

School Supportive Health Services Program Preschool Supportive Health Services Program

Questions and Answers

Note: The responses to Questions #25, #50, and #64 were revised July 21, 2015.

Note: The response to Questions #16, #19, #24, #32, #43, #44, #45, #53, #57, #64, #79, #91, #97, #108, #115, #117, #135, #142, #159, and #186 were revised November 24, 2014.

Note: The responses to Questions #11, #19, #21, #25, #31, #32, #33, #35, #98, #112, #115, #127, #137, #156, and #159 were revised December 10, 2012.

Note: The responses to Question #114 and #125 were revised August 1, 2011.

Note: The response to Question #91 was revised April 19, 2011.

Note: The response to Question #53 was revised March 4, 2011.

Note: Medicaid claiming by § 4201 schools ended October 3, 2013. See [Medicaid Alert #13-06](#) for further details.

Status of School and Preschool Supportive Health Services Program

1. Q. Who is responsible for setting Medicaid policy and reimbursement rates for the Preschool/School Supportive Health Services Program (SSHSP)?

A. The responsibility for setting Medicaid policy and reimbursement rates for the SSHSP resides with the DOH Office of Health Insurance Programs (OHIP). OHIP has restructured the Preschool/School Supportive Health Services Program to meet all applicable federal, state and Medicaid regulations, to ensure that future claims are in compliance with all applicable requirements. [June 11, 2010]

2. Q. What is a State Plan Amendment and how does it impact the SSHSP?

A. A State Plan Amendment (SPA) is a comprehensive written statement prepared by a State and submitted to CMS describing the nature and scope of Medicaid coverage and reimbursement and giving assurance that both will be administered in conformity with the specific requirements of Title XIX of the Social Security Act, the regulations in 42CFR Section 430.10 and other applicable official issuances of the New York State Department of Health. CMS determines whether the SPA can be approved to serve as a basis for federal financial participation in the State Medicaid program. The SPA submitted to CMS defines the services, providers and their qualifications, and reimbursement methodology for the SSHSP. DOH has worked closely with the NYS Department of Education to develop a SPA that meets the federal requirements applicable to the SSHSP. [June 11, 2010]

3. Q. What is the current status of the State Plan Amendment?

A. The SSHSP SPA was approved by CMS on April 26, 2010, effective September 1, 2009. For additional information, see [State Plan Amendment #09-61](#). [June 11, 2010]

4. Q. When will billing for Medicaid-covered preschool/school supportive health services resume?

A. School districts, counties and §4201 schools will be able to begin billing for the SSHSP services described in SPA #09-61 once the necessary system changes are in place. The target date is July 1, 2010. [June 11, 2010]

5. Q. Will school districts, counties, and §4201 schools be able to bill retroactively?

A. Yes. Medicaid billing will be retroactive for services provided on or after September 1, 2009 and prior to July 1, 2009, as long as those services meet the Medicaid requirements as described in SPA #09-61 and there is proper documentation to support the claims. [June 11, 2010]

6. Q. Can school districts, counties and §4201 schools bill retroactively for services provided from July 1, 2009 through August 31, 2009?

A. No. The Medicaid program does not have federal approval to pay claims for services provided during this time period. Therefore, school districts, counties, and §4201 schools may not bill for services provided from July 1, 2009 through August 31, 2009. [June 11, 2010]

Compliance Agreements

7. Q. What is the difference between the Compliance Agreement and the Compliance Program for the SSHSP?

A. There is a Compliance Agreement between NYS and CMS. This is the agreement between the federal and state government to ensure compliance with Medicaid requirements. There is also a Compliance Program required by Social Services Law (SSL) Section 363-d, which is administered by the NYS Office of the Medicaid Inspector General (OMIG). The SSL-required Compliance Program mandates that all Medicaid providers claiming over \$500,000/year implement a compliance program. [June 11, 2010]

8. Q. What are the conditions of the NYS Compliance Agreement with CMS?

A. The NYS Compliance Agreement with CMS is the legal arrangement that New York State has with the federal Centers for Medicare and Medicaid Services (CMS) to prevent fraud, abuse, and false billing to Medicaid in the SSHSP. The terms and conditions address:

- Appointment of Compliance Officer and Compliance Committee
- Audit Requirements
- Independent Audits
- Annual Written Reports
- Written Policies to Ensure Compliance
- Training
- Confidential Disclosure
- State Plan Amendment and Revisions to Reimbursement Methodology
- Implementation Plan
- Certifications

[June 11, 2010]

