

Medicaid

*School-Based Health
Services (SBHS)
Program*

Technical Assistance Guide

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Medicaid School-Based Health Services (SBHS) Program

Introduction

Under the Medicaid school-based health services program, local education agencies in Kentucky are eligible to enroll as a Medicaid health service provider for children who are eligible under the Medicaid program **and** under the Individuals with Disabilities Education Act (IDEA). This manual explains the Medicaid school-based health services (SBHS) program and is intended to provide technical assistance for local education agencies participating, or wishing to participate, in the program.

This program is a joint effort between the Kentucky Department of Education and the Kentucky Department of Medicaid Services.

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Background

In 1975, Congress amended the Education for the Handicapped Act with Public Law 94-142 to provide protections for parents and children and assist states and local education agencies with the excess cost of educating children with disabilities. Children with disabilities must be provided a free appropriate public education including the special education and any related services that are necessary for the children to benefit from special education. Some children require related services that may be medically necessary and reimbursable by Medicaid.

In 1988, Congress amended the Social Security Act to allow states and local education agencies to access Medicaid federal funds to assist in their efforts to educate children with disabilities (the Medicare Catastrophic Healthcare Act, Public Law 100-360). Title XIX of the Social Security Act (the Act) is a federal-state matching entitlement program (the Medicaid program) which provides medical assistance for *certain low-income individuals*. Federal and state governments jointly fund the Medicaid program with each individual state administering the program to assist in the provision of medical care to eligible recipients. States must operate their Medicaid programs within the parameters of federal Medicaid laws and regulations.

The state and the federal governments share funding for the Medicaid program, and the amount of total federal payment to states for Medicaid has no set limit. Federal Financial Participation (FFP), which is the federal government's share for states' Medicaid program expenditures, are generally claimed under two categories, (1) **administration** and (2) **medical assistance payments**. The information in this guide applies to **medical assistance payments** (sometimes referred to as "*fee-for-service (FFS)*" or "*direct service*"). In Kentucky, the administrative claiming program in school districts operates as a separate program.

In 1994, the Kentucky General Assembly enacted legislation (KRS 605.115) allowing local education agencies to access Medicaid **medical assistance payments** funding if they agree to provide the **matching state funds** for the Medicaid covered services.

The IDEA requires public school system to make a free appropriate public education available to all disabled children by responding to their individual needs, regardless of the nature or severity of their disabilities.

"Free appropriate public education" is defined in the IDEA as special education and related services (1) provided to children with disabilities at public expense; (2) under public supervision and direction, and without charge; (3) meet the standards of the state education agency; and (4) are provided in conformance with an Individualized Education program that is developed consistent with the federal regulations

- "Special education" is defined in federal regulations (34 CFR 300.26) to mean specially designed instruction, which meets the unique needs of the child and includes instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education.
- "Related services" are defined at 34 CFR 300.24 as "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." This includes:

- Counseling services;
- Early identification and assessment of disabilities;
- Medical services for diagnostic and evaluation purposes;
- Occupational therapy;
- Orientation and mobility services;
- Parent counseling and training;
- Physical therapy;
- Psychological services;
- Rehabilitation counseling services;
- School health services;
- Social work services in schools; and
- Speech-language pathology and audiology services.

The IDEA provides some federal financial assistance to states and local school districts for special education and related services provided to children through a child's Individualized Education Program (IEP). For those children identified and determined to be disabled in accordance with the requirements of the IDEA, an IEP must be developed by a team of individuals as defined in state and federal regulations. The IEP is statutorily defined and requires specific elements.

Not all of the special education and related services required by the IDEA and included in a child's IEP are within the scope of the Medicaid program. Only those *medically necessary* IDEA services that are described in the federal definition of "medical assistance" can be covered as Medicaid services when furnished by qualified participating Medicaid providers.

In Kentucky, the following services are covered if provided to address a medical or mental disability and assist the eligible student in benefiting from special education programming if it is included and provided in accordance with the child's IEP:

- a) Nursing;
- b) Audiology;
- c) Speech and language;
- d) Occupational therapy;
- e) Physical therapy;
- f) Mental health;
- g) Incidental interpreter services provided in conjunction with another covered service;
- h) Orientation and mobility services;
- i) Respiratory therapy;
- j) Assistive technology devices and appropriate related evaluations if the devices purchased by the Medicaid Program become the property of the recipient; and but are educational purchases and must stay at school while the child is enrolled
- k) Transportation with limitations.

Medicaid covers services included in an IEP under the following conditions:

- The services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- All other federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and
- The services are included in the state's plan or available under EPSDT.

Some of the IDEA required services are specifically excluded from Medicaid reimbursement. For example, Child Find is excluded from Medicaid reimbursement. Part B of the IDEA provides for the identification, location, and evaluation of children with disabilities within the state, and mandates that a “practical” method be developed and implemented to determine which children with disabilities should be provided services. A state is only eligible for funding under IDEA if the state demonstrates that it meets certain conditions, including conducting “child find” activities, as defined in the IDEA. These “child find” activities are undertaken to identify children in need of special education and related services. Medicaid is not responsible for covering or paying for “child find” or other activities that fulfill education mandates. Other services not covered by Medicaid reimbursement include:

- Any services not listed under covered services
- Solely educational or academic assessment
- Education-based costs normally incurred to operate a school and provide an education
- Medical care not addressed in the child’s IEP
- Routine group speech or language screenings
- Services provided to the school district by an educational cooperative during the normal course of business without charge to the district
- Time spent on documenting clinical service notes, treatment plans, or summaries on progress
- Information furnished to the district (i.e., the provider) by the recipient over the phone
- Cancelled visits or missed appointments or services
- Concurrent services for the same child involving similar services or procedures
- Transportation of therapist to or from the site of therapy with the exception of contract therapists.

Further discussion of school based medical services can be found in a guidance document issued by Centers for Medicare and Medicaid Services (formally the HCFA) entitled, “Medicaid and School Health: A Technical Assistance Guide,” August 1997.

What Are Medicaid School-Based Health Services?

Medicaid school-based health services are medically necessary health services that are provided to children who are eligible under both Medicaid and the Individual with Disabilities Education Act (IDEA). The health services must be described in the eligible student’s individual education program (IEP) by the admissions and release committee. In Kentucky, the following services are covered for Medicaid reimbursement when provided to an eligible child:

- a) Nursing
- b) Audiology
- c) Speech-Language
- d) Occupational Therapy
- e) Physical Therapy
- f) Mental Health
- g) Orientation and Mobility
- h) Incidental Interpreter
- i) Transportation
- j) Assistive Technology
- k) Respiratory Therapy

Medicaid requires services provided to eligible recipients to be medically necessary mental or physical health services. The IDEA requires that related services must be necessary for the eligible child to benefit from special education. To meet the requirements for each program, the SBHS Medicaid program regulations have been written in such a way that medical necessity is established by the admissions and release committee, stating the service in the IEP. For a school-based health service to meet medical necessity requirements, the following conditions must be met:

- All other federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions and the services must be:
 - Medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
 - Be stated in the child's IEP by the admissions and release committee (ARC); and
 - Be provided in accordance with the IEP (Plan of Care).

Covered services may include **evaluation** and **treatment** components if certain conditions are met.

What Is A “Plan Of Care?”

