PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)

MEDICAID-IN-EDUCATION

PROVIDER POLICY AND BILLING HANDBOOK (UPDATE 7)

New York State Education Department

Department of Health

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Section 1 GENERAL INFORMATION

PREFACE

The purpose of this Handbook is to provide information and guidance to those who coordinate and deliver related services and/or other special education programs and services to children with disabilities in the school districts, counties, and §4201 schools and who participate in the New York State Medicaid Program. Throughout this document the term counties includes the City of New York. Handbook #7 includes information to help providers understand Medicaid program requirements and instructions regarding documentation requirements for completing and submitting Medicaid claims.

The information and instructions in Handbook 7 apply to all Medicaid claims for school supportive health services delivered on or after September 1, 2009. Handbook 7 replaces Handbook 6 and incorporates all elements of the interim billing and claiming guidance that is posted on the Medicaid in Education website at:
http://www.oms.nysed.gov/medicaid/

Pertinent policy statements and requirements governing the Medicaid Program have been included in Handbook 7, which will serve as a central reference for updated information. Providers of preschool and school supportive health services are responsible for familiarizing themselves with all Medicaid regulations, policies and procedures currently in effect and as they are issued.

In addition to Handbook 7, primary sources of information about the Preschool/School Supportive Health Services Program, which is administered jointly by the New York State Education Department (SED) and the New York State Department of Health (DOH), are:

- Medicaid Alerts published by SED, which contain information regarding the provision of special education related services eligible for Medicaid reimbursement. Topics of Medicaid Alerts include the State Plan Amendment (SPA) for Preschool/School Supportive Health Services, updates on provider qualifications and updates on billing and claiming. Medicaid Alerts can be found on the Medicaid in Education website at: www.oms.nysed.gov/medicaid

- Medicaid Update, a monthly publication of DOH, which contains information regarding Medicaid programs, policy and billing. The Medicaid Update is **ONLY** available electronically. The newsletter is delivered monthly to your designated e-mail address in a Portable Document Format (PDF). To receive the Medicaid Update electronically, please send your e-mail address to:
  medicaidupdate@health.state.ny.us

  or write to:

  NYS Department of Health
  Office of Health Insurance Programs
  Attention: Kelli Kudlack
  Corning Tower, Room 2029
  Albany, New York 12237

  Past issues of Medicaid Update, organized by month, year and by topic, are available at:
  http://www.health.ny.gov/health_care/medicaid/program/update/main.htm

Section 1 GENERAL INFORMATION

The definitions, provider qualifications and documentation requirements included in this Handbook are for Medicaid reimbursement purposes only and may not correspond exactly to requirements for the provision of special education services as required by Federal and State law and regulations. Regardless of the requirements for Medicaid reimbursement, school districts, counties, and §4201 schools must provide special education services in compliance with Federal and State law and regulations.

MISSION

To assist school districts, counties, and §4201 schools to provide quality healthcare to students with disabilities for certain diagnostic and health support services through accessing Medicaid reimbursement for eligible services and to prevent fraud, abuse, and false billing to the Medicaid Preschool and School Supportive Health Services Program while ensuring compliance with federal and State laws, regulations and guidelines.

HISTORY OF PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)

Traditionally, all costs provided by educational institutions have been funded through educational resources. In 1988, §1903 of subdivision (c) of the Social Security Act (SSA), was added by §411(k)(13)(A) of the Medicare Catastrophic Coverage Act of 1988 (PL 100-360). §1903(c) clarified Congressional intent by stating that nothing in Title XIX of the SSA shall preclude Medicaid coverage of services included in the Individualized Education Program (IEP) of a student with a disability. This paved the way to supplement already allocated state and local educational monies earmarked for such services with Federal Medicaid dollars without impacting the State Medicaid Budget. New York State implemented the Federal Law in 1989 by amending §§368 (d) and (e) of the Social Services Law to authorize the then State Department of Social Services (SDSS) to make payment of Federal Medicaid Assistance (MA) funds for SSHSP services. The Department of Health is now the single state Medicaid agency responsible for oversight of the New York State Medicaid program.

In 2001, the Department of Justice (DOJ) and the Office of the Inspector General (OIG) initiated a federal investigation of a sample of programs in school districts, counties, and New York City as a result of litigation commenced by a whistleblower under the federal False Claims Act. This investigation provided the impetus for a complete audit of New York's School Supportive Health Services program by the OIG. Results of the audit recommended Medicaid disallowances of approximately $1.078 billion, not including interest. In July 2009, the State and New York City entered into an agreement with the federal Centers for Medicare and Medicaid Services (CMS), OIG and DOJ that calls for restitution of approximately $539.75 million by the State and City. Terms of this settlement also include a Compliance Agreement that requires the State to implement a Compliance and Integrity Program to prevent fraud, abuse, and false billing to Medicaid in its Preschool and School Supportive Health Services Program. Under the Compliance Agreement, the State was also required to submit a new State Plan Amendment (SPA) for CMS approval. The SPA details the nature and scope of Medicaid coverage and reimbursement including provider qualifications and encounter-based billing methodology. SPA #09-61 for the Preschool/School Supportive Health Services Program was approved by CMS on April 26, 2010 with a retroactive effective date of September 1, 2009.

Section 1 GENERAL INFORMATION

The Preschool/School Supportive Health Services Program (collectively "SSHSP") was developed jointly by the New York State Department of Education (SED) and the New York State Department of Health (DOH) to help school districts, counties, and §4201 schools obtain Medicaid reimbursement for certain diagnostic and health support services provided to students with disabilities. Specific services provided to school-age students from five years up to 21 years of age and to preschool students ages three to five years may be covered under SSHSP if all Medicaid requirements are met.

Section 2 MEDICAID SERVICES

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES (EPSDT)

School Supportive Health Services (SSHS) are services provided by or through school districts or §4201 schools, and Preschool Supportive Health Services (PSSHS) are provided through counties in the State or New York City to children with disabilities who attend public or State Education Department approved schools or preschools. The services must be:

- Medically necessary and included in a Medicaid covered category in accordance with §1905(a), §1905(r)(5), and/or §1903(c) of the Social Security Act;
- Ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State Law;
- Included in the student's Individualized Education Program (IEP);
- Provided by qualified professionals under contract with or employed by a school district, a §4201 school, or a county in the State or the City of New York;
- Furnished in accordance with all requirements of the State Medicaid Program and other pertinent federal and State laws and regulations including those for provider qualifications, comparability of services, and the amount, duration and scope provisions; and
- Included in the State's Medicaid plan or available under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

A school district, §4201 school, or county in the State or New York City must be enrolled as a Medicaid provider in order to bill Medicaid. **Effective September 1, 2009**, under State Plan Amendment #09-61, the services covered by the SSHSP for Medicaid eligible children under 21 who are eligible for EPSDT services that are medically necessary are included in Table 1.

Table 1 SSHSP MEDICAID REIMBURSABLE SERVICES
Medical Evaluations
Medical Specialist Evaluations
Psychological Evaluations
Audiological Evaluations
Physical Therapy
Occupational Therapy
Speech Therapy
Psychological Counseling
Skilled Nursing
Special Transportation

Section 2 MEDICAID SERVICES

MEDICAID PROVIDERS

For purposes of clarifying the term 'provider,' Medicaid claims can include three 'providers'. These are:

- Ordering provider – the professional who has ordered or recommended services. At this time, this provider's NPI need not be identified on Medicaid claims.

- Attending provider – the clinician who has the overall responsibility for the student's medical care and treatment. In cases where the servicing provider works "under the direction of" or "under the supervision of" a licensed clinician, the directing/supervising clinician is considered the "attending" clinician. Beginning with dates of service on or after January 1, 2012 this provider's NPI will be identified on Medicaid claims. The attending provider's NPI must be identified on the electronic Medicaid claim when the attending provider and the servicing provider are not the same individual.

- Billing provider – the school district, county, or §4201 school. This provider's NPI must be identified on Medicaid claims.

Section 3 CONFIDENTIALITY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires standards to be adopted in two areas;

1) Electronic health-care transactions (include standardizing the manner in which health services are claimed by any entity for any person in receipt of such a service), and

2) Privacy (confidentiality) of all health-related services provided. This involves protection of health information for anyone in receipt of such services.

Because the Central New York Regional Information Center (CNYRIC) submits all Medicaid claim data to the electronic Medicaid system in New York State (eMedNY) for processing **on behalf of school districts, counties, and §4201 schools**, it is a covered entity under this act. The electronic transmission of Medicaid data by CNYRIC is in a HIPAA-compliant format.

For more information about HIPAA please visit the US Department of Health and Human Services website at: http://www.hhs.gov/ocr/privacy/

THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level.

The Family Educational Rights and Privacy Act (FERPA), which is also known as the Buckley Amendment, is more restrictive than HIPAA with respect to the protection of privacy and security of all health related services. Because all school districts, counties, and §4201 schools are required to be in compliance with FERPA, they are also in compliance with HIPAA.

In order to assure compliance with FERPA (and thus with HIPAA), the following minimum procedures must be in place:

- All student data files and information must be protected (e.g., student files are locked or only accessible by appropriate personnel).

- Any student information/files transmitted to other appropriate recipients must also be protected. Information files must be encrypted and password protected.

Section 3 CONFIDENTIALITY

- Student information/files may be faxed to appropriate personnel, but only to secure sites.
- Parental consent is required for the release of any personally identifiable information other than those specifically excluded in 34 CFR §99.31.
- See Procedures for Transmission of Student Specific Information For Medicaid Billing Purposes on page 11 for all communications between school districts, counties, and §4201 schools, and SED/DOH pertaining to student-specific information.

For additional information, you may call 1-800-USA-LEARN (1-800-872-5327) (voice). Individuals who use TDD may call 1-800-437-0833.

Or you may visit the US Department of Education website at:
http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

Or you may contact the Family Policy Compliance Office at the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-8520

Section 3 CONFIDENTIALITY

MEDICAID ELIGIBILITY DISCLOSURE POLICIES

New York State Education Department Policy

Confidentiality requirements mandate parental consent is given to the school districts, counties, and §4201 schools before the identity of a special education student can be released. See page 20 for parental consent requirements.

New York State Department of Health Policy

Schools and preschools may disclose Medicaid eligibility information to their health related services professional staff and providers with whom they contract when such information is necessary to administer the Medicaid State Plan for SSHSP.

Eligibility information provided to school districts, counties, and §4201 schools, therefore, may be shared with staff and other individuals associated with the agency that must provide the documentation required to claim Medicaid reimbursement.

Section 3 CONFIDENTIALITY

PROCEDURES FOR THE TRANSMISSION OF STUDENT SPECIFIC INFORMATION FOR MEDICAID BILLING PURPOSES

To maintain security, all staff handling data with student identifying information, especially while seeking clarification on the processing of claims, must abide by the rules in this section. Staff includes, but is not limited to, employees and contracted staff of school districts, §4201 schools, counties, State agencies, Regional Information Centers (RICs), and other third party vendor staff.

Fax Transmissions

The sender should place the student last name, first name, date of birth and gender on a numbered line. This will allow the receiving staff to provide a response using only the number, without having to repeat the identifying information.

Call the receiver ahead of time to ensure immediate availability to retrieve the document. The intended receiver must provide the sender with a phone number for a fax machine that is located in a secure environment and not open to the general public.

E-Mail Transmissions

E-mail transmissions are permissible only if the data is encrypted and password protected. Information on encryption software is discussed later in this section.

Telephone

The telephone is preferable for small numbers of requests. Leave messages containing identifying data only on voice mail systems that are password protected.

Paper Documents

Printed documents may be mailed but be sure to mail only to a specific individual with the right to know. General addresses, where anyone can open the mail, are not appropriate.

Hand Delivered Files

Files and printed documents with personally identifying information may be hand delivered without encrypting the files. However, the information must be hand delivered to an appropriate individual with the right to know.

Files, Logs, Documentation or any Medium Containing Student Personally Identifiable Information

All files must be maintained in a secure environment which can only be accessed by appropriate staff that requires access to such information to carry out their work responsibilities. Information should not be left unattended. It should be locked or maintained where access would be denied.

Section 3 CONFIDENTIALITY

Encryption Information

School districts, §4201 schools, and counties may continue to use their current encryption software as long as it meets industry standards for security and privacy and is password protected. However, if you do not currently have encryption software you will need to purchase a package in order to meet FERPA requirements for security and privacy regarding the sending or transmitting of personally identifiable student information. SED does not recommend a particular software package or vendor. School districts, §4201 schools, or counties may pursue appropriate options, based on their existing infrastructure and support, and should involve their information technology support staff in deciding which option or software is in their best interest. However, SED requires that any software selected must be compatible with the Pretty Good Privacy (PGP®) software used by SED, DOH and Central New York Regional Information Center (CNYRIC). The website to inquire about the PGP Encryption Software is:
http:/www.symantec.com/business/theme.jsp?themeid=pgp
The PGP version that is most compatible for this purpose is the PGP Desktop 8.0 version. Whatever option you choose or software you use, the recipient of your data must be able to open the file with the password you choose.

File Transfer Protocol (FTP)

If your local RIC offers an electronic FTP to submit or retrieve files, the RIC takes the responsibility for securing the information and the authorization for its use. If interested in submitting or retrieving information using this process, contact your RIC for details and authorization.

