School Supportive Health Services Program
Preschool Supportive Health Services Program

Questions and Answers
Issued December 5, 2011

Note: The responses to Questions #156 and #159 were revised December 10, 2012

Relevant Employees

155. Q. Do we need to ensure that the doctor who is not an employee or contractor of the school writing the prescription for our students for services during the school year has completed this training?

A. Physicians who are not employed or contracted by a school district, county or §4201 school and who are providing orders for SSHSP services are not "relevant employees" and are not subject to the mandatory compliance training requirements.

Written Orders and Referrals

Note: The response to Question #156 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are underlined.

156. Q. a) If the original written order for physical therapy called for group therapy to be delivered two times weekly, would a new written order be required if the therapy recommendation is changed from group to individual? b) What if the written order didn't specifically contain a requirement that the therapy be delivered individually or in a group?

A. a) Yes, for SSHSP reimbursement purposes, a new written order is required whenever there is a change to a medically necessary service being furnished to a student pursuant to the student's Individualized Education Program (IEP).

b) Either the written order must include frequency and duration of the service to be furnished or it must adopt, by explicit reference to the IEP, the frequency and duration that will be delivered to the student based on his/her individual needs. Because districts are not required to include group or individual in the IEPs they develop, where the student's record does not document whether the service will be furnished in a group or individual session, this must be specified in the written order. Regardless, if there is a change in service delivery from group to individual or vice versa, a new written order is required because the amount billed for the sessions differs depending on whether the service was delivered individually or in a group, the student's record must specify how the service will be delivered. Medicaid reimbursement is available for medically necessary services for which all Medicaid requirements are met.

Note: Q+A # 35 indicated that it was not appropriate for the written order to state "per the IEP". This prohibition was intended to address written orders that said nothing other than "per the IEP", it was not meant to prohibit the inclusion of the phrase on a written order/referral that contained all other required elements such as the service being

ordered, the time frame for the services, etc. as delineated in Q+A #32 where the intent was to mirror the frequency and duration specified in the IEP.

157. Q. Regarding the diagnosis and/or the reason/need on written orders/referrals for Medicaid reimbursable related services, is a diagnosis of developmental delay acceptable? What about a diagnosis of preschooler with a disability?

A. A diagnosis that can be assigned an ICD-9 code is acceptable for Medicaid reimbursement purposes (315.9 unspecified delay in development). A generic diagnosis, such as preschooler with a disability, does not provide sufficient specificity about the student's medical needs and there is no corresponding ICD-9 code and is therefore, not acceptable for Medicaid reimbursement purposes. Practitioners should seek guidance on assigning ICD-9 codes from their professional organizations.

158. Q. If speech therapy is changing from 3 x 30/week to 2 x 30/week, but physical therapy is remaining the same, do we need to get new orders/referrals for both services? Or just the one that is changing?

A. A new written referral for speech therapy will be needed if speech therapy is being changed for the remainder of the IEP. If the physical therapy services will not be changed for the remainder of the IEP then there is no need for a new written order for that service. New written orders/referrals will be needed for each recommended service when a new IEP is developed.

Note: The response to Question #159 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are <u>underlined.</u>

159. Q. The April 2011 Medicaid Update had an article that stated ordering providers must now be Medicaid qualified providers, enrolled in the Medicaid program. Does this apply to the SSHS program?

A. ~~The Department of Health is consulting with the Centers for Medicare and Medicaid Services (CMS). Additional information will be forthcoming~~.
<u>Yes, this requirement will apply to the SSHS Program. Any practitioner who is eligible to enroll in NYS Medicaid Fee for Service (FFS) must be enrolled to continue to order or refer services that are paid by FFS. The Department of Health is planning to offer a streamlined ordering/referring (non-billing) practitioner enrollment process. Details will be announced in a future Medicaid Update that can be accessed online at: http://www.health.ny.gov/health_care/medicaid/program/update/main.htm.</u>

<u>Effective **April 1, 2013,** all SSHSP claims **must contain the NPI of the ordering/referring provider**. The ordering/referring providers of SSHSP services will have to be enrolled in the NYS Medicaid program. If the ordering/referring provider is not enrolled as a Medicaid provider, the SSHSP claims for the relevant services will eventually be denied. A Medicaid Alert regarding the above requirements will be published prior to implementation.</u>

<u>Session Notes</u>

160. Q. Are back-to-back therapy sessions (e.g., session with Student A from 12:00 - 12:30 PM and session with Student B from 12:30-1:00 PM) Medicaid

reimbursable? How should the time in/time out be documented in the session notes?

A. Yes. Back-to-back therapy sessions are Medicaid reimbursable. If sessions were delivered consistent with the written order, the IEP, and Medicaid policy (e.g., to be Medicaid reimbursable the speech therapy session must be a minimum 30 minutes and properly documented) then Medicaid may be billed for the sessions. Session notes must always document the actual time in/time out. If first session was from 12:00-12:30 PM and second session was from 12:30-1:00 PM, the session notes must reflect that.