9. Q. What is the purpose of the Mandatory Compliance Law?

A. The Mandatory Compliance Law, Chapter 442 of the Laws of 2006, established the NYS Office of the Medicaid Inspector General (OMIG) and created SSL §363-d, which requires Medicaid providers develop, adopt and implement effective compliance

programs aimed at detecting fraud, waste, and abuse in the Medicaid program. The purpose is to ensure that providers establish systemic checks and balances to detect and prevent inaccurate billing and inappropriate practices in the Medicaid program. [June 11, 2010]

10. Q. Who must have an OMIG compliance program?

- A. The Mandatory Compliance Law applies to Medicaid providers operating as clinics under the Public Health Law, clinics operating under Mental Hygiene Law, and those providers who order, provide, bill or claim \$500,000 or more from Medicaid in a 12-month period. The \$500,000 threshold applies if a provider receives the reimbursement directly or indirectly from Medicaid funds. If the provider meets either the statutory provisions or monetary thresholds, there are no exemptions. The law is applicable to providers of preschool and school supportive health services. [June 11, 2010]

Note: The response to Question #11 was revised December 10, 2012. Deletions are ~~struck through~~ and additions are underlined.

11. Q. How can an OMIG compliance program be developed for multiple school districts providing school supportive health services?

- A. ~~This response is under development.~~ School districts providing SSHSP services can collaborate on the development of a compliance program. Each school district must then tailor the program for its own use to meet regulations at Title 18 NYCRR (Social Services) – Part 521.

For information on the OMIG compliance program, refer to the Compliance link on the OMIG website at: <http://www.omig.ny.gov/data/>. [December 10, 2012]

12. Q. What must an OMIG compliance program contain?

- A. OMIG compliance programs apply to Medicaid billing and payments. The minimum requirements may be found in 18 NYCRR §521.3 (c) and include:
- Written policies and procedures that describe compliance expectations;
 - Designation of an employee vested with the responsibility for the day-to-day operation of the compliance program (compliance officer);
 - Training and education for affected employees and persons associated with the provider;
 - Establishment of communication lines to the compliance officer for anonymous/confidential disclosure;
 - Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals;

- Creation of a system for routine identification of compliance risk areas specific to the provider type;
- Creation of systems for responding to compliance issues as they are raised; and,
- A policy barring intimidation or retaliation for participating in the compliance program.

For additional information on compliance programs, consult the OMIG website at <http://www.omig.state.ny.us/data/content/view/79/65>
[June 11, 2010]

General Requirements – IDEA and SSHSP

13. Q. What is the Individuals with Disabilities Education Act (IDEA)?

- A.** In 1975, Congress passed Public Law 94-142 (Education of All Handicapped Children Act), which was the first major law to ensure a public education for children with disabilities, ages five to 21. The intent was to provide each student with a disability a free appropriate public education (FAPE). The Act has been reauthorized several times since, includes children ages three to five years, and is now codified as the Individuals with Disabilities Education Act (IDEA) (PL 108-446). States are required to establish and implement policies that assure a FAPE to all children with disabilities. [June 11, 2010]

14. Q. How does Medicaid relate to education for children with disabilities?

- A.** A 1988 amendment to the Social Security Act provided statutory authority for SSHSP, also known as Medicaid in Education, by allowing Medicaid coverage of medically necessary services included in the Individualized Education Programs (IEPs) of students with disabilities. The purpose of SSHSP is to assist school districts, §4201 schools and counties in obtaining Medicaid reimbursement for certain diagnostic and health support services provided to students with disabilities. The SSHSP applies to students with Medicaid coverage from age three years up to their twenty-first birthday. [June 11, 2010]

15. Q. What is an Individualized Education Program (IEP)?

- A.** An IEP is a written statement for a student with a disability that is developed, reviewed and revised by a Committee on Special Education (CSE), Subcommittee on Special Education or Committee on Preschool Special Education (CPSE). The IEP is the tool that ensures a student with a disability has access to the general education curriculum and is provided the appropriate learning opportunities, accommodations, adaptations, specialized services and supports needed for the student to progress towards achieving the learning standards and to meet his or her unique needs related to the disability. 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 New York State (NYS), IEPs developed for the 2011-12 school year and thereafter, must be on a form prescribed by the Commissioner of Education. [June 11, 2010]

Note: The response to Question #16 was revised November 24, 2014. Deletions are struck through and additions are underlined.

16. Q. What are the requirements for Medicaid reimbursement of services under SSHSP?

- A. In order for children to receive Medicaid reimbursable services under SSHSP/PSSHSP, they must be Medicaid eligible, be between the ages of three and 21 years, have been determined to have a disability through the IEP process and have an IEP.

In addition, to qualify for reimbursement under New York State Medicaid, SSHSP services must be:

- Medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.) in accordance with State Plan amendment 09-61;
- Ordered by a NYS Medicaid enrolled* practitioner acting within his or her scope of practice;
- 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~~; an approved pre-school; 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 state and federal 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 and/or available under Early Periodic Screening, Diagnosis and Treatment (EPSDT).

