School Supportive Health Services Program
Preschool Supportive Health Services Program

Questions and Answers
Issued June 6, 2011

Note: The responses to Question #114 and 125 were revised August 1, 2011
Note: The responses to Questions #115, #127, and #137 were revised December 10, 2012.

Written orders and referrals

Note: The response to Question #114 was revised August 1, 2011. Deletions are ~~struck through~~ and additions are underlined.

114. Q. Is there anything a school district, county, or §4201 school can do if SY 2009-2010 prescriptions did not have the ordering practitioner's NPI number or contact information?

A. If the physician or other ordering practitioner did not provide the license number or NPI number or contact information, you must obtain another original. In addition, the complete written order, with the license or NPI number, must be in place prior to delivering services for which Medicaid reimbursement will be sought. It is recommended that the written orders received by school districts, counties, or § 4201 schools for SSHSP services be monitored for completeness and that any necessary replacement documentation is requested as soon as possible.

See Question and Answer #32 on the Medicaid in Education website for more information on required elements of a written order.

Note: The response to Question #115 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are underlined.

115. Q. When the hold on counseling claiming is released will a "referral" be required to claim retroactively? If yes, clarification is needed as to what could count as a referral.

A. Yes. Medicaid regulations at 18 NYCRR 505.18(c)(4) provide that psychological counseling services must be supported by a referral and that an individualized education program (IEP), which includes the recommendation for psychological counseling services, fulfills the requirement for prior referral. The referral requirement may be fulfilled by having an IEP that includes psychological counseling services, or by having a referral from the student's personal physician or clinic, or from an appropriate school official, such as the chairperson of the committee on special education. For psychological counseling services furnished prior to September 1, ~~2012~~ 2013, referral documentation could include one of the items just referenced. Effective September 1, ~~2012~~ 2013 and after, a separate referral for psychological counseling services from either the student's physician or a medical resource such as a clinic, an appropriate school official, or an official or voluntary health or social agency must be included in the

student's record. The IEP will no longer serve as the referral on or after September 1, ~~2012~~ 2013.

Refer to SSHSP Billing/Claiming Guidance, posted on the State Education Department's Medicaid in Education website at http://www.oms.nysed.gov/medicaid/billing_claiming_guidance/BILLING_Claiming_guidelines_sept_2010.PDF for additional information and guidance on SSHSP billing and claiming.

116. Q. For SY 2009-2010 it is most likely that the prescription from the physician that the schools have for the recommended service(s) will not have a diagnosis and/or reason/need for the ordered services. However, the written order that the physician maintains in the student's medical record in his office may contain the information listed in question #32 of the Q&A's. Therefore, if the school district were to obtain a copy of these written orders from the physician, can they bill for the services provided in SY 2009-10?

A. If, before the service was provided, an appropriate practitioner had found and contemporaneously recorded that the service was medically necessary and should be provided, and that record can be produced, the documentation requirement for written orders for School Supportive Health Services Program (SSHSP) services would be met.

The following types of documentation that a service was ordered before it was provided (other than a written order that the district has in hand before the service is provided) would be acceptable:

1. An accurately dated (not post-dated) order signed by a prescriber, even though it had not been provided to the district when the service was provided, along with an accompanying signed and dated statement from the ordering practitioner stating that the document's date is accurate and that the document was prepared on that date.

2. A copy of the prescribing/ordering practitioner's contemporaneous record, with an accompanying signed and dated statement from the prescriber that states that the record was, in fact, created on the date indicated in the record.

Evaluations

117. Q. Must a formal evaluation be done every year?

A. New York State Education Department:
Time frames pertaining to Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE) meeting for re-evaluation for special education services as required by special education law and regulation:

Section 200.4 of the Regulations of the Commissioner of Education requires an appropriate re-evaluation not more frequently than once a year unless the parent and representatives of the school district appointed to the CSE/CPSE agree otherwise; and at least once every three years, except where the parent and district agree in writing that such reevaluation is not necessary.

New York State Department of Health - Medicaid requirements:

There is no required re-evaluation schedule for Medicaid covered SSHSP services. However, Medicaid reimbursement may be available for a re-evaluation that focuses on evaluating progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Indications for a re-evaluation include new clinical findings, a significant change in the student condition, or failure to respond to the therapeutic interventions outlined in the individualized education program (IEP).