The IEP becomes the Plan of Care for the provision of Medicaid-covered services and the student's IEP governs the health services provided to the student in the educational setting. The ARC develops an IEP consistent with requirements of the IDEA and state regulations in 707 KAR Chapter 1. The IEP and accompanying documents (i.e., evaluation reports, ARC meeting records, tests, physician reports, and other documents) support the inclusion of a health service in the IEP and document the medical necessity of the service. The IEP must contain sufficient information to determine the type of services being provided and the location, amount, anticipated frequency and duration of services.

What Are the Requirements for a School District to Participate In the Medicaid SBHS Program?

A school district must apply annually and be certified by the Kentucky Department of Education (KDE) to participate as a school-based health care provider. To be certified a school district agrees to:

- Provide services as required by IDEA as specified in an IEP developed by an admissions and release committee
- Comply with the requirements for provision of services required by IDEA and Medicaid
- Employ or contract with health care professionals who meet the specified qualifications
- Develop and implement a quality assurance program approved by the KDE
- Maintain records for a minimum of five (5) years plus any additional time required by law and submit to the KDE all required records and reports to ensure compliance with IDEA and the Medicaid SBHS program
- Maintain records on each Medicaid eligible student who receives services reimbursed by Medicaid. Service records must show the services performed for the child and the quantity or units of service; be signed and dated by the professional who provided or supervised the service; be legible with statements written in an objective manner; and indicate progress being made, any change in treatment and response to the treatment
- Annually apply to the KDE for Medicaid recertification as a Medicaid SBHS provider
- Annually the required SBHS Cost Report is due on or before April 1, with the cost reconciliation and settlement processes completed no later than July 31. The cost reported is based on expenditures for the prior fiscal year (July 1 – June 30).

- Agree to an annual review by the KDE to ensure compliance with the standards for continued participation as a Medicaid provider and have an on-site survey completed by the KDE as necessary to determine compliance with the Medicaid SBHS program
- Take actions specified by the KDE to correct a deficiency if found to be in noncompliance with the provision of the IDEA or Medicaid
- Quarterly certify expenditure of state or local funds to provide covered school-based health services to Medicaid eligible children as specified in 702 KAR 3:285

Once the KDE determines that the school district meets the criteria for enrollment in the Kentucky Medicaid Program as a provider of school-based health services, KDE notifies the Kentucky Department for Medicaid that a provider number may be issued to the school district.

How Should The District Decide If The Program Would Be Beneficial?

These questions should help guide the district in making a decision to participate.

- How many Medicaid children in the district are receiving special education and related services?
- How many children currently receive services that could be reimbursed under covered Medicaid school-based health services and what is the cost?
- How many parents of Medicaid eligible children will permit the district to access Medicaid coverage?
- What staff time demands will be required to implement the program?
- How will changes in state and local funding influence district expenditures?
- Will the benefits of the program compensate for the cost of implementation?

What Is A Quality Assurance Program?

The quality assurance program includes activities used by the school district to monitor and evaluate the quality of covered school-based health services and document that the services were provided as indicated by program requirements. The program ensures that students are provided the medically necessary services as written in the IEP and that the services are efficient, appropriate and meets prevailing standards of quality consistent with the Medicaid program. The program includes:

- Ensuring qualified staff
- Determining eligibility and developing an appropriate IEP (Plan of Care)
- Annually notifying parents and obtaining consent to release records for Medicaid billing
- Collaborating with other Medicaid service providers
- Physician involvement
- Record keeping
- PEER review including medical necessity of services and accuracy of billing

What Is PEER Review?

The PEER Review process, by reviewing students' records, is established by the district to verify the provision of appropriate and quality health services. During PEER Review, service logs are compared with IEPs, ARC Conference Summaries, student evaluation reports and any additional progress reports to validate that services have been provided as determined by the ARC for eligible children and within the practitioner's scope of practice.

A PEER Review team meets periodically during the school year to review records, discuss results, and recommend necessary changes. The team should conduct PEER Reviews on at least a quarterly basis, but only required 1 time annually. The Medicaid Liaison (or Director of Special Education) should organize the team and determine the meeting schedule. The PEER Review team is comprised of professionals who are employed or on contract with the district. The peers serving on the team should be familiar with the types of services provided to the student whose records are reviewed to validate that services have been provided as determined by the ARC and within the scope of practice of the providing practitioner. As appropriate, a PEER Review team may be organized by a Special Education Cooperative to perform PEER Reviews throughout the participating districts of the Cooperative.

The PEER Review team must have a majority of the members present in order to conduct a review. No member of the team reviews the records of a student he/she serves. At least **10** percent of the Medicaid eligible students' records are reviewed annually. The Medicaid Liaison considers these factors when selecting records for review:

- Records from a variety of service providers' professional disciplines;
- Schools where principals or other district administrators have requested the PEER Review team to review records;
- The peer team will review each new student record before claims are submitted for reimbursement.

The Medicaid Liaison maintains the record review forms and minutes of each meeting. The minutes of each meeting include the names and titles of the reviewers, any concerns identified in the review, and the disposition of the team's recommendations. The Medicaid Liaison takes steps necessary to correct any concerns including reimbursement to the Department of Medicaid Services. The provider's immediate supervisor and other relevant administrators will be notified as deemed appropriate.

What If We Have To Change Something in The District's Approved Medicaid Application?

An amendment to the application needs to be submitted within 15 days of a change in any of the information on file and approved by the KDE. If an effective date is not included in the amendment request, the effective date will be fifteen days prior to receipt of the amendment by KDE.

Failure to submit amendments in a timely manner may result in claim denials. An amendment is needed when:

1. Practitioners are added or deleted from the approved practitioner list;
2. Practitioners change license or certification status;
3. The district needs to add or delete the services approved; or
4. Changes are necessary in the Quality Assurance Program.

A change in a practitioner's license, certification or registration may disqualify the practitioner from covered Medicaid services. The district must maintain up-to-date information on current licensure, certification, or registration and immediately remove disqualified practitioners from the practitioner list. Medicaid reimbursement is available only for practitioners with specified qualifications. Medicaid reimbursement claims may be denied and recouped for services by practitioners who do not meet the qualifications and whom the district terminated as a provider.

What Is “Timely Submission Of Claims?”

According to federal Medicaid regulations, claims must be billed to Medicaid within twelve (12) months of the date of service. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d)(5) as "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim."

What Is A “Recipient?”

"Recipient" means a Medicaid-eligible child under the age of 21, including the entire month in which the child becomes 21.

How Does The School District Know When A Child Is A Medicaid Eligible Recipient?

Medicaid eligibility is a monthly issue since the financial status of the family can change from month to month. The initial eligibility status of a child is determined by: viewing the child's Medicaid Assistance Identification (MAID) card, and obtaining the ten-digit Medicaid Identification number.

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- Access KYHealth Net at <http://home.kymmis.com>;

For a child to be eligible under the Medicaid SBHS program:

- The child has a current Medicaid eligibility
- The child must be eligible under IDEA and receiving a covered service as specified in the child's IEP
- The child must be under 21 years of age (eligible through the month of the 21st birthday)
- The parent does not deny the district access to Medicaid and gives consent to release records for Medicaid billing.

Can Districts Bill For Services Provided To Institutionalized Children?

If your school district provides services (Nursing, SLP, OT, PT, Mental Health, Incidental Interpreter, Audiology, Respiratory Therapy, Assistive Technology Devices, O & M, Mental Health, or Transportation) to institutionalized children, please be sure to contact the Department for Medicaid to determine how payment is being made. It seems that some institutions are paid an all-inclusive rate for the children in their care, and you would not be eligible to bill Medicaid for the services your district provided to these children.