Note: HIPAA expressly excludes from HIPAA coverage any information maintained in school district educational records which are subject to the Family Educational Rights and Privacy Act (FERPA). Any questions regarding the above should be addressed to: MedinEd@mail.nysed.gov

Section 4 OTHER AVAILABLE REIMBURSEMENT

USE OF PUBLIC INSURANCE FUNDS FOR STUDENTS WITH DISABILITIES

The purpose of this section is to remind school districts, counties, and §4201 schools of the federal requirements relating to the use of public insurance funds for students with disabilities. Certain students with disabilities in NYS have access to public insurance. Federal regulations establish that a public agency may use a student's Medicaid or other public insurance benefit programs in which a student participates to provide or pay for school supportive health services with the following limitations:

School districts, counties, and §4201 schools cannot:

- Require parents to sign up for or enroll in public insurance programs in order for their child to receive a free appropriate public education (FAPE) under Part B of the Individuals with Disabilities Education Act (IDEA);
- Require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services, but may pay the cost that the parent otherwise would be required to pay; and
- Use a child's benefits under a public insurance program if that use would:
    - Decrease available lifetime coverage or any other insured benefit;
    - Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;
    - Increase premiums or lead to the discontinuation of insurance; or
    - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

The use of Medicaid funds to provide or pay for school supportive health services through New York State's Preschool/School Supportive Health Services Program <u>will not</u>:

- Require parents to incur an out-of pocket expense;
- Decrease a child's Medicaid benefits or available lifetime coverage; or
- Increase premiums or lead to the discontinuation of insurance or a student's eligibility for home and community-based waivers.

Special Note: Section 5 of this Handbook provides detailed information regarding IDEA written parental consent requirements. In addition, parents must be informed that refusal to permit the school district, county, or §4201 school to access public benefits or insurance does not relieve the school district, county, or §4201 school of its responsibility to ensure that all required services are provided to students at no cost to parents.

Additional information regarding the use of public insurance is available at http://www.p12.nysed.gov/specialed/publications/medicaidparentalconsent.htm.
If you have any questions regarding the above requirements, please contact the SED Medicaid Unit at 518-474-7116 or MedinEd@mail.nysed.gov.

Section 4 OTHER AVAILABLE REIMBURSEMENT

THIRD PARTY HEALTH INSURANCE (TPHI)

Preschool/School Supportive Health Service Program (SSHSP) providers do not have to bill a student's third party health insurance before Medicaid can be billed for SSHSP services.

The NYS Office of the Medicaid Inspector General (OMIG) is able to identify students that have third party insurance coverage and pursue recovery of SSHSP Medicaid costs from the insurance carrier.

Preschool/School Supportive Health Services are carved out (not included in) of the Medicaid Managed Care benefit package. This means that SSHS are billed to regular fee-for-service Medicaid for students enrolled in Medicaid Managed Care.

SECTION 504 STUDENTS

Medicaid reimbursement is not available for students receiving services from an Accommodation Plan in accordance with Section 504 of the Rehabilitation Act. Section 504 Accommodation Plans do not meet federal or State requirements for Medicaid reimbursement.

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

SUMMARY OF MEDICAID DOCUMENTATION REQUIREMENTS

In order to submit claims to the Medicaid program for SSHSP services, certain documentation requirements must be met. Some of the requirements listed in this section are solely federal/state education requirements (#1, #5, and #9) and others are both federal and/or State Medicaid/education requirements (#2, #3, #4, #6, #7, and #8). Effective September 1, 2009, billing for SSHS is encounter-based and a session note is required to document each service (session) delivered to an eligible student. Required documentation listed here is explained further in this section. Items #1,#5, and #9 are not explicitly required for Medicaid billing purposes; however, they are required as part of the special education process. Items #2, #3, #4, #6, #7, and #8 are the documentation that must be on file for every student receiving school supportive health services in order to bill Medicaid.

In summary, necessary documentation includes:

1) Referral to the Committee on Special Education (CSE) and/or the Committee on Preschool Special Education (CPSE).[1]

2) The Individualized Education Program (IEP). For Medicaid claiming purposes all school supportive health services to be provided and all evaluations used in the IEP development must be on the student's IEP.

3) Verification of current certification, licensure, and/or registration, as relevant, of clinician providing the service must be available upon request.

4) Provider Agreement and Statement of Reassignment completed by outside contractors, if applicable.

5) Parental Consent for Release of Information.

6) Written Orders/Referrals.

7) "Under the Direction of" or "Under the Supervision of" documentation, if applicable.

8) Documentation of each billable service:

    A. Evaluation report.

    B. Session note.

    C. Medication Administration Record (MAR).

    D. Special transportation logs.

9) Progress notes.

SSHSP document retention requirements are listed at the end of this section.

[1] Per Part 200 of the NYS Regulations of the Commissioner of Education

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

1) REFERRAL TO THE COMMITTEE ON SPECIAL EDUCATION (CSE) AND/OR THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION (CPSE)

§200.4 (a) Referral. A student suspected of having a disability shall be referred in writing to the chairperson of the district's committee on special education or to the building administrator of the school which the student attends or is eligible to attend for an individual evaluation and determination of eligibility for special education programs and services. The school district must initiate a referral and promptly request parental consent to evaluate the student to determine if the student needs special education services and programs if a student has not made adequate progress after an appropriate period of time when provided instruction as described in section 100.2(ii) of this Title.

For additional information, refer to Part 200.4(a) of the Regulations of the Commissioner of Education at: http://www.p12.nysed.gov/specialed//lawsregs/sect2004.htm

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

2) INDIVIDUALIZED EDUCATION PROGRAM (IEP)

The IEP is the cornerstone of the special education process for each individual student with a disability. It is designed to enable a student with a disability to receive a free appropriate public education (FAPE) or to benefit from special education. It is the tool used to document how one student's special needs related to his/her disability will be met within the context of an educational environment. For Medicaid claiming purposes, all school supportive health services, including evaluations, must be documented in the student's IEP.

Each student with a disability must have an IEP in effect by the beginning of each school year. Federal and State laws and regulations specify the information that must be documented in each student's IEP. In NYS, IEPs developed for the 2011-12 school year, and thereafter, must be on a form prescribed by the Commissioner of Education.

An IEP identifies a student's unique needs and how the school will strategically address those needs. IEPs identify how specially designed instruction will be provided in the context of supporting students in the general education curriculum and in reaching the same learning standards as students without disabilities. IEPs guide how the special education resources of a school will be configured to meet the needs of the students with disabilities in that school. IEPs identify how students will be incrementally prepared for adult living. IEPs also provide an important accountability tool for school personnel, students and parents. By measuring students' progress toward goals and objectives, schools should use IEPs to determine if they have appropriately configured how they use their resources to reach the desired outcomes for students with disabilities.

For additional information about IEP development and the required IEP form, refer to the following website: http://www.p12.nysed.gov/specialed/formsnotices/IEP/home.html

In order to be Medicaid reimbursable, SSHSP services must be included in the student's IEP.

3) VERIFICATION OF CURRENT CERTIFICATION, LICENSURE, AND/OR REGISTRATION AS RELEVANT

Providers of SSHSP services are required to meet certain qualifications as defined in the New York State Plan Amendment #09-61 and federal and State laws and regulations. It is the responsibility of Medicaid billing providers (school districts, counties, and §4201 schools) to verify qualifications prior to submitting claims for Medicaid reimbursement.

Verification of practitioner qualifications must be kept on file or be available if requested for audit purposes.

Verification of clinicians' credentials can be done in various ways. Examples include:

- Request that practitioners submit documentation of current New York State certification, licensure and/or registration, as required, on an annual basis.

- Verify license and registration credentials on SED's Office of Profession's website at: http://www.op.nysed.gov/opsearches.htm

- Verification of a teacher's certification can be accessed through SED's Teach Public Inquiry System online at: http://eservices.nysed.gov/teach/certhelp/CpPersonSearchExternal.jsp?trgAction=INQUIRY
  Reminder: Services rendered by certified teachers are not Medicaid reimbursable, with the exception of speech therapy rendered by certified teachers of the speech and hearing handicapped (TSHH) and certified teachers of students with speech and language disabilities (TSSLD) under the direction of a licensed and currently registered Speech Language Pathologist.

Licenses and PTA and OTA certificates are issued by the Office of Professions; all other certificates are issued by the Office of Teaching Initiatives.

4) PROVIDER AGREEMENT AND STATEMENT OF REASSIGNMENT

In order for school districts, counties, and §4201 schools to claim Medicaid reimbursement for services, they must have all private agencies, or service providers with whom they contract (other than a Board of Cooperative Educational Services (BOCES)), sign a Provider Agreement and a Statement of Reassignment. Specifically, if a school district, county, or §4201 school contracts directly for a service such as transportation or speech therapy with an agency or person who is not an employee of the school district, county, §4201 school, or BOCES, that provider must have signed the Provider Agreement and the Statement of Reassignment. An independent agency may be an individual person or a corporation.

The Provider Agreement requires the contractor to "keep any record necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance."

The Statement of Reassignment requires the contractor "to reassign all Medicaid reimbursements to your school district [county, §4201 school] that you contracted with for providing medical services billed under the School Supportive Health Services Program."

A Provider Agreement and Statement of Reassignment are needed from each contracted agency, but not from each individual service provider within the contracted agency. It is recommended that school districts, counties, and §4201 schools review these forms at the time of contract renewal.

The Provider Agreement and the Statement of Reassignment can be found at:
http://www.oms.nysed.gov/medicaid/resources/

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

5) PARENTAL CONSENT FOR RELEASE OF INFORMATION

Medicaid may not be billed for school supportive health services furnished to a student without a separate signed parental consent that meets IDEA and FERPA requirements.

Information on parental consent can be found online at:
http://www.oms.nysed.gov/medicaid/resources/parental_consent.html

6) WRITTEN ORDER/REFERRAL

The written order/written referral (prescription) is the documentation that establishes medical necessity for the related service to be furnished and constitutes medical direction of the ordering professional. In order to bill Medicaid, a written order/written referral is required. Written orders/written referrals must be prospective and must be kept on file. Faxed copies of the written order/referral are acceptable.

The following elements **must** be included on a written order:

- The name of the child for whom the order is written;
- The complete date the order was written and signed;
- The service(s) being ordered. Note: The frequency and duration of the ordered service must be either specified on the order itself or the order can explicitly adopt the frequency and duration of the service in the IEP by reference;
- Ordering provider's contact information (office stamp or preprinted address and telephone number);
- Signature* of a NYS licensed, registered, and/or certified, as relevant, physician, physician assistant, or licensed nurse practitioner acting within his or her scope of practice (for psychological counseling services, this also includes an appropriate school official and for speech therapy services, a NYS licensed and registered speech-language pathologist**);
- The time period for which services are being ordered;
- The ordering practitioner's National Provider Identifier (NPI) or license number; and,
- Patient diagnosis and/or reason/need for ordered service(s).

* Please note that stamped signatures are not allowable.

For purposes of the SSHSP, where **written referrals are permitted (e.g., speech therapy services, psychological counseling services), the written referral must include the information listed above.

It should be noted that the written order/written referral must be in place prior to the initiation of services (prospective), including evaluations.

Life of a Written Order/Referral

A written order/referral is required for Medicaid reimbursement for services included in the IEP. The written order/referral for service(s) must be obtained when the frequency or duration for the service(s) is changed or when an annual review is completed and an IEP is developed.

18 NYCRR 515.2(b)(1)(c) states that an unacceptable practice is conduct which constitutes fraud or abuse and includes submitting, or causing to be submitted, a claim or claims for medical care, services or supplies provided at a frequency or in an amount not medically necessary. This means that SSHSP providers cannot bill Medicaid for services that are in excess of those specified on the written order/referral. If the frequency and duration of the ordered services are not explicitly stated then there is no documentation of the determination of the medically necessary of those services and therefore they cannot be billed to Medicaid.

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

There must be a valid written order/referral annually or whenever there is a change in services for Medicaid to be billed.

For example, a written order, dated 5/5/10, for physical therapy for the time frame of 7/1/10 – 6/30/11 is received by the Committee on Special Education (CSE). On 5/16/10 the CSE met and developed the IEP for the 2010/2011 school year and included physical therapy in the IEP for 3 sessions a week. After the student's most recent physical therapy evaluation (November 2010), the CSE agreed to decrease services to 2 sessions a week. Because this is a change in both the IEP and treatment, a new written order must be obtained in order for Medicaid to be billed.

7) "UNDER THE DIRECTION OF" AND "UNDER THE SUPERVISION OF"

To be Medicaid reimbursable, clinicians furnishing services must possess certain qualifications, including New York State licensure, registration, or certification as appropriate. For SSHSP purposes, the "under the direction of" requirements apply to speech teachers and therapy assistants in physical and occupational therapy as relevant, while the "under the supervision of" requirement applies to licensed master social workers (LMSWs). Licensed practical nurses (LPNs) must be under the direction of a licensed registered professional nurse (RN), physician, or other licensed health care provider authorized under the Nurse Practice Act. "Under the direction of" requirements are different for LPNs, additional information can be found in the SSHSP Questions and Answers that are posted on the Medicaid in Education webpage.

Occupational and physical therapy assistants must have direction from a licensed practitioner in their discipline, while teachers of the speech and hearing handicapped (TSHH) and teachers of students with speech and language disabilities (TSSLD) must receive direction from a licensed speech-language pathologist. Licensed master social workers (LMSWs) must receive supervision from a licensed and registered psychiatrist, psychologist, or licensed clinical social worker (LCSW). Supervision requirements applicable to LMSWs providing SSHSP services are defined by the State Education Department's Office of the Professions and are located at http://www.op.nysed.gov/prof/sw/.