To be Medicaid reimbursable a re-evaluation must be:

- Medically necessary
- Ordered by a qualified provider
- Completed by a Medicaid qualified provider
- Documented with a written report that details evaluation results
- Included in the student's IEP

*Please note that for speech, occupational, and physical therapy the term "services" is defined to include evaluations and ongoing treatment.

118. Q. How often are evaluations and re-evaluations eligible for Medicaid reimbursement?

A. Medicaid reimbursement is available for evaluations that identify a student's health-related needs as part of the IEP process. Under the Preschool/School Supportive Health Services Program (SSHSP) evaluations must be ordered by qualified providers, performed by appropriately qualified providers, reflected in the student's IEP and documented (a written report must be completed at the end of each evaluation). Medicaid reimbursable evaluations under the SSHSP include speech, occupational therapy and physical therapy evaluations, psychological evaluations, medical evaluations, medical specialist evaluations, and audiological evaluations.

Re-evaluations ordered and performed by qualified providers and reflected in the student's IEP may also be eligible for Medicaid reimbursement. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Indications for a re-evaluation include new clinical findings, a significant change in the student's condition, or failure to respond to the therapeutic interventions outlined in the IEP.

Services

119. Q. Does SSHSP provide reimbursement for an aide for a student? If so how?

A. No, aides are not covered under the SSHS program. School districts, counties, and §4201 schools should explore other avenues such as Medicaid waiver programs through which the needed services may be provided.

120. Q. May a school district bill for administering medications?

A. Yes if the recommendation for "Skilled Nursing Services" is indicated on the IEP and the medication is administered by an RN (or LPN if within the scope of the Nurse Practice Act) and there is contemporaneous documentation of the service. See Q+A # 64-66 on

the Medicaid-in-Education website for additional information regarding Medicaid documentation requirements for medication administration.

121. Q. May a school district bill for emergency first aid?

A. No. Districts may only bill for skilled nursing services that are included in the student's IEP. They may not bill for routine or emergency first aid.

122. Q. How are oxygen treatments billed under the SSHSP?

A. Medicaid reimbursable treatments and procedures include, but are not limited to: continuous/intermittent nasal and oral care, and assessment of oxygen efficacy. Each service must be documented and billing is based on the time spent providing a covered service. Services that do not require continued administration by trained medical personnel are not Medicaid reimbursable. Services considered stand-by in nature are not Medicaid reimbursable.

123. Q. If parents are transporting their child with a disability to a preschool center-based program and being re-reimbursed for mileage, can the county bill Medicaid for special transportation?

A. No. Although State Education Department regulations encourage and allow parents to transport their children at the expense of the county/school district, this is not a Medicaid reimbursable service. According to the SSHSP SPA #09-61, Medicaid reimbursement is available for transportation services rendered by a vendor lawfully authorized to provide transportation services on the date the services are rendered. A parent is not considered a vendor for purposes of obtaining Medicaid reimbursement.

It is important to note that this does not preclude school districts, counties, and §4201 schools from contracting with a parent for transportation of their child when appropriate and/or cost effective. However, Medicaid reimbursement is not available for transportation provided under these circumstances.

Under the Direction of

124. Q. If two separate IEPs are developed for a single preschool/school age child — a 10-month IEP (school year) and a 2-month IEP (extended school year) — must the qualified therapist "see" the student before any Medicaid reimbursable service is provided by the paraprofessional (OTA, PTA)? At the commencement of the 2-month IEP as well as commencement of the 10-month IEP?

A. Yes, for Medicaid reimbursement, the qualified practitioner must see the student at the beginning of treatment. See Question #20 of the Questions and Answers on the Medicaid-in-Education website. "Under the direction of" requires that the qualified practitioner sees the student at the beginning of and periodically during treatment. "At the beginning of treatment" is defined as the beginning of each IEP period.

Documentation

Note: The response to Question #125 was revised August 1, 2011. Deletions are ~~struck through~~ and additions are underlined.

125. Q. How should a practitioner sign their session notes if their name has legally changed (e.g., marriage, divorce, etc.)? Should they use the name on their license or their new legal name?