Does A District Have To Ask Every Parent Of IDEA Eligible Students In The District Permission To Allow Medicaid Billing?

No, the district only has to annually notify parents, of IDEA eligible students who are also Medicaid eligible, of the district's intent to bill Medicaid for covered services provided to that specific child. The district can be selective in their notification, but they cannot submit claims for reimbursement for students whose parents were not notified. Also, the parent must have a way to deny district access to Medicaid reimbursement. The parent may refuse to allow the district access to Medicaid at any

time, but all IEP services must still be provided as specified by the admissions and release committee.

Parent permission (i.e., consent) is only needed to allow student information to be submitted to the Department of Medicaid Services (DMS) in a claim for reimbursement to comply with the requirements of the Family Educational Rights and Privacy Act (FERPA). The district must obtain the parent's signature for "Release of Information" to allow information to be used for claim for reimbursement. (See sample document, page 29)

Do We Have To Get Parental Consent To "Release Of Information" To Medicaid For Billing Every Year, Or Is This A One-Time Event?

Parental permission for a "Release of Information" is a onetime event. If the parent denies access and later allows access, a new consent to release information is required. The parent must be given annual written notice by the school district of the district's intent to bill Medicaid for services in their child's IEP. This written notice can be given to the parent at the initial IEP meeting or Conference Summary. (See page 30: Notice of Parent Consent for School District's Use of Public Benefits or Insurance)

What Evaluation Services Are Covered?

Evaluation means procedures used to determine whether a child has a disability and the nature and extent of the special education and related services that the child may need. Evaluation includes assessment, evaluation, tests and related activities performed under state and federal requirements in KAR Chapter 1 and IDEA. The ARC determines the evaluation or assessments necessary for each individual student and only assessment of covered components are reimbursable by Medicaid. *No academic assessments are reimbursable.*

A medical *diagnostic code* is needed to bill for Medicaid services. Therefore, assessment needs to provide information sufficient for a medical diagnosis and reasons for providing a specific related health service. Qualified practitioners provide appropriate diagnosis information and diagnostic codes within their scope of practice. The practitioners determine the diagnosis and diagnostic code based on the evaluation information that is completed for initial or continued eligibility for IDEA. Medical diagnostic codes are found in the *International Classification of Diseases (ICD-10) manual. (See Appendix page 41)*

An assessment or evaluation conducted prior to the development of an IEP is covered if the IEP is subsequently developed and implemented. Following the evaluation, if the Medicaid eligible student is determined eligible for IDEA, the assessment results in **at least one** Medicaid covered service stated in the IEP, and IDEA and Medicaid requirements have been met, Medicaid covers reimbursement for practitioners conducting assessments.

If assessment of more than one Medicaid covered service is conducted, the costs for each Medicaid covered assessment are billable if the conditions are met. For example, the ARC requires assessments in the areas of Speech-Language, Mental Health and Physical Therapy. The ARC reviews the completed evaluation and determines the student needs services only in the area of Speech-Language. The ARC includes the Speech-Language services in the IEP based upon the evaluation information. The district may submit claims for all three areas evaluated, including the time spent by each practitioner analyzing and writing the evaluation reports.

Assessment results are documented in a report. The ARC uses evaluation reports to determine the student's disability and need for special education and related services, including medically necessary health related services. Following evaluation, if the Medicaid eligible student is determined eligible for IDEA services and at least one Medicaid covered service is included in the student's IEP, the associated costs of the evaluation services (including report writing time) is Medicaid reimbursable. The district may be reimbursed for the time approved practitioners spend conducting assessments and the amount of time required to analyze and write the evaluation reports (*Please note, dictating the report for clerical transcription is not a billable service*).

In the instance where the **mental health practitioner** contacts the parent or guardian by telephone to collect evaluation information, such as the social-developmental history of the student, the time spent on the telephone collecting the information may be billed as part of the evaluation if service log documentation supports the claim.

Re-evaluations conducted in response to an ARC's decision to determine the student's continued eligibility for IDEA services are billable services. The current IEP and ARC decision to re-evaluate a student allows the district to seek reimbursement of the covered evaluations. The Medicaid covered evaluations are billable even if the results determine the student is no longer eligible or requires the covered services.

Screening: Group or mass screening is not billable. However, if an individual screening is conducted by a covered practitioner as part of the individual evaluation requested by an ARC, it may be billed.

What Treatment Services Are Covered?

Approved, qualified practitioners provide treatment and therapy services in accordance with the student's IEP (Plan of Care). Treatment services are provided with the expectation that the student's condition will improve significantly in a reasonable (and generally predictable) period, or the services are necessary to maintain a safe and effective maintenance program. These services are at a level of complexity and sophistication or the condition of the student is such that the health service can only be provided by a licensed or certified practitioner, or by a trained person under the supervision of a licensed or certified practitioner.

During the course of treatment, the areas of Speech-Language, Occupational Therapy, Physical Therapy and Mental Health may have services delivered either in an individual or group setting.

- **Individual** therapy is defined by the DMS as "therapeutic intervention provided by a qualified practitioner for the purpose of reducing or eliminating the presenting problem of the student." Individual services are provided in a face-to-face, one-on-one encounter between the student and the qualified practitioner.
- **Group therapy** services are defined by the DMS as "therapeutic intervention provided by qualified practitioners to a group of students. **Only services provided to a group of six or less are billable.** Group treatment is rehabilitation services, which offer activities in a therapeutic environment that focus on the development and restoration of the skills of daily living."

Group therapy reimbursement is limited to the following services:

- Mental Health
- Occupational Therapy

- Speech Therapy
- Physical Therapy

A therapist's time providing Community Based Instruction may be reimbursed if the therapist's role is specified in the IEP. The service log documentation would then describe the service delivery and the student's response to the services provided.

When a therapist exceeds service delivery specified in the IEP for any given week, a notation must be made in the Progress Notes of the service log if the additional services are make-up sessions. The practitioner will complete the service log showing the required information. However, the practitioner must also include the statement: **"Make-up session for 1/11/04."** The only time a session has to be made up in accordance with Due Process is when the therapist is unavailable to perform the service.

What Kinds Of Services Are Not Covered?

Services ***not covered*** by Medicaid reimbursement include:

- Any service not listed under covered services
- Educational or academic assessment
- Education-based costs normally incurred to operate a school and provide an education
- Medical care not addressed in the child's IEP
- Services provided to a school district by an educational cooperative during the normal course of business without charge to the district
- Time spent on documenting clinical service notes, treatment plans, or summaries on progress
- Information furnished to the district (i.e., the provider) by the recipient over the phone
- Cancelled visits or missed appointments or services
- Concurrent services for the same child involving similar services or procedures
- Transportation of therapist to or from the site of therapy with exception of contract therapists
- Routine group speech or language screenings
- Routine nursing services which are provided to all children by a school nurse such as screening, treatment of minor abrasions, cuts and contusions, recording of temperature or blood pressure, and evaluation or assessment of acute illness

What Nursing Services Are Covered?

Direct nursing services shall be provided face-to-face and shall be generally provided on a one-to-one basis. Extended nursing care for a technology-dependent child who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital level nursing care to avert death or further disability shall be limited to the IEP services provided during normal school hours.