The various professionals that can provide school supportive health services are listed in a table on page 25. Provider qualifications are also summarized in the SSHSP Provider Matrix on pages 36 and 37. Section 6 of this Handbook provides greater detail about the qualifications necessary for clinicians' services to be Medicaid reimbursable.

"Under the direction of" (applies to PTA, OTA, TSHH, and TSSLD) means that the qualified practitioner:

- Sees the student at the beginning of and periodically during treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has input into the type of care provided;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure students are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that providers working under his or her direction have contact information to permit them direct contact with the supervising (directing) therapist as necessary during the course of treatment;
- Keeps documentation supporting the supervision of services (including meetings and observations) and ongoing involvement in the treatment of each student.

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

"Under the supervision of" requirements apply only to licensed master social workers (LMSWs) and are described here.

Supervision of the psychological counseling services provided by the LMSW, with respect to each Medicaid beneficiary (student), shall consist of contact between the LMSW and supervisor during which:

- The LMSW apprises the supervisor of the diagnosis and treatment of each client;
- The LMSW's cases are discussed;
- The supervisor provides the LMSW with oversight and guidance in diagnosing and treating clients;
- The supervisor regularly reviews and evaluates the professional work of the LMSW; and
- The supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision. Effective 12/8/10, changes were made to the LMSW supervision requirements found in section 74.6 of the Regulations of the Commissioner of Education. As of 12/8/10, the supervisor is required to provide at least two hours per month of in-person individual or group clinical supervision.

"UNDER THE DIRECTION OF"/"UNDER THE SUPERVISION OF" CHART

SERVICE	PROVIDER	"Under the Direction Of"/ "Under the Supervision Of"
Speech-Language Services	Speech-Language Pathologist (SLP)	N/A
	Teacher of the Speech and Hearing Handicapped (TSHH)	Under the direction of a Speech-Language Pathologist
	Teacher of Students with Speech and Language Disabilities (TSSLD)	Under the direction of a Speech-Language Pathologist
Physical Therapy	Physical Therapist (PT)	N/A
	Physical Therapy Assistant (PTA)	Under the direction of a Physical Therapist
Occupational Therapy	Occupational Therapist (OT)	N/A
	Occupational Therapy Assistant (OTA)	Under the direction of an Occupational Therapist
Psychological Evaluations	Psychiatrist	N/A
	Psychologist	N/A
Psychological Counseling Services	Psychiatrist	N/A
	Psychologist	N/A
	Licensed Clinical Social Worker (LCSW)	N/A
	Licensed Master Social Worker (LMSW)	Under the supervision of an LCSW, psychiatrist, or psychologist
Skilled Nursing	Registered Professional Nurse (RN)	N/A
	Licensed Practical Nurse (LPN)	Under the direction of a licensed registered professional nurse, physician, or other licensed health care provider authorized under the Nurse Practice Act
Medical Evaluation	Physician	N/A
	Physician Assistant	N/A
	Nurse Practitioner	N/A
Medical Specialist Evaluation	Physician Specialist	N/A
	Physician Assistant	N/A
	Nurse Practitioner	N/A
Audiological Evaluations	Audiologist	N/A

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

8) MEDICAID DOCUMENTATION OF EACH ENCOUNTER

Documentation requirements to support Medicaid claims for therapy sessions, evaluations and re-evaluations, medication administration, and special transportation are described in this section.

A) SESSION NOTES

Service providers must maintain contemporaneous records. Session notes specifically document that the servicing provider delivered certain diagnostic and/or treatment services to a student on a particular date. Session notes must be completed by all qualified providers furnishing the services authorized in a student's IEP for each Medicaid service delivered and must include:

- Student's name
- Specific type of service provided
- Whether the service was provided individually or in a group (specify actual group size)
- The setting in which the service was rendered (school, clinic, other)
- Date and time the service was rendered (length of session – record session start time and end time)
- Brief description of the student's progress made by receiving the service during the session
- Name, title, signature and credentials of the servicing provider and signature/credentials of supervising clinician as appropriate

The duties of the provider are discussed in Social Services regulation at 18 NYCRR §504.3(a). Medicaid providers must prepare and maintain contemporaneous records that demonstrate the provider's right to receive payment under the Medicaid program. "Contemporaneous" records means documentation of the services that have been provided as close to the conclusion of the session as practicable. In addition to preparing contemporaneous records, providers in the Medicaid program are required to keep records necessary to disclose the nature and extent of all services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.

SAMPLE SESSION NOTE – (Includes all Medicaid-required elements)

Student Name: John Smith
Service Type: Speech Therapy
Date: December 10, 2010
Location: Springdale Elementary
Time in/Time out: 10:00am /10:30am
Indiv (I) Group (G) (incl # in group): I
Practitioner Name: Martha Clark
Session Note: During this session John produced initial, medial, and final /l/ with 80% accuracy in words. John is demonstrating good progress. He continues to improve his production of the /l/ in all positions in single words.

Martha Clark, TSHH
Practitioner's signature, title, and credentials

Mary Brown, SLP
Supervising signature and credentials if UDO required

SAMPLE

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

B) EVALUATIONS

Students without an IEP in place (initial evaluation)
An initial evaluation is the evaluation(s) that is done prior to the development of a student's first Individualized Education Program (IEP). The initial evaluation(s) for psychological counseling, physical therapy, occupational therapy, and speech therapy are not Medicaid reimbursable unless an IEP is developed which includes a recommendation for ongoing services in the same therapy type for which the student was evaluated. In addition, all other Medicaid requirements must be met:

- The written order/referral (dated prior to the evaluation) must be on file,
- The evaluation must be provided by a Medicaid qualified provider,
- The evaluation must be documented, and
- The evaluation must be included in the IEP.

A written report must also be completed at the end of each evaluation. 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. Alternatively, 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).

It is important to note that IDEA-driven evaluations are Medicaid reimbursable only for students determined to have a disability.

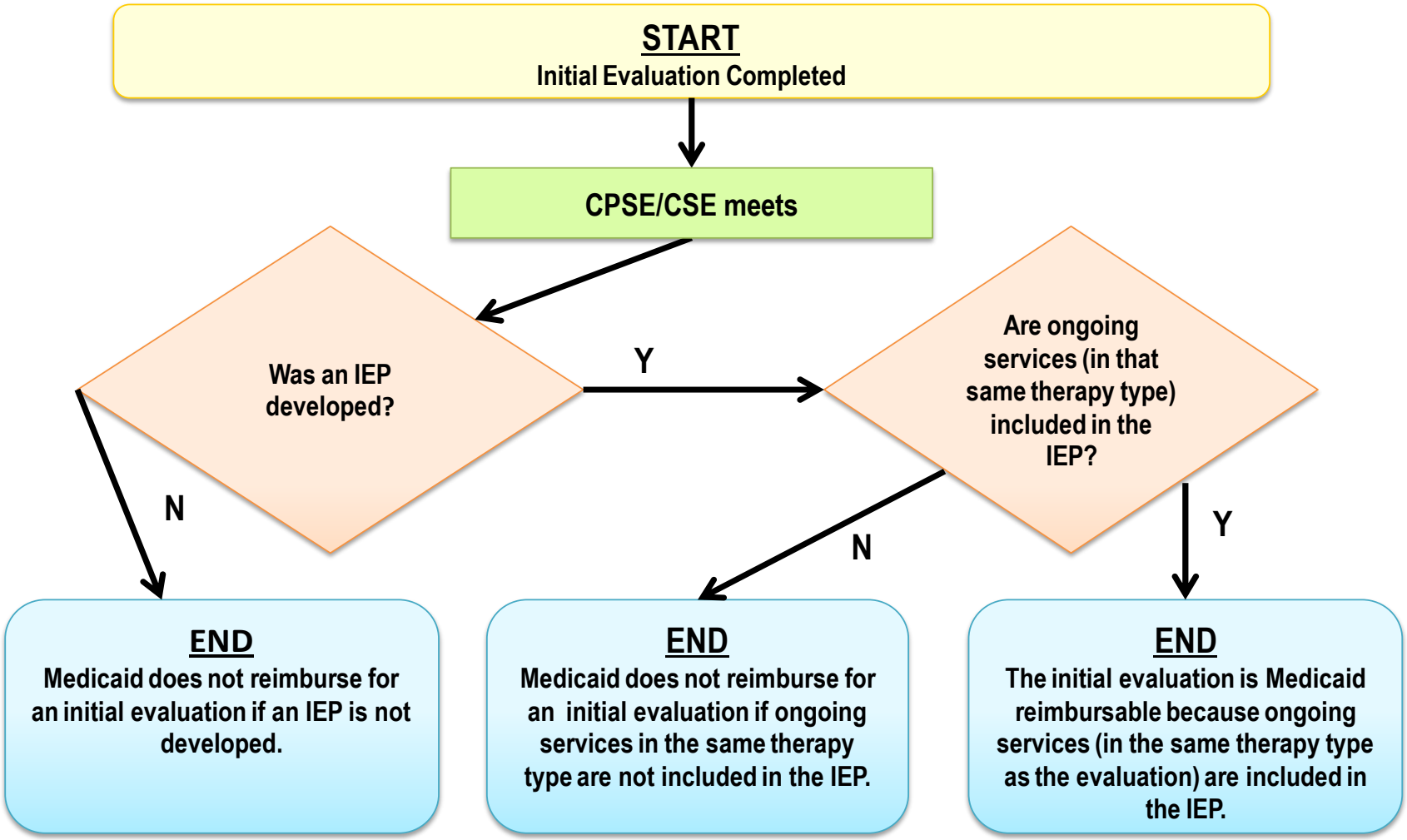
Students with an IEP in place
For students with an existing IEP, all SSHSP evaluations are Medicaid reimbursable regardless of whether ongoing services will be included in the student's IEP or not, as long all Medicaid requirements are met (see above).

RE-EVALUATIONS

A CSE is responsible for arranging an appropriate re-evaluation of a student with a disability. A re-evaluation review must occur at least once every 36 months unless the parent and school district agree in writing that the re-evaluation is not necessary to provide current assessment information for a student in special education. In addition, the CSE/CPSE must arrange for a re-evaluation more frequently if the needs of the student warrant a re-evaluation or if requested by the student's teacher or parent. A re-evaluation cannot be conducted more frequently than once a year unless the parent and school district representative on the CSE agree otherwise.

If an additional re-evaluation to identify a student's health related needs is deemed to be necessary, the re-evaluation is eligible for Medicaid reimbursement once it is conducted and reflected in the student's IEP, regardless of whether or not the services will continue to be included in the student's IEP. The CSE/CPSE must review the results of the re-evaluation and to revise the student's IEP, if appropriate. Re-evaluations are Medicaid reimbursable as long as all Medicaid requirements are met.

PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)
WHEN ARE INITIAL EVALUATIONS MEDICAID REIMBURSABLE?



JANUARY 2012

C) MEDICATION ADMINSTRATION RECORD (MAR)

School nursing personnel should maintain accurate records of the medication administered, any special circumstances related to the procedure, and students reactions/responses. Nursing personnel must maintain an individual daily medication record for each student taking medication during the time frame medication is being given.

The medication log (MAR) must include:

- Student's name and date of birth
- Grade/school
- Medication name, dosage, and route
- Order start date
- Order expiration date
- Prescriber's name/telephone number
- Parent's name/telephone number
- Date, time, and dosage of medication administered
- Signature and title of the person administering medication*

*If services are delivered by an LPN, the MAR does not need to be co-signed by the RN.

Nursing documentation should be accurate, objective, concise, thorough, timely, and well organized. All entries for paper records should be legible and written in ink that can be photocopied easily (black ink is recommended). The date and exact time should be included with each entry. A sample Medication Administration Record (MAR) can be found on pages 30 and 31.

MONTHLY MEDICATION ADMINISTRATION RECORD (P.1OF 2)

Student Name:_____ **DOB:** _____**School/District**_____ **Grade:**_____

Parent/Guardian: _____**tel#**_____ **Physician/NP/PA:** _____**tel#**_____

Medication Order: Medication Name/Dose:_____**Route:**_____

Order start date (MM/DD/YY):_____ **Order expiration date (MM/DD/YY):** _____

			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	
			☐ Out of med. ☐ Absent ☐ Refused ☐ Field trip ☐ Other (see notes)	☐ Adverse (see notes) ☐ Appropriate	

Medication Administration Procedure Codes: T1002 — RN services up to 15 min. or T1003 — LPN services up to 15 min.

SAMPLE

Additional Documentation
Monthly Medication Administration Record (p.2 of 2)

All documentation should include date, time, signature, and title.

SAMPLE

D) SPECIAL TRANSPORTATION LOG

Special transportation recommended by the Committee on Special Education (CSE) and Committee on Preschool Special Education (CPSE) and identified on the students' IEP may be eligible for Medicaid reimbursement. Special transportation can only be billed on a day that a Medicaid reimbursable service (other than transportation) was delivered and may only be billed at the rate for each one-way trip.

Claims for Medicaid reimbursement for special transportation must be supported by the following documentation:

- The IEP must specify the nature (reason/need) of the student's special transportation needs;
- The Medicaid reimbursable services to be delivered to the child must also be included in the child's IEP;
- Session notes for the Medicaid reimbursable service (other than transportation) delivered to the student.