A. School Supportive Health Services staff consulted with the Office of the Professions, Records and Archives Unit, which indicated that practitioners should always sign their name as it appears on their ~~license~~ registration. Practitioners are required by NYSED to change their name with Office of the Professions (OP) within 30 days of any legal name change (e.g., marriage, divorce, etc.). The name will be changed in the official database and will display immediately on ~~This change will show on the registration certificate and on~~ the website on-line license verification page. A new registration certificate displaying the new name will be mailed to the address on record.

Practitioners are not required to get a new license parchment ~~change the name on their license~~ [11x14 tan document ~~(parchment)~~]. ~~However, the practitioner must use whatever name is on the license when signing documents even if the current registration has a different name.~~

The OP has specific requirements for submitting name/address changes. Practitioners should follow these guidelines and complete/submit the appropriate form(s) to OP found at: http://www.op.nysed.gov/documents/anchange.pdf. The on-line license verification page can be found at http://www.op.nysed.gov/opsearches.htm.

126. Q. We have districts telling us that they have providers that perform multiple procedures during a 30-minute session. Should the provider be recording the same session time for both codes?

A. Clinicians are responsible for contemporaneous documentation of the school supportive health services they furnish to students with disabilities. Such documentation includes recording the start and end times of therapy sessions and a session note. The clinician is also responsible for selecting the Current Procedural Terminology (CPT) code or codes that are consistent with the service(s) provided. In most cases, more than one CPT code cannot be reported for the same time period. An exception to this is CPT codes 97010 – 97028, which may be reported for the same time period as other therapy services at the clinician's discretion. All other codes (timed and untimed) may not be reported for the same time period. It is not necessary to record the specific time in/time out for each CPT code billed for a single therapy session. See Question and Answer #135 for more information.

Note: The response to Question #127 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are underlined.

127. Q. Some municipalities currently require International Classification of Diseases – 9th Revision (ICD-9) code(s) to be listed on the written orders. If this is not required by SED/DOH yet, when will the requirement be implemented?

A. ICD-9 codes are required on Medicaid claims. They are not explicitly required on written orders; however, including a diagnosis ICD-9 code on a written order can supply the reason/need for the service being ordered. Question #32 discusses what written orders must include as of 9/1/09. Changes to the eMedNY system for HIPAA compliance necessitate the use of ICD-9 codes for SSHSP claims effective for dates of service on and after September 1, ~~beginning in~~ 2012. In the interim, there is nothing to prohibit a school district, county or §4201 school from requiring the use of an ICD-9 code.

128. Q. Are scanned images acceptable records for an audit?

A. 18 NYCRR 517.3 requires providers to maintain original records to support Medicaid claims for a period of six years. As long as the scanning system used produces an exact copy of the hard copy record and is subject to reproduction and audit upon request, scanned images are acceptable records. Any electronic imaging of records must result in an exact reproduction of the original (hard copy) record and may be required to be authenticated. In the event the original record is in an electronic format, it must meet all applicable requirements for privacy, security and accessibility.

129. Q. Are electronic signatures acceptable?

A. Yes, electronic signatures are acceptable if adequate security is in place and confidentiality is maintained. The use of an electronic signature has the same validity as a signature affixed by hand. However, providers must be prepared to authenticate or prove that the record was electronically signed by the person authorized to sign the record. An exception to this rule would apply where the applicable statute or regulation specifically requires a hand-written signature. The provider's electronic medical record must have control features, such as pass codes, for electronic signatures.

130. Q. Can Medicaid records be created and/or maintained in an electronic format?

A. Electronic Records are acceptable under the following circumstances:

- The electronic format conforms to the requirements of federal and State laws and regulations;
- The electronic record is the original record and has not been altered or, if altered, shows the original and altered versions, dates of creation, and creator;
- The electronic record is accessible to any auditing agency, which may require a certification that the paper reproduction is an exact copy of the electronic record;
- The content of the record meets the applicable requirements of the Medicaid program found in federal and State (18 NYCRR) regulations to support the claim for payment.

Confidentiality requirements mandated by Health Insurance Portability and Accountability Act (HIPAA) and other statutes are applicable to electronic records. These guidelines do not supersede requirements which mandate the maintenance and retention of records in the form in which they were originally created.

