanced registered nurse practitioner, physician or physician's assistant prior to billing Medicaid for nursing services. Prescription medications have already been recommended by a health care practitioner by virtue of a labeled container; thus, a separate, written recommendation is not required. Non-prescription medications, for Medicaid purposes, are recommended by a registered nurse via his or her completion of a medication log for the drug or approval of a log if dispensed by a licensed practical nurse or aide.

Diagnosis Code

Medicaid requires that an ICD-9 diagnosis code be entered on the CMS-1500 claim.

The code should represent the Medicaid-eligible student's primary diagnosis. The specific code may be obtained from the attending physician, advanced registered nurse practitioner, physician's assistant, or through use of the *International Classification of Diseases, 9th Edition, Clinical Modifications* (ICD-9–CM). The student's diagnosis statement or ICD-9 diagnosis code must be contained in his record.

For services not directly related to the student's primary diagnosis (for example, an accident in the classroom or administration of medications for illnesses not related to the student's diagnosis), for students with no specific medical diagnosis, and over-the-counter medication, the provider should enter diagnosis code 999.9 on the claim.

Nursing Services

Nursing Service—Registered Nurse (T1002)

Medicaid reimburses for nursing services as defined in this chapter that are rendered by a licensed registered nurse to or on behalf of a Medicaid-eligible student.

Nursing Service-Licensed Practical Nurse (T1003)

Medicaid reimburses for nursing services as defined in this chapter that are rendered by a licensed practical nurse to or on behalf of a Medicaid-eligible student.

Nursing Service-School Health Aide (T1004)

Medicaid reimburses for nursing services as defined in this chapter that are rendered by a qualified school health aide to or on behalf of a Medicaid-eligible student.

Service Reimbursement

Medicaid reimbursement is based on the amount of time spent by the nurse or aide with or on behalf of each Medicaid-eligible student. One unit of service for nursing services is a maximum of 15 minutes.

The total time spent per nurse or aide per day, providing nursing services to or on behalf of a Medicaid-eligible student must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, if the nurse or aide provided two nursing services of 20 minutes and 18 minutes on the same day, the nursing services equal a daily total of 38 minutes and would be billed to Medicaid as 3 units.

Only one Medicaid claim (or claim line) per day per Medicaid-eligible student can be reimbursed. This one claim must show the cumulative total units that the nurse or aide provided services to or on behalf of the Medicaid-eligible student for the day.

Medicaid will reimburse the school district for time spent preparing documentation of nursing services rendered, and the time spent may be added to the day's cumulative total for nursing services. However time spent preparing documentation for medication administration or time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Nursing Services, continued

Reimbursement Limitations

Medicaid reimburses a maximum of 32 units **per nurse or aide**, per day. The school may bill for nursing services provided by the same nurse or aide to multiple Medicaid-eligible students on the same day of service; however, the total units for the nurse or aide cannot exceed 32 units.

Travel time off school campus is not reimbursable unless nursing services are rendered during travel. For example, nursing services would be reimbursable if a licensed registered nurse, licensed practical nurse or school health aide accompanies a student on a specialized school bus or other vehicle and renders nursing services during transport.

If Medicaid is reimbursing a home health agency for the services of a private duty nurse while a Medicaid-eligible student attends school, the only nursing services billable to Medicaid by the school district for the same day are screenings for scoliosis, dental, vision, hearing and growth and development. Medicaid reimbursement for all billable nursing services provided on the same day by a home health agency and by a school district under the Medicaid certified school match program may be billed by both providers if services are not provided at the same time to a Medicaid-eligible student.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the licensed registered nurse, licensed practical nurse and school health aide services procedure codes and fees.

Medication Administration

Medication Administration-Registered Nurse (T1002KO)

The administration of medication as defined in this chapter by a licensed registered nurse may be billed to Medicaid when the nurse provides the medication directly to a Medicaid-eligible student.

Medication Administration-Licensed Practical Nurse (T1003KO)

The administration of medication as defined in this chapter by a licensed practical nurse may be billed to Medicaid when the nurse provides the medication directly to a Medicaid-eligible student.

Medication Administration-School Health Aide (T1004KO)

The administration of medication as defined in this chapter by a qualified school health aide may be billed to Medicaid when the school health aide provides the medication directly to a Medicaid-eligible student.

Service Reimbursement

Medicaid reimbursement is on a per dose basis, regardless of the route for the medication or whether the drug is prescribed or over-the-counter. If two drugs are administered at the same time, two doses may be billed to Medicaid.

Reimbursement Limitations

Travel time off school campus is not reimbursable. However, medication administered during transport on a specialized school bus or other form of transportation is reimbursable.

Time spent observing or treating a student's reaction to medication is not reimbursed as medication administration. It can be reimbursed as a nursing service.

Medicaid reimbursement for medication administration provided on the same day by a home health agency and by a school district under the Medicaid certified school match program may be billed by both providers if services are not provided at the same time to a Medicaid-eligible student.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the medication administration procedure codes and fee schedule.

Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of each Medicaid reimbursable nursing and medication administration service. Nursing services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's record must include, at a minimum, the following:

- Current IEP or FSP indicating the need for nursing services;
- Documentation describing each nursing and medication administration service; and
- Student's diagnosis statement or diagnosis code.

Diagnosis Code

A diagnosis statement or ICD-9 diagnosis code must be contained in each Medicaid-eligible student's record.

Documentation Components for Nursing Services

Documentation of each nursing service must include the following information:

- Student name;
- Date of service;
- Length of time the service was performed;
- Description of the service;
- Student's reaction to the service, unless the service was a consultation, a referral or compilation of health history; and
- Nurse's or school health aide's signature, title and date.

It is acceptable to use either narrative descriptions or logs as documentation of nursing services if the content meets the above requirements.

Audit Requirements, continued

Documentation Components for Medication Administration

Documentation of each occurrence of medication administration must include the following information:

- Student name;
- Date of service;
- Name of medication;
- Time medication was given;
- Dosage and route; and
- Nurse's or school health aide's signature, title and date.

It is acceptable to use either narrative descriptions or logs as documentation of medication administration if the content meets the above requirements.

Signature Requirements for Logs

If a log-type format is used for nursing services or medication administration, the nurse may either:

- Sign, title and date the log by each entry on the log, or
- Initial each entry and sign, title and date the log on a weekly basis.

For Medicaid purposes, all signatures (not initials) should be followed by an abbreviated title. For example, Jane Doe, RN or Jack Smith, SHA.

Electronic documentation and electronic signatures are allowed but these records must be available upon request, as required in Chapter 1 of this handbook.

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