The **bus/transportation log** must include:

- The student's name;
- Both the origination of the trip and time of pickup;
- Both the destination of the trip and time of drop off;
- Bus number or the vehicle license plate number; and,
- The full printed name of the driver providing the transportation.

The full address of each origination and destination must be documented. However, this does not necessarily have to be recorded on each daily transportation log. For example, in a situation when routine special transportation services are provided from the student's home to the school it is sufficient to use the terms 'home' and 'school' on the daily log and to document the full street addresses separately in the student's record.

It is acceptable for the transportation log to indicate the actual time the first student was picked up and the actual time the last student was dropped off. For example, when the same bus is transporting the same students from their homes to the school in the morning the transportation log could indicate the time and place the first student is picked up and the time and place all the students are dropped off. The bus manifest and/or schedule may serve as documentation of the pickup locations and times in between the first pick up and the last drop off.

It is not necessary for the provider to create a separate special transportation log for each Medicaid eligible student.

These items are considered unacceptable documentation of a trip: a driver or vehicle manifest, or dispatch sheet; an issuance of prior authorization by the authorizing agent with subsequent checkmarks on a prior authorization roster; or an attendance log from the school or program.

9) PROGRESS NOTES

Quarterly progress notes are an IDEA requirement. Although they are not required for Medicaid reimbursement, practitioners must complete quarterly progress notes to fulfill documentation requirements under IDEA. This information is included here for convenience and to differentiate this requirement from the Medicaid program requirement for encounter-based contemporaneous session notes. Progress notes are completed, at a minimum quarterly, by the service provider and must include the progress the student is making towards his/her goals as indicated in the student's IEP.

Appearance

The notes should address the goals set in the IEP and should describe how the student is reaching those goals. Progress notes containing one or two word phrases do not adequately describe a student's progress.

Frequency

Progress notes are required, under IDEA and Part 200 of the Commissioner's Regulations, to be provided to parents at the time specified in the IEP. An annual review that contains progress notes by appropriate providers qualifies as one progress note.

Report of Progress

The IEP must identify when periodic reports on the progress the student is making toward the annual goals will be provided to the student's parents (such as through the use of quarterly or other periodic reports that are concurrent with the issuance of report cards).

Section 5 SSHSP DOCUMENTATION REQUIREMENTS

DOCUMENTATION RETENTION POLICY

Section 517.3(b) of Title 18 NYCRR regulates audit and record retention for the NYS Medicaid program. As this section indicates, providers must retain records for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. The full text is included here for convenience:

18 NYCRR 517.3(b)(1)... **All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.**

In addition, student cumulative health records, which include treatment records, are to be kept until the student reaches the age of 27. The document recording records retention can be found at: http://www.archives.nysed.gov/a/records/mr_pub_ed1.pdf

Individual professions may have other documentation and record retention requirements in addition to the Medicaid program and education requirements noted. Clinicians can access discipline-specific record retention requirements on the Office of Professions website.

Section 6 MEDICAID COVERED SERVICES

COVERED SERVICES

Included in the section of **covered services** are definitions, provider qualifications, and documentation requirements that are necessary to claim Medicaid reimbursement for the provision of certain diagnostic and health related support services provided to students with disabilities.

- Medical Evaluation
- Medical Specialist Evaluation
- Psychological Evaluation
- Audiological Evaluation
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Psychological Counseling
- Skilled Nursing
- Special Transportation

Note: These definitions, provider qualifications and documentation requirements are for Medicaid reimbursement purposes and may not correspond exactly to criteria for the provision of special education services as required by IDEA. School districts, counties, and §4201 schools must also be in compliance with the provisions of IDEA.

PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)
PROVIDER QUALIFICATIONS AND DOCUMENTATION REQUIREMENTS

NOTE: To be Medicaid reimbursable a service must be: supported by a valid written order/referral and delivered by an approved Medicaid service provider[1] acting within his/her scope of practice; the encounter must be documented to support Medicaid claims; and it must be included in the IEP. Supporting documentation must be retained for a minimum of six (6) years from the date the service was furnished or billed, whichever is later.

SERVICES[2]	ORDERING/REFERRING REQUIREMENTS FOR MEDICAID REIMBURSEMENT	APPROVED MEDICAID SERVICE PROVIDER	DOCUMENTATION REQUIRED FOR EACH ENCOUNTER FOR MEDICAID BILLING PURPOSES
Speech Therapy	Signed/dated written order or referral from a physician, physician assistant, nurse practitioner or speech-language pathologist (SLP) who is currently licensed, registered and/or certified as required Written order/written referral included in student's record	Currently licensed and registered SLP or a certified teacher of the speech and hearing handicapped (TSHH)/certified teacher of students with speech and language disabilities (TSSLD) operating under the direction of a licensed and registered SLP	Evaluation: Report[3] Ongoing Therapy: Contemporaneous Session Notes[4]
Physical Therapy	Signed/dated written order from a physician, physician assistant, or nurse practitioner who is currently licensed, registered and/or certified as required Written order included in student's record	Currently licensed and registered physical therapist[5] or a certified physical therapy assistant (PTA) operating under the direction of a licensed and registered physical therapist[5]	Evaluation: Report[3] Ongoing Therapy: Contemporaneous Session Notes[4]
Occupational Therapy	Signed/dated written order from a physician, physician assistant, or nurse practitioner who is currently licensed, registered and/or certified as required Written order included in student's record	Currently licensed and registered occupational therapist or a certified occupational therapy assistant (OTA) operating under the direction of a licensed and registered occupational therapist	Evaluation: Report[3] Ongoing Therapy: Contemporaneous Session Notes[4]
Psychological Counseling	Referral by an appropriate school official, such as a school administrator or the chairperson of the CSE/CPSE or other licensed practitioner acting within his/her scope of practice Referral included in the student's record	Currently licensed and registered psychiatrist, psychologist, licensed clinical social worker (LCSW) or licensed master social worker (LMSW) operating under the supervision of a licensed and registered psychiatrist, psychologist or LCSW	Ongoing Therapy: Contemporaneous Session Notes[4]
Skilled Nursing	Signed/dated written order from a physician, physician assistant, or nurse practitioner who is currently licensed, registered and/or certified as required Written order included in student's record	Currently licensed and registered professional nurse (RN) or currently licensed and registered practical nurse(LPN) under the direction of an RN, a physician, or other licensed and registered health care provider in accordance with the Nurse Practice Act	Medication Administration: Medication Administration Record (MAR) Other Services: Contemporaneous Session Notes[4]

Section 6 MEDICAID COVERED SERVICES

NOTE: To be Medicaid reimbursable a service must be: supported by a valid written order/referral and delivered by an approved Medicaid service provider[1] acting within his/her scope of practice; the encounter must be documented to support Medicaid claims; and it must be included in the IEP. Supporting documentation must be retained for a minimum of six (6) years from the date the service was furnished or billed, whichever is later.

SERVICES[2]	ORDERING/REFERRING REQUIREMENTSFOR MEDICAID REIMBURSEMENT	APPROVED MEDICAID SERVICE PROVIDER	DOCUMENTATION REQUIRED FOR EACH ENCOUNTER FOR MEDICAID BILLING PURPOSES
Psychological Evaluation	Referral by an appropriate school official, other official, or other licensed practitioner acting within his/her scope of practice Referral included in the student's record	Currently licensed and registered psychiatrist or psychologist	Evaluation: Report[3]
Medical Evaluation	Referral by CSE/CPSE documented as part of the IEP process	Physician, physician assistant or a nurse practitioner who is currently licensed, registered and/or certified as required	Evaluation: Report[3]
Medical Specialist Evaluation	Signed/dated written order from a physician, physician assistant or nurse practitioner who is currently licensed, registered, and/or certified as required Written order included in student's record	Physician, physician assistant or a nurse practitioner who is currently licensed, registered and/or certified as required	Evaluation: Report[3]
Audiological Evaluation	Signed/dated written order from a physician, physician assistant or nurse practitioner who is currently licensed, registered, and/or certified as required Written order included in student's record	Currently licensed and registered audiologist having a certificate of clinical competence (CCC) from the American Speech-Language-Hearing Association (ASHA)	Evaluation: Report[3]
Special Transportation	CSE or CPSE must identify special transportation needs; must be indicated on the IEP; and billed only on a day that a Medicaid reimbursable service (other than transportation) was delivered, at the rate for each one-way trip	A vendor lawfully authorized to provide transportation services on the date the services are rendered	Transportation logs must be maintained for each one-way trip. Documented other Medicaid reimbursable service on the same day.

[1] Provider licenses, registrations and certifications must be on file prior to submitting claims for Medicaid reimbursement.
[2] "Services" include evaluations, therapy sessions, medication administration and other skilled nursing services, and special transportation.
[3] If the evaluation is used to identify a student's health related needs, it must be reflected in the IEP in order to be Medicaid reimbursable.
[4] Contemporaneous Session Notes: Providers must prepare and maintain contemporaneous records that demonstrate the provider's right to receive payment under the Medicaid program [18 NYCRR Section 504.3(a)]. "Contemporaneous" means as close to the conclusion of the session as practicable.
[5] Having graduated from a Commission on Accreditation in Physical Therapy Education (CAPTE) approved program.

Section 6 MEDICAID COVERED SERVICES

MEDICAL EVALUATION

Definition

A medical evaluation is the recording of chief complaints; present illness; family history; past medical history; personal history and social history; a system review; a complete physical evaluation; the ordering of appropriate diagnostic tests and procedures; and a recommended plan of treatment.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- A referral by the CPSE or CSE documented as part of the IEP process.

A referral for Medicaid reimbursement purposes in this instance is not a written referral separate from the IEP, but rather the Committee's recommendation that a medical evaluation be conducted. The evaluation must be documented in the IEP.

Providers must be Medicaid qualified.

- NYS licensed and currently registered physician,
- NYS currently certified and registered physician assistant, or
- NYS licensed and currently registered nurse practitioner

Medicaid providers must be qualified in accordance with 42 CFR §§440.50(a), 440.60(a), and /or 440.166(a) and other applicable federal and State laws and regulations acting within their scope of practice under New York State law.

The encounter must be documented.

- Signed and dated medical evaluation or examination report must be available.

The evaluation must be included in the IEP.

- The Medical Evaluation must be reflected in the IEP.

In the "Present Levels of Performance" section of SED's required IEP form, there is an Evaluation Results section. Results of evaluations that were conducted could be documented in this section.

MEDICAL SPECIALIST EVALUATION

Definition

A Medical Specialist Evaluation is an examination of the affected bodily area or organ system and other symptomatic or related organ systems; the ordering of appropriate diagnostic tests and procedures; the reviewing of the results and reporting on the tests and procedures; and, the reporting of findings, including test results and recommendations.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner.

Providers must be Medicaid qualified.

- NYS licensed and currently registered physician specialist,
- NYS currently certified and registered physician assistant specialist, or
- NYS licensed and currently registered nurse practitioner specialist

A Medicaid qualified specialist is a medical specialist practicing in the related area of specialization within his or her scope of practice under New York State law in accordance with 42 CFR §§440.50(a), 440.60(a), and/or 440.166(a) and other applicable federal and State laws and regulations.

The encounter must be documented.

- Signed and dated medical specialist evaluation or examination report must be available.

The evaluation must be included in the IEP.

- The Medical Specialist Evaluation must be reflected in the IEP.

In the "Present Levels of Performance" section of SED's required IEP form, there is an Evaluation Results section. Results of evaluations that were conducted could be documented in this section.

PSYCHOLOGICAL EVALUATION

Definition

Psychological evaluations include but are not limited to: administering psychological tests and other assessment procedures; interpreting testing and assessment results; and evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological health or related services.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order or referral from a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner; or an appropriate school official or other voluntary health or social agency.

An order/referral in this instance is not a written order/referral separate from the IEP, but rather the recommendation that a psychological evaluation be conducted. The evaluation must be documented in the IEP.

Providers must be Medicaid qualified.

- NYS licensed and currently registered psychiatrist, or
- NYS licensed and currently registered psychologist

Medicaid providers must be qualified in accordance with 42 CFR §440.60 or 42 CFR §440.50(a) and other applicable federal and State laws and regulations acting within their scope of practice under New York State law. Psychological evaluation services may only be provided by a professional whose credentials are equivalent to those of providers who are able to provide psychological evaluation services in the community.

The encounter must be documented.

- Signed and dated psychological evaluation report must be available.

The evaluation must be included in the IEP.

- The psychological evaluation must be reflected in the IEP.

In the "Present Levels of Performance" section of SED's required IEP form, there is an Evaluation Results section. Results of evaluations that were conducted could be documented in this section.

AUDIOLOGICAL EVALUATION

Definition

An audiological evaluation is the determination of the range, nature and degree of hearing loss including: measuring hearing acuity, tests relating to air and bone conduction, speech reception threshold and speech discrimination and other hearing evaluation tests as appropriate including conformity evaluations and pure tone audiometry, and, the reporting of findings, including test results and recommendations.

Medically necessary audiology services include but are not limited to: identification of children with hearing loss; determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing loss; and determination of the child's need for amplification.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner.

Providers must be Medicaid qualified.

- NYS licensed and currently registered audiologist with a certificate of clinical competence (CCC) from the American Speech-Language-Hearing Association (ASHA)

Medicaid providers must be qualified in accordance with 42 CFR §440.60(a) and 42 CFR §440.110(c)(3) and other applicable federal and State laws or regulations, acting within their scope of practice under New York State law.