Assessment: Assessment includes monitoring of eligible students with chronic medical illnesses in order to assure that medical needs are being appropriately identified, addressed and monitored.

Treatment: Examples of covered nursing services include but are not limited to:

- Assessments including referrals based on results
- Suctioning

- Emergency interventions
- Individual health counseling and instructions
- Medication administration and management including observation for adverse reactions, response or lack of response to medication
- Oxygen administration via tracheostomy and ventilator care
- Positioning
- Gastrostomy tube feeding
- Glucose monitoring
- Ileostomy and colostomy care
- Respirator dependent
- Catheterization and management and care of specialized medical equipment such as colostomy bags, nasal gastric tubes, and tracheotomy tubes
- Supervision of the health aide by the delegating nurse

Examples of Health Aid services:

- Handling and positioning
- Wheelchair care and monitoring
- Bowel care
- Skin care and monitoring
- Gastrostomy tube feeding
- Shunt monitoring, catheterization and postural drainage; and Changing tracheotomy ties, oxygen supplementation.

Certain emergency services may be provided on an as needed basis. The need for an emergency as required nursing service should be stated in the student's IEP. The practitioner's documentation (services log) must explain the treatment provided. An example of an emergency service is the administration of an inhalation treatment to a child who is having an asthma attack and who has an IEP requiring the service.

Treatment services, considered observation or standby in nature, are not covered.

Qualified Practitioners: A nursing service must be provided by:

- An advanced registered nurse practitioner with a current license from the Kentucky Board of Nursing;
- A registered nurse with a current license from the Kentucky Board of Nursing;
- A licensed practical nurse with a current license issued by the Kentucky Board of Nursing, under appropriate supervision and delegated authority; or
- A health aide if:
 - The aide is under the supervision of a specific registered nurse or advanced registered nurse practitioner;
 - A registered nurse or advanced registered nurse practitioner has trained the aide for the specific nursing service for the specific recipient; and
 - A supervising registered nurse or advanced registered nurse practitioner has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

What Audiology Services Are Covered?

Audiology services must be medically necessary and appear in the child's Individualized Education Plan. They are professional services involving the evaluation and treatment of impaired hearing that cannot be improved by medication or surgical treatment.

Assessment: Assessment services may include testing or clinical observation as appropriate for chronological or mental age for one or more of the following areas of functioning, and shall yield a written report:

- auditory acuity (including pure tone air and bone conduction)
- speech detection
- speech reception threshold
- auditory discrimination in quiet and noise
- impedance audiometry, including tympanometry and acoustic reflex
- hearing aid evaluation
- central auditory function
- auditory brainstem evoked response

Treatment: Treatment may be provided individually or in groups as appropriate. Examples of treatment include:

- auditory training
- speech reading
- aural rehabilitation
- augmentative communication

Qualified Practitioners: Audiology services must be provided by an audiologist meeting the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Kentucky Board of Speech-Language Pathology and Audiology.

What Speech-Language Services Are Covered?

Speech-Language services must be medically necessary and appear in the child's Individualized Education Plan. These are professional services involving the assessment and treatment of speech and language disorders that are not amendable to medication or surgical treatment.

Assessment: Assessment services may include formal or informal testing, medical history interviews, or clinical observation, as appropriate for chronological or mental age for all the following areas of functioning, and shall yield a formal evaluation report. Examples assessment services include but are not limited to:

- Receptive and expressive language
- Auditory processing, discrimination,
- Perception, and memory
- Augmentative communication
- Vocal quality
- Resonance patterns
- Speech sound production and use (phonetic and phonologic)
- Pragmatic language
- Rhythm or fluency

- Oral mechanism
- Swallowing assessment
- Hearing screening
- Feeding assessment

Reimbursement shall not be allowed for routine or group screenings

Treatment: Treatment services may include one or more of the following areas as appropriate and may be provided individually or in a group as appropriate:

- Articulation therapy
- Language therapy
- Receptive and expressive language
- Augmentative communication treatment or instruction
- Auditory processing dysfunction
- Disorders of fluency
- Voice therapy
- Oral motor dysfunction; swallowing therapy

Qualified Practitioners: Speech and language services must be provided by:

A speech-language pathologist:

- a) Meeting applicable requirements of 42 CFR 440.110, including the possession of a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).

What Occupational Therapy Services Are Covered?

Occupational therapy services are services to develop, improve, or restore functional abilities related to performance of self-help skills, adaptive behavior and sensory, motor, postural and emotional development. Services involve the use of purposeful activity, interventions, and adaptations to enhance functional performance.

Assessment: Assessment services include testing or clinical observation as appropriate for chronological or mental age for one or more of the following:

- Activities of daily living
- Sensory or perceptual motor development
- Neuromotor function (e.g., balance, coordination, muscle tone, postural control, reflexes, and developmental stages)
- Musculo-skeletal function (e.g., muscle strength, joint range of motion, endurance)
- Gross and fine motor function
- Adaptive equipment assessment

Treatment: Treatment services may include one or more of the following and be provided individually or in a group as appropriate:

- Activities of daily living
- Sensory or perceptual motor skills
- Neuromotor function
- Musculo-skeletal function
- Gross and fine motor skills
- Feeding or oral motor skills
- Adaptive equipment needs (design, selection, fabrication, use)

Qualified Practitioners: Occupational therapy service providers must meet the applicable requirements of 42 CFR 440.110. Service providers must also meet the following requirements:

- (a) An occupational therapist with a current license from the Kentucky Board of Licensure for Occupational Therapy;
- (b) An occupational therapy assistant who is:
 1. Licensed by the Kentucky Board of Licensure for Occupational Therapy to assist in the practice of occupational therapy; and
 2. Under the supervision of an occupational therapist; or
- (c) An unlicensed occupational therapy aide who:
 1. Provides supportive services to occupational therapists and occupational therapy assistants; and
 2. Is under the direct supervision of a licensed occupational therapist.

What Physical Therapy (PT) Services Are Covered?

Physical therapy services are services to prevent, alleviate, or compensate for movement dysfunction and related functional problems. Services involve the use of physical agents and methods and mechanical means for remedial treatment and restoration of normal bodily function.

Assessment: Assessment services may include testing or clinical observation as appropriate for the chronological or mental age for one or more of the following areas of functioning, and shall yield a written report:

- Neurometer function (e.g., balance, coordination, muscle tone, postural control, reflexes, and developmental stages)
- Musculo-skeletal function (e.g., muscle strength, posture, joint range of motion, endurance, mobility assessment, gait and wheelchair use)
- Cardio-pulmonary function
- Activities of daily living
- Feeding or oral motor function
- Adaptive equipment assessment
- Gross and fine motor function
- Soft tissue assessment
- Pain assessment
- Cranial Nerve assessment
- Clinical electromyography assessment
- Latency and velocity assessment

Treatment: Treatment services may include one or more of the following and may be provided individually or in a group as appropriate:

- Manual Therapy techniques
- Therapeutic exercise
- Functional Training
- Facilitation of motor milestones
- Sensory motor training
- Cardiac training
- Neuromotor function
- Musculo-skeletal function

- Mobility training
- Cardio-pulmonary function
- Activities of daily living
- Feeding or oral motor assessment
- Adaptive equipment skills (includes design, selection, fabrication, use)
- Gross and fine motor development
- Hydrotherapy

Qualified Practitioners: Physical therapy services must be provided by providers who meet the applicable requirements of 42 CFR 440.110 and:

- A physical therapist with a current license from the state Board of Physical Therapy;
- A physical therapist assistant with a current license from the state Board of Physical Therapy under the supervision of a licensed physical therapist;
- A physical therapist with a temporary permit issued by the state Board of Physical Therapy under the supervision of a licensed physical therapist;
- A student of physical therapy under the supervision of a licensed physical therapist; or
- A physical therapy aide under the direct on-site supervision of a:
 - Licensed physical therapist; or
 - Licensed physical therapist assistant in accordance with the provisions of 201 KAR 22:053, Section 5.