161. Q. If an SSHSP Medicaid claim was submitted based on a session note with white-out on it that was completed prior to the issuance of Q+A #133 on June 6, 2011, should the claim be voided?

A. Yes, the claim should be voided. Although SSHSP **Q+A #133** wasn't issued until June 6, 2011 this policy was in place before June 6, 2011. Session notes and other medical records containing white-out are not acceptable documentation to support a Medicaid claim.

162. Q. If service providers (e.g., SLP, PT) are keeping their original session notes, how can the county bill for services now without knowing whether or not they can retrieve the original notes at the time of a future audit?

A. The county can require that the service providers supply copies of all documentation (session notes) so that in the event of an audit, copies will be available. The auditor does reserve the right to see the originals. Most often an auditor would request an original because the copy is unclear or incomplete. In the event that a legible, complete record cannot be produced for audit, consequences will be determined in the context of the overall audit findings.

163. Q. Will session notes that do not include the setting the therapy took place in be acceptable documentation for SSHSP Medicaid reimbursement?

A. If upon review of session notes, school districts, counties, and §4201 schools find insufficient documentation of the 'setting' in which the service was delivered, the school district, county, or §4201 school should determine if they have other supporting documentation of where the service was actually furnished that could be used to support a Medicaid claim. Such other documentation may be an attendance log that can be cross-referenced with the session notes to satisfy the documentation requirements. Documentation that is "before the fact" and shows what is intended to occur (e.g., schedules, IEPs) does not provide evidence of what actually happened and is not sufficient. The documentation must demonstrate what actually occurred (e.g., a session note or a transportation log).

164. Q. Are session notes that indicate the therapy setting as "Erie 1 BOCES" acceptable for Medicaid billing purposes?

A. The school, clinic, or other setting where services are delivered should be sufficiently clear that the specific location can be discerned. If there is only one address associated with the name "Erie 1 BOCES" it is sufficient. If there is more than one location associated with that same name, then the setting must be uniquely identified in the session note (e.g., the physical address could be recorded). If, upon review of session notes, the school district, county, or §4201 school finds insufficient documentation of the

'setting' in which the service was delivered, the school district, county, or §4201 school may have other supporting documentation of where the service was actually furnished that could be used to support a Medicaid claim. Such other documentation may be an attendance log that can be cross-referenced with the session notes to satisfy the documentation requirements. Documentation that is "before the fact" and shows what is intended to occur (e.g., schedules, IEPs) does not provide evidence of what actually happened and is not sufficient. The documentation must demonstrate what actually occurred (e.g., a session note or a transportation log).

165. Q. Can several session notes be created on one sheet of paper? Is it acceptable for unchanging information to be listed at the heading of the page rather than in each separate session note?

A. Medicaid providers must prepare and maintain contemporaneous records that demonstrate the provider's right to receive payment under the Medicaid program. Acceptable documentation can take different forms, including hard copy or electronic records. It is permissible for a form to be formatted in a manner that would allow unchanging demographic information (e.g., the student's name, the therapy type, the therapist's name, etc.) to be printed as a heading on a form that includes more than one session note. This heading must be included on every page. If in an electronic format, when printed out, the heading must also be on every page.

166. Q. Session notes are data entered into a computer program and the program does not have a field to capture the setting the therapy took place in. If the therapist has the original hand written session note that includes the setting and all other required information, is the original hand-written session note acceptable proof for Medicaid billing purposes?

A. Original complete (see Q+A #25) hand-written or typed session notes are acceptable documentation that demonstrates the provider's right to request reimbursement. These session notes must be available upon audit.

Under the Direction of (UDO) / Under the Supervision of (USO)

167. Q. Can supervision of a licensed master social worker (LMSW) for psychological counseling services be done via telephone or Skype?

A. No. Licensed master social workers (LMSW) require at least two hours per month of in-person individual or group clinical supervision by a licensed and registered psychologist or a licensed and registered psychiatrist or a licensed clinical social worker (LCSW). A telephone conversation will not satisfy the in-person requirement, and Skype does not meet the HIPAA requirements for confidentiality.

168. Q. If there is a gap in time between the date a new IEP goes into effect mid-year and the next meeting between the directing physical therapist and the student (which we now believe is the new initial meeting), is that period billable?

A. If there is a new IEP, there is a need for the directing clinician to meet with the student on or before the start of the new IEP period. It is permissible for this initial meeting to occur just prior to the start of the new IEP period. Medicaid reimbursement is only available for dates of service on and after the 'directing' clinician (e.g., physical therapist)

has completed the initial meeting with the student for the new IEP period. The initial meeting must be documented. Initial meetings completed after the new IEP period has begun renders the services provided between the beginning of the IEP period and the meeting "unbillable."