The encounter must be documented.

- Signed and dated audiological evaluation or examination report must be available.

The evaluation must be included in the IEP.

- The audiological evaluation must be reflected in the IEP.

In the "Present Levels of Performance" section of SED's required IEP form, there is an Evaluation Results section. Results of evaluations that were conducted could be documented in this section.

PHYSICAL THERAPY

Definition

Physical therapy services include but are not limited to:

- Identification of children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to: heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices; and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical, and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

The term "services" is defined as including both evaluations and ongoing therapy. Physical therapy services may be provided in an individual or group setting.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner.

Providers must be Medicaid qualified.

- NYS licensed and currently registered physical therapist, or
- NYS certified physical therapy assistant "under the direction of" a qualified NYS licensed and currently registered physical therapist.

Medicaid providers must be qualified in accordance with the requirements of 42 CFR §440.110(a) and with applicable federal and State laws and regulations, acting within their scope of practice under New York State law; and having graduated from a Commission on Accreditation in Physical Therapy Education (CAPTE) approved program.

The encounter must be documented.

- Evaluation: Signed and dated physical therapy evaluation report must be available.
- Ongoing Therapy: Contemporaneous session note for each encounter.

The service must be included in the IEP.

OCCUPATIONAL THERAPY

Definition

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention, initial or further impairment or loss of function; and
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximal physical and mental functioning of the student in daily life tasks.

The term "services" is defined as including both evaluations and ongoing therapy. Occupational therapy services may be provided in an individual or group setting.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required**:** physician, physician assistant, or nurse practitioner.

Providers must be Medicaid qualified.

- NYS licensed and currently registered occupational therapist; or
- NYS certified occupational therapy assistant (OTA) "under the direction of" a qualified licensed and currently registered occupational therapist

Medicaid providers must be qualified in accordance with the requirements of 42 CFR §440.110(b) and with applicable federal and State laws and regulations, acting within their scope of practice under New York State law.

The encounter must be documented.

- Evaluation: Signed and dated occupational therapy evaluation report must be available.
- Ongoing Therapy: Contemporaneous session note for each encounter.

The service must be included in the IEP.

SPEECH THERAPY

Definition

Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders;
- Evaluation and application of principles, methods and procedures of measurement, prediction diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to the development of disorders of speech, voice, and/or language, and
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

The term "services" is defined as including both evaluations and ongoing therapy. Speech therapy services may be provided in an individual or group setting.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner; or
- Written referral that is signed and dated by a NYS licensed and currently registered speech-language pathologist.

Providers must be Medicaid qualified.

- NYS licensed and currently NYS registered speech-language pathologist;
- Teacher of the speech and hearing handicapped (TSHH) or teacher of students with speech and language disabilities (TSSLD) certified to provide speech therapy services "under the direction of" a qualified NYS licensed and currently registered speech-language pathologist.

Medicaid providers must be qualified in accordance with the requirements of 42 CFR §440.110(c) and applicable federal and State laws and regulations acting within their scope of practice under NYS law.

The encounter must be documented.

- Evaluation: Signed and dated speech therapy evaluation report must be available.
- Ongoing Therapy: Contemporaneous session note for each encounter.

The service must be included in the IEP.

PSYCHOLOGICAL COUNSELING

Definition

Psychological counseling services include treatment using a variety of techniques to assist the child in amelioration of behavioral and emotional problems that are severe enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- A written order/referral from a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner; or a written referral from an appropriate school official or other voluntary health or social agency.

A referral in this instance is not a written referral separate from the IEP, but rather the recommendation that psychological counseling be provided. This means that recommended psychological counseling services must be documented in the IEP.

Providers must be Medicaid qualified.

- NYS licensed and currently registered psychiatrist,
- NYS licensed and currently registered psychologist,
- NYS licensed clinical social worker (LCSW), or
- NYS licensed master social worker (LMSW), "under the supervision of" a NYS licensed clinical social worker (LCSW), a NYS licensed and currently registered psychologist, or a NYS licensed and currently registered psychiatrist

Medicaid providers must be qualified in accordance with the requirements of 42 CFR §§440.60(a) or 440.50(a) (2) and applicable federal and State laws and regulations acting within their scope of practice under New York State law.

Psychological counseling services may only be billed to Medicaid if provided by a professional whose credentials are comparable to those of providers who are able to furnish psychological counseling services in the community.

The encounter must be documented.

- Contemporaneous session note for each encounter.

The service must be included in the IEP.

Section 6 MEDICAID COVERED SERVICES

SKILLED NURSING

Definition

Skilled nursing services include but are not limited to:

- Health assessments and evaluations;
- Medical treatments and procedures;
- Administering and/or monitoring medication needed by the student during school hours; and
- Consultation with licensed physicians, parents and staff regarding the effects of the medication.

Skilled nursing services eligible for Medicaid reimbursement only include those services listed on the student's IEP, i.e., the medically necessary services the student requires to remain in school in order to benefit from special education services. Medicaid reimbursement is available only for skilled nursing services that are episodic in nature, rather than full-day 1:1 nursing.

An individualized health care plan (IHCP) developed by a registered professional nurse (RN), is a plan of nursing care for a child with health needs. It is not required by law, but is customarily used in nursing practice and is recommended for all students with special health care needs.

Treatments and procedures include, but are not limited to:	
Feeding	Initiating gastrostomy tube or nasogastric tube feeding, bolos tube feeding and flushes, stoma care and dressing changes, feeding students with feeding difficulties such as choking
Ostomies	Ostomy care, and ostomy irrigation
Respiratory	Performing postural drainage and percussion, oral-pharyngeal, nasal, and endo-trachial suctioning, nebulizer treatment administration, ventilator care, tracheostomy care and suctioning, tracheostomy tube change/reinsertion, respiratory assessments
Initiating, discontinuing, and monitoring oxygen administration	Continuous/intermittent nasal and oral care, assessment of oxygen efficacy
Catheterization	Insertion of indwelling catheter, assessing and monitoring intake/output, intermittent catheterization, external care of indwelling catheter, and catheter irrigation
Medications	Administering medications via oral, gastrostomy or nasogastric tube or other indwelling lines, intramusclular (IM), (sub cutaneous), intravenous (IV) & parenteral nutrition (IV), topical, ocular, ear canal, rectal, vaginal, or respiratory routes. Assessing for medication side effects and efficacy.

Treatments and procedures include, but are not limited to:	
Medical Support System	Monitoring intravenous (IV) fluid administration and site care, initiating IV line and reinserting prn, assessing shunt functioning, central line care including dressing change and emergency intervention, insulin pump care, emergency care of student (including but not limited to: seizures, choking, respiratory and cardiac arrest, status asthmaticus, and anaphylaxis.)
Specimen Collecting	Venous or arterial blood draws; blood glucose monitoring and urine glucose monitoring; wound, stool or urine sample collection
Other Nursing Procedures	Collecting and assessing vital signs, applying sterile dressings, prevention and care of decubitus ulcers, cool and warm applications, and special skin care assessment cast care, skin assessment of incontinent student, medical aspects of bowel and bladder training programs
Health Assessment	Collecting, documenting, assessing and evaluating a student's health information to determine the student's state of health. Evaluating patterns of functioning and need for health services, counseling and education. This includes assessing the student's current health status and on an as needed basis, reviewing medical diagnoses, treatments, or orders and requesting clarification or a change in a licensed health prescriber's order as necessary. Creating, implementing and evaluating nursing care plans. Collaborating with other disciplines on a student's health needs.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- Written order that is signed and dated by a NYS licensed and currently registered and/or certified, as required: physician, physician assistant, or nurse practitioner.

Providers must be Medicaid qualified.

- NYS licensed and currently registered professional nurse, or
- NYS licensed and currently registered practical nurse under the direction of a NYS licensed and currently registered professional nurse, physician, physician assistant, dentist or other licensed health care provider legally authorized under the Nurse Practice Act

Medicaid providers must be qualified in accordance with the requirements of 42 CFR §440.60(a) and other applicable federal and State laws and regulations acting within their scope of practice or a New York State licensed practical nurse qualified in accordance with 42 CFR §440.60(a) and other applicable federal and State laws or regulations acting within his or her scope of practice "under the direction" of a licensed registered professional nurse, or

licensed physician, dentist, or other licensed health care provider authorized under the Nurse Practice Act.

The encounter must be documented.

- Medication administration: Medication Administration Record (MAR)
- Skilled nursing services: Contemporaneous session note for each encounter.

Note: If services are provided by an LPN, the MAR or session note does not need to be co-signed by an RN.

The service must be included in the IEP.

SPECIAL TRANSPORTATION

Definition

Special transportation is provided when a student requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR §300.34(c)(16)(iii). Special transportation is limited to those situations where the student receives transportation to obtain a Medicaid-covered service (other than transportation), or returns from a Medicaid-covered service.

Documentation needed for Medicaid reimbursement:

Medical necessity must be documented.

- The Committee on Special Education (CSE) or the Committee on Preschool Special Education (CPSE) is responsible for determining whether a student's disability prevents him or her from using the same transportation provided to a student without a disability, or getting to school in the same manner as a student without a disability. For additional information please refer to the March 2005 memo entitled, "Special Transportation for Students with Disabilities," from Rebecca Cort. This can be viewed at: http://www.oms.nysed.gov/medicaid/services/transportation/Cort_Special_Transportation.pdf

Providers are Medicaid qualified.

- Special transportation services must be provided by a vendor who is legally authorized to provide transportation services on the date the services are rendered.

The encounter must be documented.

- Bus/transportation log for each one-way trip:
  - Student's name;
  - Both the origination and time of pick up for each trip;
  - Both the destination and time of drop off for each trip;
  - Bus number or vehicle license plate number; and,
  - The full printed name of the driver providing the transportation.

It is acceptable for the transportation log to indicate the actual time the first student was picked up and the actual time the last student was dropped off. For example, when the same bus is transporting the same students from their homes to the school in the morning the transportation log could indicate the time and place the first student is picked up and the time and place all the students are dropped off. The bus manifest and/or schedule may serve as documentation of the pickup locations and times in between the first pick up and the last drop off.

It is not necessary for the provider to create a separate special transportation log for each Medicaid eligible student.

These items are considered unacceptable documentation of a trip: a driver or vehicle manifest, or dispatch sheet; an issuance of prior authorization by the authorizing agent with subsequent checkmarks on a prior authorization roster; or an attendance log from the school or program.

The service must be included in the IEP.

- The IEP must include specific transportation recommendations to address each of the student's needs, as appropriate. It is **not** appropriate for the IEP to simply indicate, "special transportation needed," without including the nature (reason/need) of the special transportation.

Section 7 MEDICAID CLAIMING PROCESS

MEDICAID BILLING PROVIDER REQUIREMENTS

In order to bill for Medicaid eligible services and evaluations, the following conditions must be met:

- The school district/county/§4201 school must be an approved /enrolled Medicaid provider;
- The school district/county/§4201 school must have a National Provider Identifier (NPI);
- Beginning with dates of service on and after 1/1/12, the attending provider must have a National Provider Identifier (NPI);
- The student must be eligible for Medicaid (have an eligible Client Identification Number (CIN));
- The school district/county/§4201 school must obtain parental consent to bill Medicaid (in accordance with IDEA) prior to billing Medicaid;
- The school district/county/§4201 school must incur a cost for the service and/or evaluation (i.e., the school district/county/§4201 school must not bill Medicaid for a service and/or evaluation that is paid partially or in full by Federal funds);
- Provider Agreements and Statement of Reassignments must be completed by outside contractors other than BOCES; and
- Medicaid billing providers must ensure that each service or evaluation is:
    - Medically necessary;
    - Documented (evaluation report, session note, MAR, or transportation log);
    - Provided by a Medicaid-qualified provider; and
    - Included in the IEP.