131. Q. Is a fax or photocopy of a written order/referral for a related service valid (with a handwritten signature)?

A. A faxed or photocopy image of a written order/referral is acceptable and the service is Medicaid reimbursable as long as all required elements are included in the order/referral.

See Question and Answer #32 on the Medicaid in Education website for all required elements of a written order.

132. Q. Where can evaluations and re-evaluations be documented on the individualized education program (IEP) to be eligible for Medicaid reimbursement?

A. The State's IEP form includes an Evaluation Results section as a place to document the results of evaluations that were conducted and considered in the development of the student's IEP. The Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE) could document its consideration of the evaluation and assessment results under the four need areas (academic achievement, functional performance and learning characteristics; social development; physical development; and management needs).

133. Q. If a session note is done in ink, may white out be used to make a correction? Or should all errors be lined out and initialed?

A. White out is not permissible when making corrections in session notes or any medical record. If a handwritten note must be corrected, the clinician must put a line through the ~~**material to be deleted from the record**~~ (JK) error and initial it.

Billing and Claiming Guidance

134. Q. Can certified school-based providers use other professional credentials they possess to bill Medicaid for services which they rendered and documented as certified school-based providers?

A. No. Although individuals may hold multiple certifications and/or licenses, they may not decide after the service has been furnished which certification or license to use, nor alter existing session notes. The capacity in which the practitioner delivered the service and documented the actual service that was furnished to the student cannot be altered after the fact. Prospectively, if practitioners meet the provider qualifications specified in SSHSP SPA (#09-61), and deliver and document services in accordance with SPA #09-61, the services can be billed to Medicaid.

For additional information on provider qualifications under the SSHSP, refer to Handout #1 and for information about "under the direction of" and supervision requirements, refer to Handout #2 under the Billing and Claiming tab on the Medicaid-in-Education website.

135. Q. When using untimed CPT codes for physical and occupational therapy services, may providers submit claims for Medicaid reimbursement containing more than one CPT code per encounter (session)?

A. For untimed Current Procedural Terminology (CPT) codes, you may only submit claims for Medicaid reimbursement with more than one CPT code for CPT codes 97010 – 97028 (physical/occupational therapy).

Please refer to Handout #5 - Current Procedural Terminology (CPT) codes, on the NYS Medicaid In Education website. Under Special Rules in Handout #5, for CPT codes 97010 – 97028, footnote #2 applies.
Footnote #2 reads as follows: With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. The only exception involves a "supervised modality" defined by CPT codes

97010-97028, which may be reported for the same fifteen minute time period as other therapy services.

This means that CPT codes 97010 - 97028:

- Are untimed codes and are billed per session - not per unit;
- May be billed in conjunction with other timed or untimed codes and
- Per footnote #2, these codes are defined as supervised modality codes, which may be reported for the same time period as other therapy services provided by the same clinician.

136. Q. If an occupational therapist sees a student for 30 minutes and provides 20 minutes of wheelchair management (Current Procedural Terminology (CPT) code 97542) and 10 minutes of self care/home management training (CPT code 97535), how should this be billed? Is there more than one acceptable way to bill this 30-minute session?

A. The total treatment time equals 30 minutes, so two units may be charged. When it is split unevenly, as in this example, it is acceptable to charge 2 units of the same CPT code or one unit of each CPT code. As always, when submitting claims for Medicaid reimbursement, the service must be:

- Included in the individualized education program (IEP);
- Medically necessary (written order in place prior to service delivery);
- Provided by a Medicaid qualified provider; and
- The session must be documented and reflect delivered services.

Note: The response to Question #137 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are <u>underlined.</u>

137. Q. Under the SSHSP, is there any limitation on the number of therapy sessions that can be billed to Medicaid for a student?

A. Medicaid can be billed for medically necessary services that are provided by Medicaid qualified personnel and documented properly. Related services must be delivered in the manner stated in the student's IEP. Medical necessity is established by the written order/referral. Medicaid reimbursement will be consistent with the frequency and duration of services specified on the written order~~, or if not specified on the written order, with the frequency and intensity documented in the IEP.~~ <u>Either the written order must include the frequency and duration of the service to be furnished or it must adopt — by explicit reference to the IEP — the frequency and duration that will be delivered in accordance with the IEP.</u> See Question and Answer #36 on the Medicaid in Education website for additional information.