What Mental Health Services Are Covered?

Mental health services are services required to sustain behavioral or emotional goals or to restore cognitive functional levels that have been impaired. Children who are at risk for developing or who require treatment for maladaptive coping strategies or who present a reduction in individual adaptive and coping mechanism or who demonstrate an extreme increase in personal distress may require mental health services to benefit from special education. Covered services may include assessment, treatment, and collateral services.

Assessment: Assessment service may include the following:

- comprehensive psychological evaluations
- testing
- Obtaining information from the parents or home behavior, social and developmental history and parents' perceptions of the problems may be included in the assessment.
- clinical evaluation, observation and interviews as appropriate for chronological or mental age including, but not limited to, the following areas of functioning:
 - cognitive
 - emotional or personality development
 - adaptive behavior
 - behavior
 - perceptual or visual motor
 - developmental
 - psycho-social
 - psycho-educational
 - psycho-neurological

Treatment: Treatment services may include one of the following as appropriate:

- individual therapy or counseling
- group therapy or counseling

Examples of group therapy topics are building and maintaining healthy relationships, personal goal setting, etc. The topic of each group session shall be relative to all children participating.

Qualified Practitioners: Mental health services may be reimbursed only if provided by one of the following practitioners:

- An individual currently licensed by the Kentucky Board of Examiners of Psychology in accordance with KRS Chapter 319 as a:
 - Licensed psychologist;
 - Licensed psychological practitioner;
 - Certified psychologist with autonomous functioning;
 - Certified psychologist; or
 - Licensed psychological associate;
- A licensed clinical social worker currently licensed by the Kentucky Board of Social Work;
- A licensed social worker currently licensed by the Kentucky Board of Social Work;
- A certified social worker currently licensed by the Kentucky Board of Social Work; or
- An advanced registered nurse practitioner who has a specialty area in accordance with the American Nurses' Association Statement on Psychiatric Mental Health Clinical Nursing Practice and Standards of Psychiatric Mental Health Clinical Nursing Practice in accordance with 201 KAR 20:057.

What Incidental Interpreter Services Are Covered?

Incidental interpreter services are interpreter services that are necessary to allow the child to benefit from other covered school-based health services. Incidental interpreter services are Medicaid reimbursable when provided *with* another covered service.

These services must be stated in the student's IEP and cannot be the only covered service needed. For example, an interpreter might be required as an incidental service in order for the school psychologist to administer a portion or all of a mental health assessment to a child who is deaf or hard of hearing. Another instance requiring the use of an incidental interpreter might take place during the ARC meeting where a parent is in need of an interpreter in order to understand and participate in the meeting. There must be at least one Medicaid covered service stated in the IEP in order for the interpreting services provided to a parent during an ARC meeting to be Medicaid reimbursable.

Qualified Practitioners: Effective July 1, 2003, interpreters must be licensed by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing as required by KRS 309.300 to 309.319;

What Orientation And Mobility (O&M) Services Are Covered?

Orientation and mobility services include assessment and instruction services to correct or alleviate movement deficiencies created by a loss or lack of vision.

Assessments may include the following:

- visual functioning
- sensory awareness
- gross or fine motor skills
- concept development
- pre-cane and cane skills
- protective and navigational techniques
- sighted guide techniques
- community awareness
- public transportation
- vocational training

Treatment services include using cognitive and physical skills enabling a child to establish his/her position and relationship in the environment in a safe, efficient and purposeful manner. Treatment services may be provided individually or in a group as appropriate.

Qualified Practitioners: Orientation and mobility services shall be provided by an orientation and mobility specialist certified by the:

- Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP);
or
- National Blindness Professional Certification Board (NBPCB).

What assistive technology services are covered?

An assistive technology device is an item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of a child with a disability and is medically necessary to implement the health services in the child's individualized education program. **These devices must be stated in the IEP and is covered only when provided with another IEP service.**

Evaluation: The cost of the evaluation to establish medical necessity (e.g., related to an identified medical or mental disability, and appropriateness of the device, item or system prior to purchase or rental) is included in the assistive device or item's overall cost. Evaluations may be provided by an occupational therapist, a physical therapist, or a speech therapist. Other appropriate professionals also may provide evaluations with prior approval by the Department for Medicaid Services. An assistive device or item cannot be covered without an evaluation by the appropriate professional.

The DMS requires that the device becomes the property of the student once the district receives Medicaid reimbursement for the assistive device. Should the student outgrow the device or the student's needs require a change in devices, the old device remains the property of the student. A parent CAN however donate the item. There are no limitations as to the frequency of purchasing assistive devices, as long as an evaluation to determine the need for a different device has been conducted and the type of device is documented in the student's IEP.

What Transportation Services Are Covered?

Transportation costs incurred by the district to provide special transportation for a child to receive a Medicaid covered related service may be billed to Medicaid if the following criteria are met. Special transportation includes special arrangements, special equipment or a special vehicle.

- Transportation must be prior approved by KDE as a service to be provided
- The child must be Medicaid eligible;
- The child qualifies for special education, related services and special transportation;

- The ARC qualifies the child’s need for special transportation and determines what transportation is appropriate for the child’s disability. **The need and type of special transportation must be identified in the child’s IEP.**
 - The child must receive at least one Medicaid reimbursable related service on the day transportation is billed.
 - Only one round trip per day may be billed even if the child receives several billable related services. If the child is transported to a different location to receive a second billable service on the same day, mileage may be combined to make a single round trip.
 - **Detailed transportation logs (attendance logs) are maintained and signed by the bus driver.**
 - The transportation must meet the specifications established by KRS 156.153, 702 KAR 5:060, and 702 KAR 5:130. These are the state regulations that apply to the transportation of all school children.
 - Transportation cost originally paid from *federal* funds such as IDEA cannot be billed to Medicaid.
 - Group billing cannot be used to determine mileage. If more than one child is transported at the same time, the exact mileage for each child must be calculated. *Specially adapted vehicles may have riders who are not eligible for Medicaid or who are not eligible for school based transportation on a given day. However, only claims that are pro-rated (see example below) for the portion of the ride allocated to the Medicaid beneficiary receiving the specialized transportation, are reimbursable by Medicaid.*
- Example:** If one (1) general education/non-physically disabled child rides the specially adapted vehicle with one (1) physically disabled child that has a medical service and transportation in the IEP on the date of service, the cost of the ride must be divided by the two (2) children; if there are two (2) general education/non-physically disabled children plus the physically disabled child, the cost must be divided by three (3); additional number of children riding the specially adapted bus must be calculated accordingly.
- Mileage may not be claimed when a member of the child’s household provides transportation if that person is not an employee of the school district.