Billing

169. Q. A student's IEP contains a recommendation for physical therapy for 30 minutes three times a week, one of the weekly sessions is a group session and the other two are individual sessions. One week the student missed one individual session and received one individual session. During the same week, the student was the only group member present on the day of the group therapy session (making this session an individual session). Can the district bill Medicaid for two individual therapy sessions if that is what the student received for the entire week?

A. Yes. Medicaid can be billed. The two individual therapy sessions provided were consistent with the recommendations of the IEP.

170. Q. Can Medicaid be billed for more than one group physical or occupational therapy session per day?

A. Yes. A Medicaid claim with two units of CPT code 97150 (untimed code) may be submitted only when a student receives:

- group physical therapy and group occupational therapy on the same day, or
- two distinctly separate group physical therapy sessions on the same day and one of the sessions is a make-up for a session missed during the same week or cycle, or
- two distinctly separate group occupational therapy sessions on the same day and one of the sessions is a make-up for a session missed during the same week or cycle.

To bill Medicaid for multiple sessions on the same date of service the school district, county, or §4201 school needs to submit one claim with two units of 97150. Each unit billed represents one session provided.

171. Q. Can Medicaid be billed for more than one individual or group speech therapy session per day?

A. Yes. A Medicaid claim with two units of CPT codes 92507 or 92526 may be submitted only when the student receives two distinctly separate individual speech therapy sessions on the same day and one of the sessions is a make-up for a session missed during the same week or cycle. A Medicaid claim with two units of CPT code 92508 may be submitted only when the student receives two distinctly separate group speech therapy sessions on the same day and one of the sessions is a make-up for a session missed during the same week or cycle. Speech therapy session must be a minimum of 30 minutes to be Medicaid reimbursable and sessions lasting longer can only be billed as one unit.

To bill Medicaid for multiple sessions on the same date of service the school district, county, or §4201 school needs to submit one claim with two units of 92507, or 92526, or 92508. Each unit billed represents one session provided.

172. Q. Can Medicaid be billed for more than one group psychological counseling session per day?

A. Yes. A Medicaid claim with two units of CPT codes 90853 or 90857 may be submitted only when the student receives two distinctly separate group psychological counseling sessions on the same day and one of the sessions is a make-up for a session missed during the same week or cycle.

To bill Medicaid for multiple sessions on the same date of service the school district, county, or §4201 school needs to submit one claim with two units of 90853 or 90857. Each unit billed represents one session provided.

173. Q. Are there CPT codes other than those for "psychotherapy" that could be used to bill Medicaid for psychological counseling services?

A. No. There are no other CPT codes that can be used to bill Medicaid for SSHSP psychological counseling services.

174. Q. A student is scheduled to receive group therapy with two other students. Can the school district, county, or §4201 school bill for the group session when one of the three students is absent?

A. Yes. The school district, county, or §4201 school may bill for a group therapy session when the group consists of two or more students.

175. Q. Can a therapy group consist of both Medicaid-eligible and non-Medicaid-eligible students? How would this be documented for billing?

A. Consistent with Section 200.1 of the Regulations of the Commissioner of Education, students should be grouped together according to similarity of individual needs for the purpose of special education. The student's Medicaid eligibility status is not a consideration when deciding the composition of the students in the group. Session notes must be completed for each Medicaid eligible student in the group therapy session, and when the student's Medicaid eligibility has been verified, the school district, county, or §4201 school may submit claims for those services that have been documented appropriately.

176. **Q. Will the State be supplying providers with a list of ICD-9 codes that are acceptable for SSHSP Medicaid billing purposes?**

A. No. NYS Medicaid does not plan to supply a discreet list of International Classification of Diseases, 9th Revision (ICD-9) codes to providers for use in SSHSP claim submission. Questions regarding coding for reimbursement can be referred to professional organizations such as:

- American Physical Therapy Association (APTA)
- American Occupational Therapy Association (AOTA)
- American Speech-Language-Hearing Association (ASHA)
- American Psychological Association (APA)
- American Medical Association (AMA)

177. **Q. How do we bill for ongoing assessment conducted during therapy sessions (e.g., to assist in establishing whether a student has mastered a particular skill) vs. formal re-evaluations that are reflected in the student's IEP?**

A. Ongoing assessment conducted during a scheduled therapy session may be billed to Medicaid as part of the ordered treatment. A session that includes assessment and services can be billed to Medicaid using procedure based CPT codes which most closely match the service rendered.

For example, a 30-minute physical therapy session that included 6 minutes of ongoing assessment and 24 minutes of other therapeutic activities can be billed to Medicaid using 2 units of CPT code 97530. In this situation, documentation would be in the form of a session note.

If testing is done for an annual or triennial re-evaluation such testing should occur separately from ongoing therapy. Medicaid can only be billed for the evaluation upon completion of the documentation which is the evaluation or re-evaluation report.