138. Q. Can a group and individual session(s) be billed for a student on the same day?

A. Yes, billing for both individual (one-to-one) and group services provided to the same student in the same day is allowed, provided the Current Procedural Terminology (CPT) and Centers for Medicare and Medicaid Services (CMS) rules for individual and group therapy are both met. The Correct Coding Initiative (CCI) edits require the group therapy and the individual therapy to occur in different sessions, timeframes, or separate

encounters that are distinct or independent from each other when billed on the same day.

139. Q. Are there different CPT codes available for evaluations and re-evaluations?

A. The list of available SSHSP CPT codes includes two that are specific to a re-evaluation; 97002 (physical therapy re-evaluation) and 97004 (occupational therapy re-evaluation). Other disciplines (speech, psychology, and audiology) should report the appropriate evaluation code when claiming Medicaid reimbursement for a properly ordered and documented re-evaluation.

140. Q. Can a district bill Medicaid for one unit (15 minutes) of an OT or PT session if the service delivered was more than 15 minutes but less than 30 minutes in duration and the IEP specifies PT or OT services at 2 x 30 minutes per week?

A. No. To be Medicaid reimbursable, the frequency and duration of the service furnished to the student must comply with both the recommendation on the student's IEP (special education policy) and the written order or referral (Medicaid policy).

141. Q. Is Medicaid reimbursement available for a student who receives two 15-minute sessions/ week of speech therapy (per the IEP)?

A. No. Medicaid reimbursement for speech therapy is only available for sessions lasting a minimum of 30 minutes. The Current Procedural Terminology (CPT) code used under SSHSP for speech therapy services is an untimed code for which the Medicaid program has established a minimum session length of 30 minutes. Regardless of eligibility for Medicaid reimbursement, services must be provided as recommended on the student's IEP.

142. Q. How do nurses bill for skilled nursing services?

A. A claim is submitted for each service provided. Claims must contain a Current Procedural Terminology (CPT) code with the appropriate number of units if applicable. Refer to the SSHSP list of CPT codes for more specific information. Services must be medically necessary, included on the IEP, ordered by a Medicaid qualified provider, delivered by a licensed RN or LPN, and documented (per the Nurse Practice Act).

143. Q. If the nurse sees a student 3 times per day, but not a total of 15 minutes each time, does the practitioner accumulate minutes to reach 15 minute increments; or do they bill 3 times per day for 15 minute increments each?

A. The applicable CPT code for skilled nursing services is timed at "up to 15 minutes." Depending on the nature and complexity of the service being provided, a professional nurse may opt to bill one code for each of the three sessions furnished, or to bill a single unit to account for several less complex and less time-consuming encounters occurring in a single calendar day. When multiple visits occur on a single day, the total number of units billed to Medicaid must not exceed the total face-to-face time spent providing skilled nursing services to the student.

144. Q. a) Must all IEPS now describe nursing services as "skilled nursing services" to be Medicaid reimbursable? b) Must the specific nursing service or medication be detailed on the IEP?

A. a) The phrase "Skilled Nursing Services" must be listed on the IEP.
b) The actual procedure need not be detailed in order to maintain the confidentiality of the student's treatment plan and medical records maintained by the school. Ideally, the student should have an Individual Health Care Plan (IHP or IHCP – see question # 145), maintained by the school nurse (RN). The IHCP is fluid and can then be updated by the RN as needed without requiring a CSE meeting. You should not indicate the specific skilled nursing services or medications on the IEP.

145. Q. a) What is an individualized health care plan (IHCP)? b) Who writes the IHCP? c) Must we give the billing clerk (data entry staff) the individualized health care plan in order to bill Medicaid?

A. a) The IHCP is a fluid nursing care plan that generally consists of the demographics of the student followed by the medical information, pertinent provider orders and the nurse's plan of care.
b) Generally, the school nurse (RN) is responsible for the development and implementation of the IHCP. An LPN may not develop or update an IHCP per the nurse practice act.
c) No, only documentation required to bill for services rendered is required for Medicaid billing purposes. The information on the IHCP is fluid and confidential and should remain with the student's other confidential medical records.