Mileage may be claimed from:

- The child’s *residence* to and from the school building where the child receives the reimbursable related service.
- The child’s *residence* to and from the office of a medical provider or clinic where the child receives the reimbursable related service.
- The child’s home if the child is a home-bound student and receives general education services at home

To calculate a claim amount, use the district’s actual cost per mile to transport the child times the number of miles transported round trip. The actual cost per mile for special transportation is available from the Pupil Transportation Director at your district or you may use MapQuest, Yahoo or other online mapping service.

What Respiratory Therapy Services Are Covered?

A respiratory care practitioner may perform respiratory care procedures under medical direction with documented competency, in accordance with agency or facility guidelines and only in accordance with the prescription of a physician. The procedures shall include, but not be limited to the assessment and therapeutic use of the following:

- Oxygen therapy;
- Humidity therapy;

- Aerosol therapy;
- Air clearance techniques;
- Respiratory assist device (RAD);
- Chest physiotherapy;
- Assessment of patients' cardiopulmonary status.

Qualified Practitioners: Respiratory Therapist must be certified by the Kentucky Board of Respiratory Care as required by KRS 314A.

What About Monitoring and Compliance?

In accordance with an interagency agreement between the Cabinet for Health Services, the Kentucky Department for Medicaid services and the Kentucky Department of Education, the KDE conducts site surveys as a tool for program monitoring. The KDMS conducts periodic quality assurance and utilization reviews or other audit procedures required by state or administration of the Medicaid program.

Upon informed consent of the parent, the LEA provides records and other pertinent information, to the KDMS, the Health Care Financing Administration, or any agency commissioned to audit the program. Records are provided upon request and at no cost to the requesting party. Also, as requested, each practitioner provides records or copies of records relating to and substantiating services billed by the practitioner. These records are provided without charge.

The KDE conducts site visits as part of established monitoring protocol. The focus of the monitoring of each LEA includes:

- Medicaid related criteria (as stated in KDE monitoring documents);
- Review of records of Medicaid eligible students;
- Reporting Medicaid related site visit results with the LEA monitoring report; and
- Addressing areas or noncompliance in the Corrective Action Plans (CAPs) submitted by LEAs.

During the site visit, the LEA makes the following materials available for review (inspection):

- Personnel files of the service providers (staff and other practitioners) including copies of licensure, certifications; employment contracts; and in-service (professional development) participation.
- Educational records of Medicaid eligible students receiving school-based health services.
- Financial records regarding the Medicaid program.
- A list of Medicaid covered school-based health services the LEA provides.
- The Quality Assurance Plan with verification of implementation within one (1) year of outline approval.
- Records of Peer Review Committee meetings.

The LEA maintains adequate records and documentation to ensure the delivery of quality care and post-payment review by the KDE or KDMS. Each record is legible and contains the signature and the title of the practitioner. Delegated services and services provided by persons under the supervision of a practitioner include the name and title of the supervisory person.

Insufficient documentation may result in rejection of claims, development of corrective action plans, and/or financial penalties. Continued noncompliance may result in removal from the Medicaid School-Based Health Services Program.

In the absence of proper and complete records, claims may be denied and previous payments may be recovered. Each LEA maintains:

- Verification that the services being claimed for reimbursement are listed in the student's IEP. A sample form "IEP Services Summary" is included in the Appendix section of this manual. The use of this form may be beneficial in establishing medical records.
- Professional service logs reflect the date, type, diagnosis code, procedure code and description of the service(s) provided to the student. Progress reports are included as part of the treatment notes. These progress reports are used to measure the student's progress toward the goals defined in the IEP (Plan of Care). Any alterations to documents must be signed and dated. No white-out is permitted. A minimum, the service log includes:
 - Name of the student.
 - Date the child was seen
 - The length of time spent with the child in 15 minute increments.
 - The description of the service provided and result(s)
 - The procedure code
 - The diagnosis code
- Verification of the attendance of both the child and the service provider for claims submitted.

What Service Records Must Be Kept?

Medicaid requires records to be maintained on each Medicaid eligible recipient (student) who receives services that are reimbursed by Medicaid. These records must:

- Substantiate the services billed to Medicaid by identifying the student, the services performed, the quantity or units of service, and the medical necessity of the services
- Indicate progress being made, any change in treatment, and response to the treatment
- Must be signed and dated by the professional who provided or supervised the service
- Must be legible with statements written in an objective manner
- Are maintained for a minimum of five (5) years plus any additional time required by law to provide a clear audit trail. If service logs are also being used for Due Process documentation, the log must be kept in accordance with Due Process procedures. This is currently for 3 years after last activity in special education or graduation. School districts might also have a procedure in place to keep Due Process records until the student has reached their 24th birthday.

Entries in a service log are required by each practitioner providing covered services billed to Medicaid. (See Service Log Examples)

What Are Grounds For Sanctions Against Providers?

The Kentucky Department of Education or Kentucky Department for Medicaid Services may impose sanctions against a provider (LEA) for any one or more of the following reasons:

1. Violations of applicable laws, regulations, or codes of ethics related to programs or conduct of Medicaid providers (LEAs) or service providers (practitioners). (Failure to meet standards required by State or Federal law for participation.)
2. Failure to correct deficiencies within specified timelines after receiving written notice of these deficiencies from the KDE. (Failure to comply with a Corrective Action Plan)
3. Obtaining funds through deception:
 - a. Charging recipients for services (This does not include incidental fees charged to all students as part of the regular education program.)
 - b. Presenting for payment false or fraudulent claims for services or equipment.

- c. Submitting false information to obtain greater reimbursement than that to which the LEA is legally entitled, including charges in excess of the fee schedule.
 - d. Overusing the program by inducing, furnishing or otherwise causing an eligible student to receive service(s) or equipment not otherwise required or requested through the IEP.
 - e. Submission of a false or fraudulent application for Provider status.
4. Failure to adequately or appropriately manage programs.
- a. Failure to provide and maintain services to eligible students within accepted community standards
 - b. Breach of the requirements for provider participation, or failure to comply with the terms of the provider certification
 - c. Engaging in a course of conduct or performing an act deemed improper or abuse.
Examples of abusive acts include:
 - i. Furnishing services or supplies to eligible students that are substantially in excess of the needs, harmful or grossly inferior in quality.
 - ii. Solicitation or acceptance of any amount from the family of eligible child for specially designed instruction and related services specified in the IEP unless it is an incidental fee normally charged to all enrolled students as part of the regular education program.
 - iii. Separate schedule of charges for services to eligible children and non-eligible students which results in higher charges for eligible students than non-eligible students.
5. Failure to disclose or make available to the KDE or DMS records of services provided to eligible students and records of payments made.
6. Conviction of a criminal offense relating to negligent practice resulting in death or injury, or misuse or misapplication of program funds.
7. Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the LEA's students.

What Sanctions May Be Invoked?

The following sanctions may be invoked by the KDE or the DMS against providers, on the basis of a finding of violation consistent with Grounds for Sanctions:

1. Corrective Action Plan
2. Termination from participation in the program.
3. Suspension or withholding of payments.
4. Recoupment of funds
5. Referral to the Office of Education Accountability for investigation.
6. Referral to the appropriate licensing/certification organization for investigation and appropriate disciplinary action.

When a provider (LEA) has been sanctioned, the DMS notified the KDE of the findings made and the sanctions imposed. If, during the course of program monitoring, the KDE finds grounds for imposing sanctions, the KDE notifies the DMS and other appropriate agencies in writing within 30 calendar days of the finding(s).

