



Kent ISD
We Lead Learning

MEDICAID SCHOOL BASED SERVICES

Provider Manual

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Foreword

This Medicaid School Based Services Manual for Providers was created to assist Special Education staff with an understanding of the Medicaid School Based Services program. It contains specific information regarding program requirements and procedures based from the Michigan Department of Health and Human Services Medicaid Manual dated July 1, 2015.

If you have any questions pertaining to the School Based Services Manual for Providers or the Medicaid School Based Program, please contact:

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MDHHS Contact Information

To help a student or family apply for Medicaid or other covered services contact the nearest Michigan Department of Health and Human Services Office

Kent County Mailing Address:
Michigan Department of Health and Human Services
121 Franklin SE
Grand Rapids, MI 49507
Telephone: 855-275-6424
Fax: 616-248-1059

REPORT ABUSE & NEGLECT—24/7 HOTLINE
Children’s & Adult Protective Services 855-444-3911

Overview of Medicaid School Based Services Program

Medicaid is a jointly funded Federal-State health insurance program for persons with low income and/or disabilities. School Based Services (SBS) allows reimbursement under the Medicaid Fee-For-Service program for services administered to students with special needs under the Individuals with Disabilities Education Act (IDEA) and is administered through the Intermediate School District. Coverage applies to individuals up to the age of 21 years who are enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). The Fee-For-Service (FFS) program covers direct medical services, targeted case management, personal care services and transportation.

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. Medicaid reimbursement is not allowed for these services.

Coverage is based on medically necessary, Medicaid-covered services already being provided in the school setting and enables these services provided to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid covered services.

The Medicaid School Based Services program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SBS providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only), and must not submit claims for these beneficiaries.

Terminology

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.
Assistive Technology Service	The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device.

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.
Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)	<p>DME items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when:</p> <ul style="list-style-type: none"> • It is medically and functionally necessary to meet the needs of the beneficiary. • It may prevent frequent hospitalization or institutionalization. • It is life sustaining. <p>Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that:</p> <ul style="list-style-type: none"> • Treat a medical condition. • Prevent unnecessary hospitalization or institutionalization. • Support DME used by the beneficiary. <p>Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to:</p> <ul style="list-style-type: none"> • Improve and/or restore the beneficiary's functional level. • Enable a beneficiary to ambulate or transfer. <p>Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to:</p> <ul style="list-style-type: none"> • Improve and/or restore the beneficiary's functional level. • Prevent or reduce contractures. • Facilitate healing or prevent further injury.
Fee-For-Service (FFS) Program	The direct medical, specialized transportation, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid.
HT Modifier (Multidisciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team).
Michigan Department of Health & Human Services (MDHHS)	Responsible for health policy and management of the state's health, mental health, and substance use care systems.
Random Moment Time Study (RMTS)	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School Based Services	A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.
	Schools, and Michigan School for the Deaf and Blind participate in the Fee-for-Service Direct Medical Program.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
TL Modifier (Reevaluation Of Existing Data (REED))	The TL modifier is used with the appropriate procedure codes to identify when a reevaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.
TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]).
Treatment Plan	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection of this section.

Covered Services & Expectations

Medicaid covered services billed by ISDs include: Evaluations and tests performed for assessments, Occupational Therapy Services; Orientation and Mobility Services; Assistive Technology Device Services; Physical Therapy Services; Speech, Language and Hearing Therapy Services; Psychological, Counseling and Social Work Services; Developmental Testing Services; Nursing Services; Personal Care Services; Targeted Case Management Services; Specialized Transportation Services

The IEP/IFSP treatment plan must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures, and schedules for determining whether the objectives are being achieved within an appropriate period of time (at least annually). All therapy services must be skilled (i.e., require the skills, knowledge, and education of a licensed occupational therapist, licensed physical therapist or CCC (Clinical Certificate of Competency) certified speech-language pathologist or licensed audiologist). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, or speech, language and hearing therapy by this program.

To be covered by Medicaid, occupational, physical, and speech, language and hearing therapy must address a beneficiary's medical need that affects his/her ability to learn in

the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure, and reading).

Group therapy or treatment must be provided in groups of two to eight. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one beneficiary who is part of the class currently in session, the service is not reimbursable.

Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music and recreation therapies are not covered services.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

Billing Requirements

The District may claim reimbursement for special education and related services specified in the IEP/IFSP if all of the following are achieved:

- The student is eligible for Medicaid
- The student aged birth through five has an IFSP, or the recipient over five has an IEP
- The student under the age of 21
- Parental Notification has been provided to the parent/guardian
- The District has a signed parental consent form on file
- The services are medically necessary and covered under an existing Medicaid category
- The required physician's referral/authorization is on file
- The service is provided by a qualified health care professional and the District has their signature on file
- The scope, frequency and duration of the service is documented
- A Monthly Progress Summary for therapy services has been completed
- Documentation of services requiring supervision of another provider is on file

Services That Are NOT Reimbursable

- Academic instructional services provided directly to the student
- Group therapy involving more than 8 students
- Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable

- Attendance of the Designated Case Manager at the initial IEP Team meeting (once the DCM is identified in the IEP, any further meetings are covered)
- Services not related to the IEP
- Notes/meetings without any explanation of the purpose or its connection to the IEP
- IDEA assessments that do not result in implementation of an IEP/IFSP within one year
- Vocational or work skills services
- Report writing is included as part of an evaluation and is not separately reimbursable
- Services considered observational or stand-by in nature, including “supervision” of medication administration or other medical services
- First Aid
- Manifestations Reviews

Service Log Do's & Don'ts

- **DO:** Use the Tip Sheet for your Medicaid Practitioner Type available at www.kentisd.org/Special_Education/medicaid/medicaidstaff for guidance in recording services.
- **DO:** Ensure you are properly licensed to deliver the services contained within your tip sheet. See tip sheet for licensing information.
- **DO:** Complete and submit services within 10 days of service delivery.
- **DO:** Include a detailed daily progress note for all direct services. See tip sheet for examples.
- **DO:** A Monthly Progress Summary is required for each student for each month services have been recorded for Medicaid eligible students. Make sure your notes are complete, they are required for billing and must describe the student's actual progress for the month.
- **DON'T:** Do not record services such as testing and reports related to a MET or IEP/IFSP separately from the MET or IEP/IFSP itself. These are bundled services and include report writing and testing.
- **DON'T:** Do not report services delegated to non-Medicaid qualified staff (i.e., meds administered by school administrative staff).
- **DON'T:** Do not report academic services with service types containing a procedure code.
- **DON'T:** Do not share your ID and password with subs, co-workers, etc.

IDEA Assessment and IEP/IFSP Development, Review and Revision

The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the beneficiary. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered.

Qualified staff can bill for three distinct types of assessments/evaluations/tests as follows. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable.

The HT Modifier is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or early-on services. The determination date must be included in the assessment/evaluation/test.

The TM Modifier is used with the procedure code when billing for the multidisciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment.

TL modifier is used when billing for the REED.

No modifier is used when assessments/evaluations/tests are provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with no modifier. The date of service is the date the assessment/evaluation/test is completed.

Monthly Progress Summary

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment with rationale for change

Under the Direction or Supervision of another Provider

Certain specified services may be provided under the direction of or under the supervision of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter. "Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling

supervision or consultation. The purpose is to assist the practitioner to learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

Supervision of limited-licenses mental health professionals consist of the practitioner meeting regularly with the supervising professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

Random Moment Time Study

In accordance with Centers for Medicaid & Medicaid Services (CMS) policy, some activities performed by medical professionals and Intermediate School District staff in a school-based setting are eligible for federal matching funds. These activities may be performed by staff with multiple responsibilities. CMS reimbursement requirements include the use of a random moment time study (RMTS) as a component of the Medicaid reimbursement methodology.

The time study results are used to determine the amount of staff time spent of Medicaid-allowable activities. One statewide time study per staff pool is performed each quarter. The time study responses are coded with the appropriate activity code based on the participant's answers to 3 questions:

1. What are you doing?
Sample response: providing speech therapy working on S/L blends
2. Who are you with?
Sample response: student; group of students
3. Why are you doing it?
Sample response: Per student's IEP to address articulation errors

(Why are you doing it is asking why does the student need it.)

Very Important Information for Staff:

When you receive notification of your RMTS

- Note the time of your RMTS on your schedule
- At the time of your moment, make a written note of what you are doing
- After the moment passes, you can log into the RMTS system online and respond to moment – please note you cannot access the moment online until a few minutes after the moment has passed
- You will be required to read through the screens containing the directions before responding to the questions.
- Be sure to click the “submit” button after you have answered all questions
- Be sure to provide your email address and/or phone number so PCG staff can contact you should they have questions about your response
- Complete the time study within 3 days after the moment has passed
- You must respond to the RMTS even if you are not working

Parental Notification and Consent

Pursuant to the regulation regarding parental notification and consent (34 CFR §300.154(d)(2)(v). 2.), the district must provide the parent/guardian with written Notification Regarding Parental Consent prior to seeking Medicaid reimbursement for the first time, and annually thereafter.