Section 7 MEDICAID CLAIMING PROCESS

SSHSP BILLING/CLAIMING GUIDANCE

I. Documentation necessary to bill Medicaid (kept on file)
- Provider Information:
  - Certification/Licensure of all servicing/attending providers (see Provider Qualifications and Documentation Requirements on pages 36 and 37)
  - "Under the Direction of" (UDO) documentation, if applicable (see UDO explanation/requirements on pages 23-24)
  - Provider Agreement and Statement of Reassignment (completed by outside contractors)
- Student Information:
  - Medicaid-eligible student
  - Referral to the CSE/CPSE
  - Individualized Education Program (IEP)
  - Parental consent to bill Medicaid
  - Referrals or written orders for services as required
  - Special Transportation (medical need must be documented in IEP)

II. Provision of Service:
- Service must be medically necessary and
  - Documented in IEP
  - Ordered/referred by a practitioner acting within his/her scope of practice
  - Provided by a Medicaid qualified provider
  - Provided "Under the Direction of" (UDO) or "Under the Supervision of" as applicable

III. Each encounter must have the following documentation:
- Student's name
- Specific type of service provided
- Whether the service was provided individually or in a group (include actual # in group)
- The setting in which the service was rendered (school, clinic, other)
- Date and time the service was rendered (length of session; record start and end times)
- Brief description of the student's progress made by receiving the service during the session
- Name, title, signature, and credentials of the person furnishing the service and signature/credentials of directing/supervising clinician as appropriate

IV. For claims with date of service 6/30/09 and earlier:
- Supporting documentation from Sections I and II is required
- Supporting documentation from Section III is required for the applicable minimum visits per month as required by Medicaid (e.g., two documented speech therapy sessions per month)
- Select applicable monthly rate code
- Transmit to billing agent

V. For claims with date of service 9/1/09 and later:
- Supporting documentation from Sections I, II and III is required
- Provider who furnished the service documents Current Procedural Terminology (CPT) code(s) (**see Appendix A for SSHSP CPT codes**) and an appropriate ICD-9 code for to each encounter
- Attending provider NPI identified
- Transmit to billing agent

Section 7 MEDICAID CLAIMING PROCESS

Date of Service	Documentation Requirements	Process
Pre-July 1, 2009	• Provider Agreement and Statement of Reassignment • Referral to CSE/CPSE and the consent for release of information • Provider Qualifications (current license, certification and/or registration) • Documentation of "under the direction of" or "under the supervision of" if appropriate • Written orders/written referrals (establishes medical necessity) • All services must be included in the IEP to be Medicaid reimbursable • Special transportation needs if applicable • **Documentation requirements: (evaluation report, transportation log, medication records or a minimum of two contemporaneous session notes per billing month)**	Transmit to Billing Agent: • Date of Service; • Billing Code; • Actual number of services provided in the month; • Parental consent indicator for eligible students
July 1, 2009 - August 31, 2009	**Only Targeted Case Management (TCM) services may be billed during this time frame.** **See Medicaid Alert #11-01 for further clarification on TCM services.** **Note that TCM services cannot be billed for dates of service after 6/30/10**	Follow process for Pre-July 1, 2009.
September 1, 2009 and forward	• Provider Agreement and Statement of Reassignment • Referral to CSE/CPSE and the consent for release of information • Provider Qualifications (current license, certification and/or registration) • Documentation of "under the direction of" or "under the supervision of" if appropriate • Written orders/written referrals (establishes medical necessity) • All services must be included in the IEP to be Medicaid reimbursable • Special transportation needs if applicable • **Document each encounter (contemporaneous session note, evaluation report, Medication Administration Record or transportation log)**	Transmit to Billing Agent: • Date of Service; • CPT code that corresponds to type of service and duration of session; • ICD-9 code • Attending provider NPI • Parental consent indicator for eligible students

Section 7 MEDICAID CLAIMING PROCESS

MEDICAID CLAIMING PROCESS SCHOOL DISTRICT, COUNTY, AND §4201 SCHOOL RESPONSIBILITIES

MEDICAID ELIGIBLE (ME) LIST

School districts, counties, and §4201 schools who elect to participate in SED's billing process receive their listing of Medicaid eligible students through a file matching process handled by Central New York Regional Information Center (CNYRIC). This identified special education population is transmitted to CNYRIC where a file match is performed against DOH's file of Medicaid eligible students.

A list of Medicaid eligible recipients, along with a Non-Matching report that includes a near-match/multiple match/match not found list, is created for the school districts, counties, and §4201 schools.

BILLING PROCESS

Once the listing of Medicaid eligible students is provided to the school districts, counties, and §4201 schools the related supportive health services provided to these students must be identified. The Medicaid billing provider may claim Medicaid services at the appropriate fee once documentation exists establishing that services were provided in conjunction with federal and State policies.

For school districts, counties, and §4201 schools that elect not to use the SED billing process, the fees and supporting documentation remain the same.

The federal and non-federal shares associated with the provisions of SPA #09-61 are funded from appropriations by the State Legislature to two separate State agencies, the State Education Department (SED) and the State Department of Health (DOH) (the single State Medicaid agency) which enables the DOH to draw general fund dollars directly to fund the non-federal share of payments for the SSHSP. Payment by DOH to school districts, counties, and §4201 schools represents 100% of the State and federal share of the Medicaid claim. The non-federal share represents an advance of state aid dollars and is subsequently deducted from a school district/county state aid payment.

All providers are required to maintain confidentiality pursuant to HIPAA and FERPA as described in Section 3 of this Handbook.

Section 7 MEDICAID CLAIMING PROCESS

STEP	RESPONSIBILITY	PROCESS
I	The school district/county/§4201 school gathers Biographical (BIO) Data.	School district/county/§4201 school collects student name, date of birth (DOB), gender and social security number, if available. Include all students referred to the Committees on Special Education (CSE/CPSE) whether or not classified as disabled in the school district/county/§4201 school.
II	The school district/county/ §4201 school is responsible for transmitting biographical data through MEDWeb to the Central New York Regional Information Center (CNYRIC).	CNYRIC maintains the student database. CNYRIC will match this data monthly against the Department of Health's Eligibility File to determine which students are Medicaid eligible.
III	CNYRIC will post the electronic file and report of Medicaid eligible students from the school district/county/§4201 school to the CNYRIC Web Reports website based on the Monthly Claiming/Billing Calendar. Any students that are new to the school district/county/§4201 school and missing from the report should be added by providing the BIO data for these students (see Step I).	School districts/counties/§4201 schools can retrieve the electronic files and corresponding reports from the CNYRIC Web Reports website.
IV	The school district/county/§4201 school collects data regarding eligible services provided to their students from the appropriate service providers.	The school district/county/§4201 school assures that all documentation required for claiming Medicaid reimbursement for eligible services is on file in the school district/county/§4201 school.
V	The school district/county/§4201 school transmits the Medicaid claim data through MEDWeb to CNYRIC.	The school district/county/§4201 school's claims for each student must include the appropriate data for the service provided: On/after September 1, 2009 (encounter-based): month, day and year of service; CPT code; units of service provided.

STEP	RESPONSIBILITY	PROCESS
VI	The school district/county/§4201 school verifies the biographical/claim data waiting for monthly processing through MEDWeb.	CNYRIC collects the biographical and claim data per the Monthly Claiming/Billing Calendar.
VII	The school district/county/§4201 school verifies that the claims that have been submitted to CNYRIC have been appropriately processed.	The Service Update Report will provide the detail of each claim submitted in order to verify the claim. Your regional RIC can assist in resolving any discrepancies the school district/county/§4201 school found in the Service Update Report.
VIII	CNYRIC will transmit monthly all eligible claims to the Computer Sciences Corporation's electronic Medicaid system in New York State (eMedNY).	CNYRIC will follow the Monthly Claiming/Billing Calendar.
IX	CNYRIC will post the Billing Summary Report, representing all billed claims, to the Web Reports website.	The CNYRIC will post the Billing Summary Report based on the Monthly Claiming/Billing Calendar.
X	Computer Sciences Corporation (CSC) will process the claims submitted on behalf of each school district/county/§4201 school based on the Monthly Claiming/Billing Calendar. CSC will distribute Medicaid payment to each school district, county, and §4201 school.	CSC will distribute Medicaid reimbursement to school districts/counties/§4201 schools based on the Monthly Claiming/Billing Calendar. CNYRIC will post remittance files (MR) and remittance reports to the Web Reports website.

NOTE #1: All CNYRIC reports provided and available to school districts, counties, and §4201 schools, are listed and explained on the Medicaid in Education website at www.oms.nysed.gov/medicaid. A listing of CNYRIC processing error messages is also provided at the website.

NOTE #2: The processing of the near match and multiple match students on the Medicaid Biographical Non-Match Report and the processing of claims for students not found on the eligible lists or the Medicaid Biographical Non-Match Report (CIN Transaction) is described on Pages 57 and 58 of this Handbook.

NOTE #3: Students may be deleted from the Student Database (SDB) maintained at CNYRIC. Procedures on the Delete Transaction are on Page 59 of this Handbook.

Section 7 MEDICAID CLAIMING PROCESS

PROCESSING OF A STUDENT'S MEDICAID BIOGRAPHICAL DATA

Non-Match Report and CIN Transactions Processing

Students identified on the Medicaid Biographical Non-Match Report as either a "Near Match," "Multiple Matches Found" or "Match Not Found" are possible Medicaid matches. The school district/county/§4201 school should review each group as indicated below to determine if this information (CIN) is related to their students. The final decision to determine if the Medicaid client and the student are the same person lies with the school district/county/§4201 school, not the state.

Medicaid Biographical Non-Match Report

A. **Near-Match:** (Students identified as possible matches).
   1) The students whose biographical data are identified as Near Matches are students whose date of birth and gender match exactly and whose:
      a) First 3 letters of the last name match, and
      b) First 2 letters of the first name match.
   2) The Near Match report contains the following information:
      a) Line 1 contains the biographical information the school district/county/§4201 school submitted for matching.
      b) Line 2 contains the Near Match indicator.
      c) Line 3 contains the:
         - CIN,
         - Provider number of any other school districts, counties, and §4201 schools that also submitted this student for matching,
         - Exact spelling of the student,
         - Top line of the begin/end eligibility dates (Note-additional eligibility before the begin date could exist) and,
         - SSI indicator.
   3) If you are unable to determine if the student listed is the same student, contact DOH staff or the parent/guardian for additional information (CIN/county of residence) to help you determine if the student listed is your student.
   4) If you determine that your student is listed on the report, submit, as a demographic "ADD", the name, date of birth, gender and CIN exactly as they appear on Line 3 of the report (according to your software requirements).

B. **Multiple Matches Found:** (Students identified with more than one CIN).
   1) More than one CIN is on the report because the biographical data submitted matches the biographical data on file for more than one CIN.
   2) The Multiple Match report contains the following information:
      a) Line 1 contains the biographical information the school district/county/§4201 school submitted for matching.
      b) Line 2 contains the Multiple Matches Found indicator.
      c) The subsequent lines contain the:
         - CIN,

- Provider number of any other school district/county/§4201 school that also submitted this student for matching,
- Exact spelling of the student,
- Top line of the begin/end eligibility dates and
- SSI indicator.

3) If you are unable to determine if the student listed is the same student, contact DOH staff or the parent/guardian for additional information (CIN/county of residence) to help you determine if the student listed is your student.
4) If you determine that your student is listed on the report, submit, as a demographic "ADD", the name, date of birth, gender, and CIN exactly as they appear on the appropriate line (3, 4, and 5) on the report (according to your software requirements).

C. Match Not Found: (Students whose biographical data submitted was not matched against the DOH eligibility file and did not fit the criteria as a Near Match or Multiple Match).

1) These students may need to be reviewed for name spelling, date of birth and/or gender errors (date of birth and gender must match exactly).
2) If you determine that your student is listed in error on the Match Not Found section, just submit, as a demographic "ADD", the correct name, date of birth, and gender per your software system requirements.
3) If a brother or sister is matched as a student to a CIN, then you should look into why the student in question was not a match.

CIN TRANSACTIONS

Students identified as eligible by ascertaining the CIN from another source.

A. If you have an appropriate CIN for a student, but the student does not appear on the complete student eligible list

1) Submit the name, date of birth, gender, and CIN as a demographic "ADD" (according to your software requirements).
2) This information must be submitted exactly as listed on eMedNY or an inconsistent data error message will be generated and it can create a claiming problem.

B. You can then submit any appropriate claim after entering the appropriate CIN information.

Section 7 MEDICAID CLAIMING PROCESS

ADJUST/VOID PROCESS

The Adjust/Void process was developed by CNYRIC in conjunction with New York State DOH and Computer Science Corporation (CSC). This process is designed to give the provider a mechanism to make changes to, or delete claims, that have been submitted to Medicaid for payment and have been **paid**.

- **An adjustment transaction corrects the number of units previously submitted and paid at a particular rate code.**
- **A void transaction cancels a previously submitted paid bill.**

The processing of adjustments and voids can be achieved through the current software package you are using or through the MEDWeb Client Claiming application. Please refer to your software manual or contact your software support person for any processing questions.

DELETE TRANSACTION

Students placed on the Student Database (SDB) at CNYRIC are matched monthly against the DOH Medicaid Eligibility File to determine which students from a school district, county, or §4201 school are Medicaid eligible.

CNYRIC will clean up the SDB automatically by removing students who have not matched the DOH Eligibility file every month, for over two years or are over 23 years old. School districts, counties, and §4201 schools will be given the opportunity each year to revise the time period for deletions or bypass this process.

Matched Students with no claims processed for three years (or the cutoff time specified for the provider), are inactivated.

The processing of delete/inactivation transactions can be achieved through the current software package you are using or through the MEDWeb Client Claiming application. Please refer to your software manual or contact your software support person for any processing questions.

MONTHLY CLAIMING/BILLING CALENDAR

The monthly claiming and billing calendar is available online at: www.oms.nysed.gov/medicaid/resources/

MEDICAID WEB REPORTS

Medicaid web reports and files, along with a brief description of each, is available online at: www.oms.nysed.gov/medicaid/handbook/handbook_7/medicaid_reports.

CNYRIC PROCESSING ERROR MESSAGES

CNYRIC processing error messages, along with a brief description of each, is available online at: www.oms.nysed.gov/medicaid/handbook/handbook_7/error_messages.

Section 7 MEDICAID CLAIMING PROCESS

EXCEPTIONS TO SCHOOL DISTRICTS CLAIMING MEDICAID REIMBURSEMENT FOR CERTAIN ELIGIBLE SERVICES

A school district may claim Medicaid reimbursement for any eligible SSHSP service included in a student's IEP provided by the school district to any student with a disability with the following exceptions:

Intermediate Care Facilities

If the New York State Office for People with Developmental Disabilities (OPWDD) places a child in an Intermediate Care Facility (ICF) in your school district, the school district may not claim Medicaid reimbursement for any related services provided to these students since the SED reimburses 100% of the costs to educate these children including transportation. SED claims the Medicaid reimbursement for these services. However, the school district may claim reimbursement for any evaluations provided to these students.