Glossary of Selected Terms

"Admissions and release committee" or "ARC" means a group of individuals required by 707 KAR 1:320 and 34 C.F.R. 300.344 who are responsible for developing, reviewing, and, as necessary, revising the individualized education program for a child with a disability.

"Assistive technology device" means an item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of a child with a disability; and medically necessary to implement the health services in the child's individualized education program.

Audit means checking the district's documentation and procedures to determine if claims were consistent with Medicaid and IDEA program requirements.

Claim means the form or electronic request for reimbursement submitted by the provider (the school district) to the Department of Medicaid Services.

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency that is responsible for administering the Medicaid program (formerly the **HCFA** Health Care Financing Administration).

Certification means the process used for the Kentucky Department of Education to recommend approval to the Department of Medicaid Services for a school district to become a health services provider in Kentucky.

Consent means that the parent has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language or other mode of communication, and the parent understands and agrees in writing to the carrying out of the activity for which his or her consent is sought. The signed consent describes that activity and lists the records that will be released and to whom. The parent understands that the granting of consent is voluntary and may be revoked at any time.

"Covered services" means the medically necessary services included in the eligible child's IEP and specified in the Medicaid SBHS program requirements. In Kentucky, the following services are covered for Medicaid reimbursement when provided to an eligible child:

- Nursing
- Audiology
- Speech-Language
- Occupational Therapy
- Physical Therapy
- Mental Health
- Orientation and Mobility
- Incidental Interpreter
- Transportation
- Assistive Technology
- Respiratory Therapy

"Date of Service" means the actual date that the covered service was provided.

Denial means that Medicaid refuses a claim for reimbursement.

“Direct supervision” means that the licensed or certified practitioner is physically present as required by Kentucky statute or regulation or the Kentucky board issuing the practitioner’s license or certification.

HCFA means the Health Care Financing Administration which was renamed the Centers for Medicare and Medicaid Services (**CMS**). CMS is the federal agency that is responsible for administering the Medicaid program.

"IDEA" means the Individuals with Disabilities Education Act, 20 U.S.C. Chapter 33.

"Incidental interpreter services" means those interpreter services that are necessary to allow the child to benefit from other covered school-based health services.

"Individualized Education Program" or **"IEP"** means a written plan for a child with a disability that is developed, reviewed and revised in accordance with 707 KAR 1:320.

Practitioner means the covered professional or other approved individual providing the covered health service.

“Procedure code” means a standardized code established by the Kentucky Department of Medicaid Services that is used on documentation and claim forms to identify a particular service performed by a qualified practitioner.

“Progress note” means a dated, signed or initialed entry on the service log detailing the service provider’s encounter with the student and the student’s response to the encounter.

Provider means the local school district or the Kentucky School for the Deaf or the Kentucky School for the Blind providing covered health services under the Medicaid school-based health services program.

“Provider agreement” means a contract between the school district (provider) and the Kentucky Department of Medicaid Services that states the conditions of participation the Medicaid SBHS program.

“Provider number” means the number assigned by the Kentucky Department of Medicaid Services to the provider (i.e., the approved participating school district, KSB or KSD).

Recipient means a Medicaid-eligible child under the age of twenty-one (21), including the entire month in which the child becomes twenty-one (21).

Reimbursement means the amount of money remitted to the provider from the Department of Medicaid Services.

"School-based health services" or **"SBHS"** means medically-necessary health services provided for in 907 KAR 1:034 and as specified in an individualized education program for a child determined to be eligible under the provisions of the Individuals with Disabilities Education Act, 20 U.S.C. Chapter 33, and 707 KAR Chapter 1.

“Service log” means the documentation which supports the district’s claims that are submitted to Medicaid for reimbursement. Service logs:

- identify the student and the approved individual providing the service;

- show the time, date, and units of service provided;
- contain legible statements written in an objective manner that describe the services performed and the progress being made, any change in treatment, and response to the treatment; and
- are signed and dated by the professional who provided or supervised the service.

Unit means a fifteen minute block of time. Medicaid reimburses school districts for the cost of services in units. For example, a school district would bill for Medicaid for two units of a practitioner's cost if the practitioner provided a covered service from 9:00 a.m. to 9:30 a.m.

Medicaid Annual Parent Notification Letter

Today's Date: _____

Student's Name: _____ Current School: _____

Dear _____ (*parent's name*),

The _____ (*name*) School District is pleased to provide your child with special education and related services as stated in his or her Individual Education Program (IEP). Your child is entitled to a free appropriate public education, which means at no cost to you.

State and federal laws allow school districts to be Medicaid service providers for children with disabilities who are eligible under the Individuals with Disabilities Education Act (IDEA) and the Medicaid program. This means that our school district can bill the Department of Medicaid for related health services stated in your child's IEP.

Our school district is approved by the Department for Medicaid Services to take part in the Medicaid School-Based Health Services Program. School claims for Medicaid payment for these services will not affect your child's receipt of health services from your family physician or other health providers in any way.

Our school district cannot submit claims to Medicaid for your child's services if you do not want us to do so. Our district's billing Medicaid for these services will not change your child's IEP services or your right to receive Medicaid services as long as your son or daughter continues to be eligible for Medicaid services.

If you wish to deny the district's access to reimbursement from Medicaid for health services in your child's IEP, you should do so in writing. Our school district will continue to bill Medicaid for special services unless you notify us in writing that you wish us to stop. We will remind you once a year. If you wish to stop the district from submitting claims to Medicaid for your child, send a written statement to the district's Medicaid Liaison.

If you have any questions or concerns about your child's Medicaid coverage, please contact _____ (*name*) at _____ (*phone number*). Also, if you think another provider may be billing your child's medical card for the same services provided by the school district, please notify _____ (*name*) _____ as soon as possible

If we do not hear from you we will begin or continue to submit claims to Medicaid for your child's IEP health services. I want to thank you for your support of our efforts.

Sincerely,

(*name*)
Medicaid Liaison
(*phone number*)

File copy of notice maintained in student folder

Notice of Parent Consent for School District's Use of Public Benefits or Insurance (Medicaid) under 34 CFR §300.154(d)(2)(iv)

I hereby authorize the release of *(child's name)* _____ educational records as listed below to Medicaid, for the purpose of processing Medicaid claims or for agency review of records.

Medicaid's examination of records for program audit purposes shall take place in my child's school district. No copies of my child's records will be provided to Medicaid.

Please mark statement, sign and date at the bottom:

___ I give my permission for _____ (Name of Local Educational Agency) to allow the Department of Medicaid Services to examine information in my child's educational files which is needed to bill the Kentucky Medicaid program for services provided through my child's Individual Education Program (IEP). My signature does not give permission to bill my private insurance company. This information to be released may include:

- My child's name and Social Security Number;
- My child's date of birth;
- My child's referral and evaluation information and reports pertaining to the billing of Medicaid services.
- The dates and times that service is provided to my child at school;
- My child's IEP goals that relate to these services; and
- Progress notes pertaining to the billing of Medicaid services

___ I do not give my permission for this information to be released.

___ I understand that services provided by _____ (Name of Local Educational Agency) special education program will not count against limits for Medicaid programs.

This consent form gives the school system listed above permission to release information needed to recover costs from Medicaid for eligible school-based services provided as outlined within the IEP.