The regulation also requires the District to obtain a one-time signed consent from the parent/guardian that meets the requirements of 34 CFR §99.30 and §300.622. Parental consent means:

- To be fully informed about the School Based Services program;
- To provide consent to release school records containing the student's information to MDCH and billing agencies for the purpose of participating in the School-Based Services program;
- To understand that consent is voluntary and can be revoked.

Parental consent must be obtained prior to accessing the child or family's public benefits or insurance and must be kept on file for seven (7) years after the last claimed date of service.

Electronic Signature Policy

Since services are recorded electronically, an Electronic Signature Form is needed for all providers. This form is intended to record a physical copy of provider's signature in the event an audit is done of the electronic documentation. The electronic signature is a unique combination of the provider's login account name and password. This unique combination will ensure, for audit and confidentiality purposes, that all work completed electronically is completed by the provider.

False Claims Act

The Federal False Claims Act, among other things, applies to the submission of claims by healthcare providers for payment by Medicare, Medicaid and other federal and state healthcare programs. The False Claims Act is the federal government's primary civil remedy for improper or fraudulent claims. It applies to all federal programs, from military procurement contracts to welfare benefits to healthcare benefits.

The False Claims Act prohibits among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;
- Knowingly making or using, or causing to be made or used a false record or statement in order to have a false or fraudulent claim paid or approved by the government;
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid; and

- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

Any person who knowingly attempts to defraud the federal government is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information.

Examples of Medicaid Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports
- Billing for missed appointments

To Report Suspected Fraud or Abuse

Kent ISD is committed to ensuring that its coding, billing and reimbursement procedures comply with all federal and state laws. The "back-end" billing system, MeduClaim provided by CompuClaim, has been designed to limit the recording of services to those procedure codes that are appropriate for the user's profession and only up to the maximum amount allowed per day or month. However, the system cannot ensure that the services were provided as stated, that they were medically necessary or were not false or misleading.

In most cases, an employee's supervisor is in the best position to address an area of concern. Supervisors and managers are required to report suspected violations to the Compliance professional, Anne Papa, (indicated on page 1 of this document) who has specific and exclusive responsibility to investigate all reported violations regarding the filing of false or fraudulent claims.

If you are not comfortable speaking with your supervisor or you are not satisfied with your supervisor's response, you are encouraged to speak directly to the compliance professional, Anne Papa, listed on Page 1 of this manual.

You may also report suspected fraud and abuse by:

Submitting an online complaint form:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220056--,00.html

Phone: 1-855-MI-FRAUD (643-7283) (voicemail available for after hours)

Send a letter to:

Office of Inspector General
PO Box 30479
Lansing, MI 48909

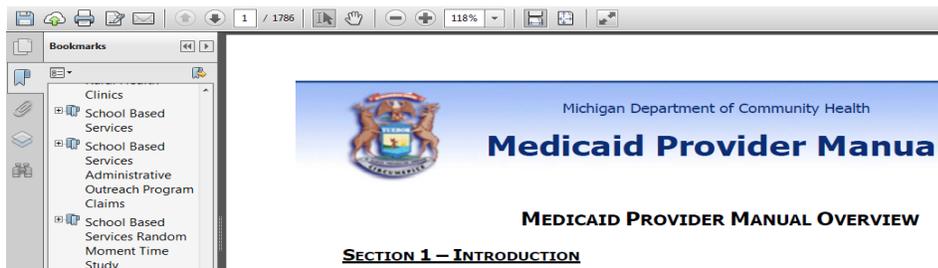
The following information is preferred when reporting suspected fraud or abuse:

- Nature of the complaint
- The names of those involved in the suspected fraud and/or abuse, including their address, phone number, Medicaid identification number, date of birth (for beneficiaries), and any other identifying information if available/applicable

MDHHS Medicaid Manual

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

The electronic Medicaid Provider Manual contains coverage, billing, and reimbursement policies for Medicaid and other healthcare programs administered by the Department of Community Health. Although MDCH will continue to issue paper policy bulletins as necessary, paper manuals are not provided. The online version of the Manual is updated quarterly to incorporate any policies transmitted via policy bulletins since the last Manual update.



Using the Manual

The Manual was created in Adobe Acrobat portable document format (PDF). To view and utilize the link and search functions of the Manual, you will need to have Adobe Acrobat version 6.0 or higher. Use the bookmarks section on the left to locate the School Based Services chapter.