NOTE: OPWDD has converted some ICFs residences to Individual Residential Alternatives (IRAs) or initially opened a new residence as an IRA. If a child resides in an IRA, the school district is entitled to claim Medicaid reimbursement for all eligible services provided to that child.

Article 28 Facilities

When a student is not placed in an Article 28 facility full time but receives only related services from the staff at that facility, the school district may claim Medicaid reimbursement for these services. The Article 28 facility may not.

Certain Article 28 facilities may claim Medicaid reimbursement for students placed full time in the facility.

Other than the above exceptions, if a school district pays for the delivery of eligible services, they may claim Medicaid reimbursement. If you have any questions please contact the Medicaid Unit at 518-474-7116 or at MedinEd@mail.nysed.gov.

A listing of Intermediate Care Facilities (ICF) and Community Residence Programs (CRP) can be accessed online at:
http://www.oms.nysed.gov/medicaid/icfs_crps/

APPENDIX A
Preschool/School Supportive Health Services Program (SSHSP)
Claiming Methodology and Billing Codes

NEW BILLING METHODOLOGY

According to SPA #09-61, effective September 1, 2009, all SSHSP services will be reimbursed using an encounter-based claiming methodology, based on fees established by the Department of Health.

Except for special transportation, fees have been set at 75% of the 2010 Medicare fee schedule for the Mid-Hudson Region. Payment for special transportation services was set based on a statistically valid cost study that was conducted in 1999 to establish round trip transportation rates. These rates were trended forward based on changes in the Consumer Price Index (CPI). The round trip rates were then converted to one-way rates.

All SSHSP providers will now bill on an encounter-based claiming methodology, using the select list of Current Procedural Terminology (CPT) codes that begins on page 62. CPT codes are numbers assigned to services practitioners may provide to a patient including medical, surgical and diagnostic services. CPT codes are then used by insurers to identify the service provided and ultimately the reimbursement rates. Since CPT codes are used nationally, they ensure uniformity, while adding a level of precision.

CPT codes are developed, maintained and copyrighted by the American Medical Association (AMA). As the practice of health care changes, new codes are developed for new services, current codes may be revised, and old, unused codes are discarded. Thousands of codes are in use, (over 14,000) and are updated annually. Development and maintenance of these codes is overseen by editorial boards at the AMA. DOH in coordination with SED has developed a list (just over 100 codes) that is available for SSHSP claiming.

CPT codes are either **timed or untimed**. **Timed codes** require the entry of units. When the practitioner chooses a code, the number of units must also be indicated. For example, if the physical therapist provided a service (CPT code 97140) and the session lasted 30 minutes, two units would be billed. **Untimed codes** are used on a one-per-session/per day basis.

With one exception, providers should not report more than one physical medicine and rehabilitation therapy service for the same 15 minute time period. The only exception involves a "supervised modality" defined by CPT codes 97010-97028 which may be reported for the same 15 minute time period as other therapy services.

For more information on the use of CPT codes and the claiming parameters, please contact your individual professional organizations.

APPENDIX A
SSHSP BILLING CODES

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Psychological Evaluation	90801	2000	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION	Psychotherapy includes continuing psychiatric evaluation, CPT codes 90801 and 90802 are not separately reportable with individual psychotherapy codes.	1 per session	$118.25
Psychological Evaluation	90802	2001	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION	Psychotherapy includes continuing psychiatric evaluation, CPT codes 90801 and 90802 are not separately reportable with individual psychotherapy codes.	1 per session	$127.67
Psychological Evaluation	96101	2002	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI, RORSCHACH, WAIS), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT		60 minutes	$63.53
Psychological Evaluation	96105	2003	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPORT, PER HOUR	There is no published rule regarding time necessary to qualify for *subsequent* one-hour codes.	60 minutes	$60.13
Psychological Evaluation	96110	2004	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN), WITH INTERPRETATION AND REPORT		1 per session	$5.76
Psychological Evaluation	96111	2005	DEVELOPMENTAL TESTING; EXTENDED (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS) WITH INTERPRETATION AND REPORT	There is no published rule regarding time necessary to qualify for *subsequent* one-hour codes.	1 per session	$99.66
Psychological Evaluation	96116	2006	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOGIST'SOR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT	CPT code 96116 should never be reported with psychiatric diagnostic examinations (CPT codes 90801 or 90802)	60 minutes	$70.38
Psychological Evaluation	96118	2007	NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY, WECHSLER MEMORY SCALES AND WISCONSIN CARD SORTING TEST), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT		60 minutes	$77.81

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Psychological Counseling	90804	2008	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 20-30 minutes	$49.03
Psychological Counseling	90805	2009	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 20-30 minutes	$55.40
Psychological Counseling	90806	2010	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 45-50 minutes	$67.61
Psychological Counseling	90807	2011	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 45-50 minutes	$77.46
Psychological Counseling	90808	2012	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 75-80 minutes	$99.33
Psychological Counseling	90809	2013	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 75-80 minutes	$109.41
Psychological Counseling	90810	2014	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 20-30 minutes	$51.98
Psychological Counseling	90811	2015	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 20-30 minutes	$61.84
Psychological Counseling	90812	2016	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 45-50 minutes	$73.83

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Psychological Counseling	90813	2017	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 45-50 minutes	$83.91
Psychological Counseling	90814	2018	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;	See Footnote 1	Approximately 75-80 minutes	$107.24
Psychological Counseling	90815	2019	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	See Footnote 1	Approximately 75-80 minutes	$115.93
Psychological Counseling	90847	2020	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)		1 per session	$82.97
Psychological Counseling	90853	2021	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	CPT code 90801 or 90802 is separately reportable with a group psychotherapy code if the diagnostic interview and group psychotherapy service occur during separate time intervals on the same date of service. Diagnostic services performed during the group therapy session are not separately reportable. The unit of service for CPT code 90853 (Group psychotherapy (other than of a multiple family group)) is the patient encounter with completed therapy session even if it lasts longer than one hour. A practitioner may report only one unit of service on a single date of service.	1 per session	$24.50
Psychological Counseling	90857	2022	INTERACTIVE GROUP PSYCHOTHERAPY	Used when the patients do not have the ability to interact by ordinary verbal communication	1 per session	$27.35

1. Individual psychotherapy codes (CPT code 90804-90829) include separate codes for psychotherapy with medical evaluation and management (E&M) services as well as codes for psychotherapy without E&M services. For practitioner services other E&M codes (e.g. 99201-99215) are not separately reportable with individual psychotherapy codes on the same date of service.

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Speech	92506	2023	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY PROCESSING	Evaluation of aural rehabilitation is no longer part of 92506; speech-language pathologists and audiologists should use 92626 and 92627	1 per evaluation	$122.94
Speech	92507	2024	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY PROCESSING DISORDER; INDIVIDUAL	Includes training and modification of voice prosthetics. Medicare directs SLPs to use 92507 for auditory rehabilitation.	1 per session	$50.57
Speech	92508	2025	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSINGDISORDER; GROUP, 2 OR MORE INDIVIDUALS	Generally limited to 4 individuals.	1 per session	$24.85
Speech	92520	2026	LARANGEAL FUNCTION STUDIES (I.E. AERODYNAMIC TESTING AND ACOUSTIC TESTING)		1 per session	$48.07
Speech	92526	2027	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING	There is no dysphagia group tx code. Payers may accept 97150 for dysphagia group tx.	1 per session	$77.73
Speech	92597	2028	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC DEVICE TO SUPPLEMENT ORAL SPEECH	DO NOT USE FOR TRAINING & MODIFICATION OF VOICE PROSTHESES. Use 92507 for training and modification of voice prostheses. Applies to tracheoesophageal prostheses, artificial larynges, as well as voice amplifiers.	1 per session	$82.17
Speech	92605	DO NOT USE	EVALUATION FOR PRESCRIPTION FOR NON-SPEECH GENERATING AAC DEVICES	CMS requires use of 92506 instead, for this type of evaluation.		
Speech	92606	DO NOT USE	THERAPEUTIC SERVICES FOR USE OF NON-SPEECH GENERATING DEVICES, INCLUDING PROGRAMMING AND MODIFICATION	CMS requires use of 92507 instead, for these therapy services.		
Speech	92626	2029	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR		60 minutes	$62.56
Speech	92627	2030	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		15 minutes	$15.11

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Audiological Evaluation	92550	2031	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS	DO NOT REORT 92550 IN CONJUNCTION WITH 92567, 92568. AUDIOLOGISTS BILLING 92567 AND 92568 ON THE SAME DAY SHOULD NOW USE 92550. IF NOT PERFORMING BOTH CODES ON THE SAME DAY, ONE MAY BILL THE INDIVIDUAL CPT CODE.	1 per session	$15.95
Audiological Evaluation	92552	2032	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY		1 per session	$17.42
Audiological Evaluation	92553	2033	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE	CCI EDITS DISALLOW 92552 OR 92556 ON SAME DAY.	1 per session	$22.37
Audiological Evaluation	92555	2034	SPEECH AUDIOMETRY THRESHOLD;		1 per session	$12.47
Audiological Evaluation	92556	2035	SPEECH AUDIOMETRY WITH SPEECH RECOGNITION	CCI EDITS DISALLOW 92555 ON SAME DAY.	1 per session	$19.17
Audiological Evaluation	92557	2036	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (92553 AND 92556 COMBINED)	CCI EDITS DISALLOW 92552, 92533, 92555, OR 92556 ON SAME DAY.	1 per evaluation	$31.49
Audiological Evaluation	92565	2037	STENGER TEST, PURE TONE		1 per session	$9.55
Audiological Evaluation	92567	2038	TYMPANOMETRY (IMPEDANCE TESTING)	SEE 92550	1 per session	$12.12
Audiological Evaluation	92568	2039	ACOUSTIC REFLEX TESTING, THRESHOLD	SEE 92550	1 per session	$12.85
Audiological Evaluation	92569	DO NOT USE	ACOUSTIC REFLEX TESTING; DECAY	DELETED IN 2010. AUDIOLOGISTS SHOULD NOW USE 92570, SINCE ACOUSTIC REFLEX DECAY TESTING IS ALWAYS DONE IN CONJUNCTION WITH TYMPANOMETRY AND ACOUSTIC REFLEX THRESHOLD TESTING.		
Audiological Evaluation	92570	2040	ACOUSTIC IMMITTANCE TESTING, INCLUDES TYMPANOMETRY (IMPEDANCE TESTING), ACOUSTIC REFLEX THRESHOLD TESTING, AND ACOUSTIC REFLEX DECAY TESTING	DO NOT REPORT 92570 IN CONJUCTION WITH 92567, 92568. AUDIOLOGISTS BILLING 92567, 92568, AND ACOUSTIC REFLEX DECAY TEST (FORMERLY 92569) ON THE SAME DAY SHOULD NOW USE 92550. IF NOT PEROFRMING ALL CODES ON THE SAME DAY, ONE MAY BILL THE INDIVIDUAL CPT CODE.	1 per session	$24.29
Audiological Evaluation	92571	2041	FILTERED SPEECH TEST		1 per session	$13.05

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Audiological Evaluation	92572	2042	STAGGERED SPONDAIC WORD TEST		1 per session	$18.29
Audiological Evaluation	92576	2043	SYNTHETIC SENTENCE IDENTIFICATION TEST		1 per session	$17.42
Audiological Evaluation	92577	2044	STENGER TEST, SPEECH		1 per session	$11.88
Audiological Evaluation	92579	2045	VISUAL REINFORCEMENT AUDIOMETRY (VRA)		1 per session	$33.58
Audiological Evaluation	92582	2046	CONDITIONING PLAY AUDIOMETRY		1 per session	$33.74
Audiological Evaluation	92583	2047	SELECT PICTURE AUDIOMETRY		1 per session	$25.88
Audiological Evaluation	92585	2048	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THECENTRAL NERVOUS SYSTEM; COMPREHENSIVE		1 per session	$78.87
Audiological Evaluation	92586	2049	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THECENTRAL NERVOUS SYSTEM; LIMITED		1 per session	$48.32
Audiological Evaluation	92587	2050	EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)		1 per session	$27.62
Audiological Evaluation	92588	2051	EVOKED OTOACOUSTIC EMISSIONS; COMPREHENSIVE OR DIAGNOSTIC EVALUATION (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)		1 per evaluation	$47.63
Audiological Evaluation	92620	2056	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; INITIAL 60 MINUTES		60 minutes	$59.40
Audiological Evaluation	92621	2057	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; EACH ADDITIONAL 15 MINUTE		15 minutes	$13.62

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Physical Therapy	97001	2058	PHYSICAL THERAPY EVALUATION		1 per evaluation	$54.81
Physical Therapy	97002	2059	PHYSICAL THERAPY RE-EVALUATION		1 per evaluation	$29.74
Physical Therapy	97010	2060	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR COLD PACKS	See Footnotes 2 and 3	1 per session	$3.91
Physical Therapy	97012	2061	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL	See Footnotes 2 and 3	1 per session	$11.45
Physical Therapy	97014	2062	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	See Footnotes 2 and 3	1 per session	$10.70
Physical Therapy	97016	2063	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES	See Footnotes 2 and 3	1 per session	$12.45
Physical Therapy	97018	2064	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH	See Footnotes 2 and 3	1 per session	$6.53
Physical Therapy	97022	2065	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL BATH	See Footnotes 2 and 3	1 per session	$14.51
Physical Therapy	97024	2066	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY (EG, MICROWAVE)	See Footnotes 2 and 3	1 per session	$4.49
Physical Therapy	97026	2067	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED	See Footnotes 2 and 3	1 per session	$3.91
Physical Therapy	97028	2068	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET	See Footnotes 2 and 3	1 per session	$5.04
Physical Therapy	97032	2069	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL) EACH 15 MINUTES	See Footnote 3	15 minutes	$12.92
Physical Therapy	97033	2070	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES	See Footnote 3	15 minutes	$20.18
Physical Therapy	97034	2071	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES	See Footnote 3	15 minutes	$12.11
Physical Therapy	97035	2072	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND THERAPY, EACH 15 MINUTES	See Footnote 3	15 minutes	$9.20

2. 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.)
3. Please note that the 97000 series physical medicine and rehabilitation codes may apply to both physical therapy and occupational therapy.