Child's full name: _____

Parent's or guardian's name (printed): _____

Parent or guardian's signature: _____

Date signed: ___/___/_____

Release is given to the following agencies or their designated representatives, for the sole purpose of billing Medicaid services or for auditing of the school districts School-Based Health Services program:

- Kentucky Department for Medicaid Services
- Kentucky Department for Public Health/Local Health Departments
- Centers for Medicare and Medicaid Services (CMS)
- Any agency commissioned to audit this program
- Contractual Third-party Billing Agency (Agency performing billing and related services for the school district)

I understand that the records will remain confidential and will only be used for the purposes listed above. The above agencies have been advised that they are bound by FERPA and cannot release the information they have obtained from the child's records without informed parent consent.

Your consent is voluntary. If you have any questions or concerns, please contact your school principal or the district's Medicaid Liaison at _____(phone numbers) _____.

Qualifications/Modifiers of Medicaid SBHS Practitioners

School-based health services (SBHS) are reimbursable by Medicaid if provided by specific practitioners acting within their scope of practice as defined by state law. The titles of practitioners, the credentialing requirements, and the practitioner modifiers are contained in this chart.

CODE	DESCRIPTION	CREDENTIALS
AH	Licensed Psychologist	Current license from the KY Board of Examiners of Psychology in accordance with KRS Chapter 319
AJ	Clinical Psychologist	Current license from the KY Board of Examiners of Psychology in accordance with KRS Chapter 319
GN	Speech-Language Pathologist	Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).
GO	Occupational Therapist	Current license from KY Occupational Therapy Board (KAR 201 Chapter 28)
GOU3	Occupational Therapy Assistant	Current license from the KY Occupational Therapy Board and under the supervision of a licensed Occupational Therapist (KAR 201 Chapter 28)
GOUA	Occupational Therapist Aide	Under the direct supervision of the KY licensed Occupational Therapist (KRS 319A. 010 (5))
GP	Physical Therapist	Current license from the KY Board of Physical Therapy or a temporary permit issued by the KY Board of Physical Therapy (KAR 201 Chapter 22)
GPHL	Physical Therapy Student (Intern)	Student of Physical Therapy under the supervision of a KY licensed Physical Therapist (KAR 201 Chapter 22)
GPU3	Physical Therapist Assistant	Current license from the KY Board of Physical Therapy and under supervision of a licensed Physical Therapist (KAR 201 Chapter 22)
GPUA	Physical Therapist Aide	Under the direct on-site supervision of the KY licensed Physical Therapist or Physical Therapy Assistant (201 KAR 22:053, Section 5.)
HL	Intern	Per Practice Guidelines

HO	Licensed Professional Clinical Counselor	Current license from the KY Board of Licensed Professional Counselors (KRS Chapter 335)
HP	Doctoral Level	Per Practice Guidelines
SA	Advanced Registered Nurse Practitioner (ARNP)	Current license from the Kentucky (KY) Board of Nursing (201 KAR 20:057)
TD	Registered Nurse	Current license from the KY Board of Nursing (201 KAR 20:057)
TE	Licensed Practical Nurse	Current license from the KY Board of Nursing under appropriate supervision and delegation (201 KAR 20)
U1	Health Aide	Under the supervision of and with training by a KY licensed ARNP or RN and being monitored by the supervising nurse in provision of the delegated and supervised nursing services (201 KAR 20:400)
U2	Audiologist	Current license from KY Board of Speech Language Pathology and Audiology (201 KAR 17:012)
U4	Licensed Psychological Practitioner	Current license from the KY Board of Examiners of Psychology (KRS Chapter 319)
U4HO	School Psychologist-Master's Level	Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319). (KRS Chapter 319)
U4HP	School Psychologist-Doctoral Level	Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319). (KRS Chapter 319)
U5	Certified Psychologist with autonomous functioning (AF)	Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)
U5HO	Certified Psychologist	Current license and under the supervision of a KY Licensed Psychologist (KRS Chapter 319)
U6HO	Licensed Psychological Associate	Current license and under the supervision of a KY Licensed Psychologist (KRS Chapter 319)
U8	Board Certified Behavior Analyst	Current license from the Kentucky Applied Behavior Licensing Board (KRS Chapter 319C)

U8U3	Board Certified Assistant Behavior Analyst	Current license from the Kentucky Applied Behavior Licensing Board as an Assistant Behavior Analyst and under the supervision of a Certified Behavior Analyst (KRS Chapter 319C)
U9	Psychometrist	Refer to the KY Board of Examiners of Psychology. KRS 319
UB	Interpreter	Effective July 1, 2003, interpreters must be licensed by the KY Board of Interpreters for the Hearing Impaired as required by KRS 309.300 to 309.319
UC	Orientation and Mobility	Current certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or the National Blindness Professional Certification Board (NBPCB)
UD	Respiratory Therapist	Certification by the KY Board of Respiratory Care as required by KRS 314A

PROCEDURE CODES

90853	GROUP PSYCHOTHERAPY
90887	CONSULTATION WITH FAMILY-EXPLANATION OF PSYCHIATRIC, MEDICAL EXAMINATION, PROCEDURES AND DATA TO OTHER THAN PATIENT
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION AND/OR HEARING PROCESSING DISORDER
92508	SPEECH THERAPY – GROUP
92521	EVALUATION OF SPEECH FLUENCY
92522	EVALUATION OF SPEECH SOUND PRODUCTION
92523	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHS
92524	BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE
92551	AIR TONE CONDUCTION HEARING ASSESSMENT SCREENING
96150	EVALUATIONS
96153	MENTAL HEALTH THERAPY - GROUP
*97001	PHYSICAL THERAPY EVALUATION
*97003	OCCUPATIONAL THERAPY EVALUATION
97110	PHYSICAL THERAPY – GROUP
*97150	THERAPEUTIC PROCEDURES IN A GROUP SETTING
97530	OCCUPATIONAL THERAPY – GROUP
97533	ORIENTATION AND MOBILITY
A0160	TRANSPORTATION
CODE	PROCEDURE
E1399	ASSISTIVE TECHNOLOGY
H0031	BEHAVIOR ANALYST ASSESSMENT
H0032	BEHAVIOR ANALYST THERAPY
T1002	RN SERVICES UP TO 15 MINUTES
T1003	LPN/LVN SERVICES UP TO 15 MINUTES
T1004	QUALIFIED NURSING AIDE, UP TO 15 MINUTES
T1013	INTERPRETER
*CODES	CODE 97001, 97003 & 97150 ARE IN PROCESS TO BE EFFECTIVE 8/1/2015

The procedure coding system, ICD-10-PCS, may be viewed and downloaded from the [Centers for Medicare and Medicaid Services' Web site](#).

IEP SERVICES SUMMARY
(May be attached to the IEP)

SCHOOL DISTRICT _____	SERVICE DATE _____
SCHOOL _____	MEDICAID ID _____
STUDENT NAME _____	STUDENT PHONE _____
STUDENT ADDRESS _____	NUMBER _____
STUDENT DOB _____	STUDENT SS# _____
GENDER _____	

SERVICE SPECIALITY	SERVICE PROVIDER NAME	DIAGNOSTIC CODE
NURSING SERVICES		
AUDIOLOGY SERVICES		
SPEECH/LANGUAGE SERVICES		
OCCUPATIONAL THERAPY SERVICES		
PHYSICAL THERAPY SERVICES		
MENTAL HEALTH SERVICES		
INCIDENTAL INTERPRETER SERVICES		
ORIENTATION & MOBILITY SERVICES		