146. Q. What CPT codes can be used for skilled nursing services under the School Supportive Health Services Program (SSHSP)?

A. There are two CPT codes for skilled nursing services available for SSHSP billing; T1002 (RN Services, up to 15 minutes), and T1003 (LPN/LVN Services, up to 15 minutes). The list of SSHSP CPT Codes is available on the Medicaid in Education website.

147. Q. Q&A #79, issued on December 13, 2010, clarified that effective 9/1/09 the IEP must list psychological counseling (versus counseling or social work) in order for the psychological counseling services to be Medicaid reimbursable. Is it permissible to amend the IEPs to say "psychological counseling" (assuming the practitioner is qualified, has session notes and has furnished a service for which s/he is willing to assign a CPT code)? Is there a time limit on amending the IEP?

A. Retroactive amendments to the IEP for the purpose of billing Medicaid are not allowed. In order to bill Medicaid for "psychological counseling" services when the IEP did not specify "psychological counseling," the district must demonstrate that the service for which they are seeking reimbursement as "psychological counseling" was intended to and, in fact, does come within the description of psychological services set out in the applicable SPA. If the IEP identifies the specific behavioral and emotional problems, describes them as severe or as requiring treatment and specifies they are to be provided by a service provider type identified in the SPA, it may have identified "psychological counseling" as a service a child required, even though the service was called by a different name (e.g., counseling or social work). If it is not clear from the IEP itself (description of the child's needs, the recommended services, and the long- and short-term goals), that psychological counseling services as defined in either SPA #09-61 or

#92-42 were delivered, school districts may provide additional documentation, described below, to demonstrate that the services furnished met the definition of psychological counseling services under SSHSP.

For retroactive Medicaid claims for both the pre-July 1, 2009 time period and for the 2009-12 school years (through June 30, 2012) districts are afforded the opportunity to provide additional, child-specific documentation* in the student's record as evidence that would demonstrate that the service delivered met the definition of “psychological counseling” services pursuant to SPA #92-42 (pre-July 1, 2009) or to SPA #09-61 (9/1/09 and later).

*The documentation would be a child-specific memo in the child’s file which identifies the specific language in the IEP and that establishes that:

(1) the child has behavioral and emotional problems that are severe enough to require treatment,
(2) the counseling or social work service is a treatment service,
(3) the counseling or social work is provided by a qualified Medicaid provider who meets all relevant requirements (*e.g.*, supervision of LMSW),
(4) what is called "social work" or "counseling" in the IEP is a well established technique that is used to assist in the amelioration of the child's behavioral or emotional problem, and
(5) the goals and activities described in the IEP are within the accepted scope of treatment services provided to help ameliorate behavioral and emotional problems that are severe enough to require treatment.

The child-specific memo can be added to the student’s record after the fact; however, the language in the IEP itself cannot be altered to meet this requirement.

In addition, in order to be Medicaid reimbursable, the psychological counseling services must have been provided by a Medicaid-qualified provider, documented properly, and billed using the appropriate CPT code.

Please note that IEPs developed on or after January 1, 2012 must include the term “psychological counseling” in order for those services to be Medicaid reimbursable.

148. Q. Is Medicaid reimbursement available if frequency/duration of related services is specified per ‘cycle’ rather than per ‘week’?

A. Scheduling of related services on a per cycle basis is acceptable for Medicaid reimbursement purposes.

149. Q. Does a cycle schedule affect Medicaid reimbursement for make-up therapy sessions?

A. In order for a make-up therapy session to be Medicaid reimbursable it must be consistent with the written order/referral (medically necessary) and must:

- Be a service that is documented in the IEP
- Occur within the cycle in which the missed visit occurred
- Be documented (session notes must be kept for each session including made up sessions)
- Be provided by a qualified Medicaid provider

- Fit with the desired treatment outcome

Example:

Refer to **Table 1** for a sample schedule using a six-day cycle. The written order indicates three 30-minute physical therapy sessions per cycle and the student is scheduled for physical therapy on days A, C and E of the six-day cycle per the IEP. The student misses one session due to absence from school. If the session is made up within the same cycle, Medicaid can be billed for all three sessions because only the three sessions have been provided within one cycle. If the missed session is provided in a subsequent cycle Medicaid can only be billed for three of the four sessions provided that cycle because the IEP specified three therapy sessions per cycle, not four.