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Physical Therapy	97036	2073	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES	See Footnote 3	15 minutes	$21.25
Physical Therapy	97110	2074	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	See Footnote 3	15 minutes	$22.19
Physical Therapy	97112	2075	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	Intended to identify therapeutic exercise designed to re-train a body part to perform some task that the body part was previously able to do. This will usually be in the form of some commonly performed task for that body part. Some common examples include Proprioceptive Neuromuscular Facilitation (PNF), Feldenkreis, Bobath, BAP's Boards, and dessensitization techniques. See Footnote 3	15 minutes	$23.29
Physical Therapy	97113	2076	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	See Footnote 3	15 minutes	$28.04
Physical Therapy	97116	2077	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)	See Footnote 3	15 minutes	$19.65
Physical Therapy	97124	2078	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	See Footnote 3	15 minutes	$17.99
Physical Therapy	97140	2080	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	Therapist performing massage as a manual therapy technique in order to increase active pain-free range of motion, increase extensibility of myofascial tissue and facilitate the return to functional activities. Each 15 minutes should be reported. See Footnote 3	15 minutes	$20.77
Physical Therapy	97150	2081	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)	See Footnote 3	1 per session	$14.33

3. Please note that the 97000 series physical medicine and rehabilitation codes may apply to both physical therapy and occupational therapy.

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Occupational Therapy	97003	2082	OCCUPATIONAL THERAPY EVALUATION		1 per evaluation	$59.11
Occupational Therapy	97004	2083	OCCUPATIONAL THERAPY RE-EVALUATION		1 per evaluation	$34.98
Occupational Therapy	97530	2084	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES	See Footnote 3	15 minutes	$23.96
Occupational Therapy	97532	2085	DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING (INCLUDES COMPENSATORY TRAINING), DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES	See Footnote 3	15 minutes	$19.00
Occupational Therapy	97533	2086	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES	See Footnote 3	15 minutes	$20.75
Occupational Therapy	97535	2087	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (adl) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ASSISTIVE TECHNOLOGY DEVICES/ADAPTIVE EQUIPMENT) DIRECT ONE-ON-ONE CONTACT BY THE PROVIDER, EACH 15 MINUTES	See Footnote 3	15 minutes	$23.94
Occupational Therapy	97537	2088	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, MONEY MANAGEMENT, AVOCATIONAL ACTIVITIES AND/OR WORK ENVIRONMENT/MODIFICATION ANALYSIS, WORK TASK ANALYSIS, USE OF ASSISTIVE TECHNOLOGY DEVICE/ADAPTIVE EQUIPMENT), DIRECT ONE-ON-ONE CONTACT BY PROVIDER, EACH 15 MINUTES	See Footnote 3	15 minutes	$21.32
Occupational Therapy	97542	2089	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING), EACH 15 MINUTES	See Footnote 3	15 minutes	$21.61
Occupational Therapy	97760	2107	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING ASSESSMENT AND FITTING WHEN NOT OTHERWISE REPORTED), UPPER EXTREMITY(S), LOWER EXTREMITY(S) AND/OR TRUNK, EACH 15 MINUTES	See Footnote 3	15 minutes	$25.61
Occupational Therapy	97761	2108	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S), EACH 15 MINUTES	See Footnote 3	15 minutes	$22.70
Occupational Therapy	97762	2109	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE,ESTABLISHED PATIENT, EACH 15 MINUTES	See Footnote 3	15 minutes	$28.07

3. Please note that the 97000 series physical medicine and rehabilitation codes may apply to both physical therapy and occupational therapy.

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Medical Evaluation	99201	2090	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHT FORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 10 minutes	$30.45
Medical Evaluation	99202	2091	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; STRAIGHT FORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 20 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 20 minutes	$52.51
Medical Evaluation	99203	2092	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 30 minutes	$75.88
Medical Evaluation	99204	2093	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 45 minutes	$117.17
Medical Evaluation	99205	2094	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 60 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 60 minutes	$147.11

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Medical Evaluation	99211	2095	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN,. USUALLY THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 5 minutes	$15.08
Medical Evaluation	99212	2096	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHT FORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 10 minutes	$30.45
Medical Evaluation	99213	2097	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 15 minutes	$51.05
Medical Evaluation	99214	2098	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 25 minutes	$76.46
Medical Evaluation	99215	2099	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 40 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes (90804-90829) on the same date of service.	Approximately 40 minutes	$102.91

APPENDIX A
SSHSP Billing Codes

Service Type	CPT Code	Rate Code	Description	Special Rules	Session Time/Units	2010 Payment Rate
Skilled Nursing	T1002	2102	RN SERVICES, UP TO 15 MINUTES		15 minutes	$9.25
Skilled Nursing	T1003	2103	LPN/LVN SERVICES, UP TO 15 MINUTES		15 minutes	$8.00

APPENDIX A

SSHSP Billing Codes

Special Transportation One-Way Rates

CPT Code T2003

County *	Preschool Rate	School
Albany	$14.21	$7.92
Allegany	$36.50	$14.70
Broome	$14.21	$7.92
Cattaraugus	$20.42	$14.82
Cayuga	$20.42	$14.70
Chautauqua	$20.42	$14.70
Chemung	$20.42	$14.70
Chenago	$20.42	$14.70
Clinton	$20.42	$14.70
Columbia	$14.21	$7.92
Cortland	$20.42	$14.70
Delaware	$36.50	$14.70
Dutchess	$14.21	$7.92
Erie	$17.76	$17.03
Essex	$36.50	$14.70
Franklin	$36.50	$14.70
Fulton	$20.42	$14.70
Genesee	$20.42	$14.70
Greene	$20.42	$14.70
Hamilton	$36.50	$14.70
Herkimer	$20.42	$14.70
Jefferson	$20.42	$14.70
Lewis	$36.50	$14.70
Livingston	$20.42	$14.70
Madison	$20.42	$14.70
Monroe	$14.21	$7.92
Montgomery	$20.42	$14.70
Nassau	$19.68	$17.03
Niagara	$14.21	$7.92

County*	Preschool Rate	School
Oneida	$14.21	$7.92
Onondaga	$14.21	$7.92
Ontario	$20.42	$14.70
Orange	$20.42	$14.70
Orleans	$20.42	$14.70
Oswego	$20.42	$14.70
Otsego	$20.42	$14.70
Putnam	$20.42	$14.70
Rensselaer	$14.21	$7.92
Rockland	$20.42	$14.70
St Lawrence	$36.50	$14.70
Saratoga	$20.42	$14.70
Schenectady	$14.21	$7.92
Schoharie	$20.42	$14.70
Schuyler	$20.42	$14.70
Seneca	$20.42	$14.70
Steuben	$20.42	$14.70
Suffolk	$16.98	$17.03
Sullivan	$20.42	$14.70
Tioga	$20.42	$14.70
Tompkins	$20.42	$14.70
Ulster	$20.42	$14.70
Warren	$20.42	$14.70
Washington	$20.42	$14.70
Wayne	$20.42	$14.70
Westchester	$25.16	$17.03
Wyoming	$20.42	$14.70
Yates	$36.50	$14.70
NYC	$17.27	$21.69

APPENDIX B
ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

AMA	AMERICAN MEDICAL ASSOCIATION
AOTA	AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
APA	AMERICAN PSYCHOLOGICAL ASSOCIATION
APTA	AMERICAN PHYSICAL THERAPY ASSOCIATION
ASHA	AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
BOCES	BOARD OF COOPERATIVE EDUCATIONAL SERVICES
CAPTE	COMMISSION ON ACCREDITATION IN PHYSICAL THERAPY EDUCATION
CFR	CODE OF FEDERAL REGULATIONS
CIN	CLIENT IDENTIFICATION NUMBER
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES
CNYRIC	CENTRAL NEW YORK REGIONAL INFORMATION CENTER
CPSE	COMMITTEE ON PRESCHOOL SPECIAL EDUCATION
CPT	CURRENT PROCEDURAL TERMINOLOGY
CSC	COMPUTER SCIENCES CORPORATION
CSE	COMMITTEE ON SPECIAL EDUCATION
DOH	DEPARTMENT OF HEALTH
EMEDNY	ELECTRONIC MEDICAID SYSTEM OF NEW YORK
EPSDT	EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
FAPE	FREE APPROPRIATE PUBLIC EDUCATION
FERPA	FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT
FTP	FILE TRANSFER PROTOCOL
HIPAA	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
IDEA	INDIVIDUALS WITH DISABILITIES EDUCATION ACT
IEP	INDIVIDUALIZED EDUCATION PROGRAM
IHCP	INDIVIDUALIZED HEALTH CARE PLAN
LPN	LICENSED PRACTICAL NURSE
ME	MEDICAID ELIGIBILITY
NPI	NATIONAL PROVIDER IDENTIFIER
OHIP	OFFICE OF HEALTH INSURANCE PROGRAMS
OP	OFFICE OF THE PROFESSIONS
OPWDD	OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
OT	OCCUPATIONAL THERAPY/THERAPIST
OTDA	OFFICE OF TEMPORARY AND DISABILTY ASSISTANCE
OTA	OCCUPATIONAL THERAPY ASSISTANT
PT	PHYSICAL THERAPY/THERAPIST
PTA	PHYSICAL THERAPY ASSISTANT
RIC	REGIONAL INFORMATION CENTER
RN	REGISTERED PROFESSIONAL NURSE
SED	STATE EDUCATION DEPARTMENT
SLP	SPEECH-LANGUAGE PATHOLOGIST
SPA	STATE PLAN AMENDMENT
SSHSP	PRESCHOOL/SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM
SSI	SUPPLEMENTAL SECURITY INCOME
TCM	TARGETED CASE MANAGEMENT
TPHI	THIRD PARTY HEALTH INSURANCE
TSHH	TEACHER OF THE SPEECH AND HEARING HANDICAPPED
TSSLD	TEACHER OF STUDENTS WITH SPEECH AND LANGUAGE DISABILITIES

APPENDIX B
ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

ARTICLE 28-Article 28 facilities refer to "hospitals" which are established, operated, and regulated under Public Health Law Article 28. The term "hospital" is defined broadly and includes acute care or general hospitals, nursing homes, diagnostic and treatment centers, and free-standing ambulatory surgery centers.

CENTERS FOR MEDICARE AND MEDICAID SERVICES - is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

CENTRAL NEW YORK REGIONAL INFORMATION CENTER (BOCES Onondaga-Cortland-Madison) - is the clearinghouse for the School Supportive Health Services Program (New York State Medicaid in Education). SED contracts with the Central New York Regional Information Center to submit Medicaid claims on behalf of all New York State school districts, counties, and §4201 schools.

CODE OF FEDERAL REGULATIONS - are Federal regulations that define Medicaid rules and regulations.

COMPUTER SCIENCES CORPORATION - is the current eMedNY contractor for the New York State Medicaid Program.

CURRENT PROCEDURAL TERMINOLOGY - is a listing of descriptive terms and five-digit, numeric codes for reporting medical services and procedures performed by healthcare professionals.

eMedNY - is the name of the New York State Medicaid program claims processing system.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, and TREATMENT - is a program for Medicaid-eligible recipients under the age of twenty-one (21); EPSDT offers free preventive health care services such as screenings, well-child visits, and immunizations; if medical problems are discovered, the recipient is referred for further treatment.

FILE TRANSFER PROTOCOL - is a standard network protocol used to exchange and manipulate files over a TCP/IP- based network, such as the Internet.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT - the HIPAA privacy regulations require health care providers and organizations, as well as their business associates, develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared.

APPENDIX B
ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

INDIVIDUALIZED EDUCATION PROGRAM - is the IDEA required educational program to be provided to a child with a disability and refers to the written document that describes that educational program.

INDIVIDUALIZED HEALTH CARE PLAN - The IHCP is a written document that outlines the provision of student healthcare services intended to achieve specific student needs.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT - is a law ensuring services to children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services.

REGIONAL INFORMATION CENTER - a regional public education service organization. There are 12 regional information centers across New York State. Each RIC is contracted by SED to provide support services to school districts, counties, and §4201 schools on the School Supportive Health Services Program.

SUPPLEMENTARY SECURITY INCOME - is the federal supplemental security program that provides cash assistance to low-income aged, blind, and disabled persons.

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