Table 1: Sample Schedule Using a Six-Day Cycle

January 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 **A** Physical Therapy (#1)	4 **B**	5 **C** Physical Therapy (#2)	6 **D**	7 **E** Physical Therapy (#3)	8
9	10 **F**	11 **A** **Missed** ~~Physical Therapy (#1)~~	12 **B**	13 **C** Physical Therapy (#2)	14 **D** **Make-up** Physical Therapy (#1)	15
16	17 Holiday	18 **E** Physical Therapy (#3)	19 **F**	20 **A** Physical Therapy (#1)	21 **B**	22
23	24 **C** Physical Therapy (#2)	25 **D**	26 **E** Physical Therapy (#3)	27 **F**	28 **A** Physical Therapy (#1)	29
30	31 **B**					

National Provider Identifier (NPI)

150. Q. Please clarify the different NPI numbers that can be included on a Medicaid claim. When will the SSHSP require them?

A. There are three NPI numbers that can be reported on Medicaid claims: the billing provider, the ordering provider and the attending (servicing) provider. At this time, only the billing provider (school district, §4201 school, county) must report their NPI when

submitting SSHSP claims for NYS Medicaid reimbursement. See question and answer #151 – SSHSP claims will require an NPI number for both the billing provider (school districts, §4201 schools, counties) and the servicing provider effective January 2012.

151. Q. NPI number: Must each individual related service provider apply for an NPI number?

A. Licensed servicing providers meeting the definition of health care provider (45 CFR 160.103) must obtain an NPI number if they do not already have one. Certified teachers of the speech and hearing handicapped (TSHH), certified teachers of students with speech and language disabilities (TSSLD), and non-emergency transportation providers do not meet the definition of health care provider and are not eligible for an NPI number.

Although physical therapy assistants, occupational therapy assistants, and licensed master social workers are eligible to obtain an NPI number, only the NPI number of the physical therapist or occupational therapist providing direction ("under the direction of") or the appropriately licensed and registered psychiatrist, psychologist, or licensed clinical social worker providing supervision – who has overall responsibility for the student's medical care and treatment – is reported on the Medicaid claim for SSHSP services. Effective January 2012, SSHSP claims will require the NPI number of the billing provider (school district, §4201 school, county) and the servicing provider, or clinician providing direction or supervision, as appropriate. Additional information will be forthcoming.

152. Q. My question is two-fold: do we as a BOCES need to obtain an NPI that identifies us as an agency that provides Medicaid reimbursable service; and, do each of my providers need to also obtain NPI's for the work that they do under contract with us? Second, do we need either or both only for the limited Early Intervention (EI) that we provide, or do we need it for the K-12 as well?

A. For purposes of the Preschool/School Supportive Health Services Program (SSHSP), the billing provider's NPI (school district, county, §4201 school) is currently used. In January 2012, the NPI of the attending (servicing) provider will also be required. Because you are not the billing provider in this instance, your agency is not required to obtain an NPI number for SSHSP purposes at this time. Questions about the provision of EI services should be directed to the Bureau of Early Intervention at (518) 473-7016 or bei@health.state.ny.us.

153. Q. Should the NPI be reported on the session form if the related service provider has one already?

A. Recording the NPI on the session form is not necessary for Medicaid purposes. Medicaid requires the NPI number on claim forms. However, individual school districts, counties, and §4201 schools may choose to record NPI number on session forms for their own administrative purposes.

Exclusion Lists

154. Q. What are the exclusion lists that should be checked monthly and where can they be found? Is there any way to make checking them more efficient?

A. In addition to the Office of Medicaid Inspector General (OMIG) exclusion list, providers (school districts, counties, and §4201 schools) should check the Office of Inspector General (OIG) exclusion list and the General Services Administration (GSA) exclusion

list. The OMIG exclusion list is accessible on the OMIG Web site (www.omig.ny.gov) on the home page. Once providers have checked the OMIG list once, they can then refer to the 30-day updates to check existing staff members. The OIG list is located at http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp. The GSA list can be found at https://www.epls.gov/.