[November 24, 2014]

* Please note that referrals for psychological evaluations and counseling services may be made by an appropriate school official or other voluntary health or social agency. School officials are not allowed nor required to enroll as NYS Medicaid providers.

17. Q. What is a §4201 school?

- A. §4201 State-Supported Schools are institutions for the instruction of the deaf, blind, physically, or multiply disabled under §4201 of the New York State Education Law. There are two State Operated and Supported (4201) Schools and 11 State-Supported (4201) Schools in New York State that offer services to children with disabilities ages three through twenty-one years:

- Cleary School for the Deaf
- Henry Viscardi School
- Lavelle School for the Blind
- Lexington School for the Deaf
- Mill Neck Manor School for the Deaf
- New York Institute for Special Education
- New York School for the Deaf
- Rochester School for the Deaf
- St. Francis de Sales School for the Deaf
- St. Joseph's School for the Deaf
- St. Mary's School for the Deaf

[June 11, 2010]

Medicaid Covered Services and Provider Qualifications Under SSHSP

18. Q. What Medicaid services are covered under SSHSP?

A. The ten covered services are:

- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Psychological evaluations
- Psychological counseling
- Skilled nursing services
- Medical evaluations
- Medical specialist evaluations
- Audiological evaluations
- Special transportation services

[June 11, 2010]

Note: The response to Question #19 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are underlined.

19. Q. What are the requirements for ordering services and what are the credentials for providing services under SSHSP for each of the covered services?

A. Physical Therapy

To be Medicaid reimbursable these services require a signed and dated written order from a NYS Medicaid enrolled physician, a physician assistant or a nurse practitioner who is acting within the scope of his or her practice under NYS law. The written order must include a diagnostic statement and purpose of treatment. The

written order is required prior to treatment. The need for physical therapy services must also be documented in the Individualized Education Program (IEP).

Physical therapy services must be provided by:

- A New York State licensed and registered physical therapist qualified in accordance with the requirements of 42 CFR Section 440.110(a) and with applicable state and federal law and regulations, acting within his or her scope of practice under New York State Law; ~~and having graduated from a Commission on Accreditation in Physical Therapy Education (CAPTE)–approved program; or,~~
- A certified physical therapy assistant “under the direction of” such a qualified licensed and registered physical therapist (~~graduate of a CAPTE–approved program~~), acting within his or her scope of practice under New York State Law. See Q&A #20 for “under the direction of” requirements.

Occupational Therapy

To be Medicaid reimbursable these services require a signed and dated written order from a NYS Medicaid enrolled physician, a physician assistant or a nurse practitioner who is acting within the scope of his or her practice under NYS law. The written order must include a diagnostic statement and purpose of treatment. The written order is required prior to treatment. The need for occupational therapy services must also be documented in the IEP.

Occupational therapy services must be provided by:

- A New York State licensed and registered occupational therapist qualified in accordance with the requirements of 42 CFR Section 440.110(b) and with applicable state and federal law and regulations, acting within his or her scope of practice under New York State Law; or
- A certified occupational therapy assistant (COTA) “under the direction of” such a qualified licensed and registered occupational therapist, acting within his or her scope of practice under New York State Law. See Q&A #20 for “under the direction of” requirements.

Speech Therapy Services

These services require a signed and dated written order referral from a NYS Medicaid enrolled physician, a physician assistant, a nurse practitioner or a written referral from a NYS Medicaid enrolled speech-language pathologist. The written order/referral must include a diagnostic statement and purpose of treatment. The written order/referral is required prior to treatment. The need for speech and language services must also be documented in the IEP.

Speech therapy services must be provided by:

- A licensed and registered speech-language pathologist qualified in accordance with 42 CFR Section 440.110©, who is a graduate of a master's program with a certificate of clinical competence (CCC) from the American Speech-Language-Hearing Association (ASHA) or equivalent, and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A teacher certified to provide speech and language services, under the direction of such a qualified licensed and registered speech-language pathologist (ASHA-Certified or equivalent), acting within his or her scope of practice under New York State Law. See Q&A #20 for "under the direction of" requirements.
- A speech-language pathologist who has completed the academic program and has a "Notification of Approval of the Supervisory Plan" in accordance with the requirements of the State Education Law on file and is in the process of acquiring supervised work experience to obtain a license. See [Q&A #50](#) for additional information.

Psychological Evaluations

To be Medicaid reimbursable, psychological evaluations must be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological evaluations in the community and reflected in the IEP. If a psychological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the student's IEP. See Q&A #31 for additional information on documentation of evaluations.

Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a) and other applicable state and federal laws and regulations. Refer to Q&A #21-23, which establish that Medicaid reimbursement is unavailable for school-based personnel. Psychological evaluations must be provided by:

- A New York State licensed and registered psychiatrist, qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law; or
- A New York State licensed and registered psychologist, qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Psychological Counseling Services

To be Medicaid reimbursable, these providers must have credentials which would allow them to provide the same service in the community. Refer to Q&A #21-23, which establish that Medicaid reimbursement is unavailable for school-based personnel. Services require a referral from a NYS Medicaid enrolled physician, physician assistant or nurse practitioner, or an appropriate school official¹, such as a school administrator or the chairperson of the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). The need for psychological counseling must also be documented in the IEP.

¹Please note that referrals for psychological evaluations and counseling services may be made by an appropriate school official or other voluntary health or social agency. School officials are not allowed nor required to enroll as NYS Medicaid providers.

Psychological counseling services must be provided by:

- A New York State licensed and registered psychiatrist qualified in accordance with 42 CFR Section 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law; or,
- A New York State licensed and registered clinical psychologist, qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law; or,
- A New York State licensed clinical social worker (LCSW), qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law; or,
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State Law, under the supervision of such a qualified LCSW, a licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the LMSW, with respect to each Medicaid beneficiary, shall consist of contact between the LMSW and supervisor during which:

- The LMSW appraises 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,
- Applicable prior to 12/8/10: 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. 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.

Skilled Nursing Services

To be Medicaid reimbursable, skilled nursing services must be supported by a written order, signed and dated by a NYS licensed and registered and NYS Medicaid enrolled physician, a physician assistant, or a licensed and registered nurse practitioner acting within the scope of their practice. The written order is required prior to the initiation of services and new orders are required when there are any significant changes in the student's condition. The need for skilled nursing must also be documented in the IEP.

Special Note on Nurse Practitioners

In addition, New York State Education Law §6902(3)(a) scope of practice requirements specify that a nurse practitioner must have a collaboration agreement with a physician, as well as written practice protocols that the nurse practitioner follows and quarterly reviews by the physician of the nurse practitioner's case records. In order to bill Medicaid, documentation of this collaboration agreement, practice protocols, and evidence that the collaborating physician has reviewed patient records must be made available to the Department of Health or its agents for audit purposes (18 NYCRR §505.32(b)).

Skilled nursing services must be provided by:

- A New York State licensed and registered nurse qualified in accordance with the requirements of 42 CFR Section 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or,
- A New York State licensed practical nurse qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice "under the direction of" a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

Note that for licensed practical nurses, the "under the direction of" requirement originates from New York State Education Law §6902(2) and is not the same as the "under the direction of" requirements that apply to therapy assistants or teachers of the hearing handicapped.

Medical Evaluations

Medical evaluations must be reflected in the IEP and must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR Section 440.50(a), 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law. If a medical evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the student's IEP. See Q&A #31 for additional information on documentation of evaluations. Refer to the Skilled Nursing Services section (page 9) for additional information on requirements for nurse practitioners.

A medical evaluation is the assessment and recording of:

- Chief complaints;
- Present illness;
- Past medical history;
- Personal history and social history;
- A system review;
- A complete physical evaluation;
- Ordering of appropriate diagnostic tests and procedures; and,
- Recommended plan of treatment.

Medical Specialist Evaluations

A medical specialist evaluation must be included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP. See Q&A #31 for additional information on documentation of evaluations. Refer to the Skilled Nursing Services section (page 11) for additional information on requirements for nurse practitioners.

A medical specialist evaluation is:

- An examination of the affected bodily area of 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.

Medical specialist evaluations must be provided by:

- A New York State licensed and registered physician specialist acting within his or her scope of practice and related area of specialization;
- A New York State licensed and registered specialist assistant acting within his or her scope of practice and related area of specialization; or,
- A New York State licensed and registered nurse practitioner acting within his or her scope of practice and related area of specialization.

Audiological Evaluations

To be Medicaid reimbursable, audiological evaluation services must be supported by a written order, signed and dated by a NYS licensed and registered and NYS Medicaid enrolled physician, physician assistant or nurse practitioner acting within the scope of their practice. The need for an audiological evaluation must also be documented in the IEP. If an audiological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the student's IEP. See Q&A #31 for additional information on documentation of evaluations.

An audiological evaluation is the determination of the range nature and degree of hearing loss including:

- Measurement of hearing acuity;
- Tests relating to air and bone conduction;
- Speech reception threshold;
- Speech discrimination;
- Conformity evaluations;
- Pure tone audiometry; and,
- The reporting of findings, including test results and recommendations.

Audiological evaluations must be provided by:

- A New York State licensed and currently registered audiologist with a certificate of clinical competence (CCC) from the American Speech-Language-Hearing Association (ASHA), qualified in accordance with 42 CFR 440.60(a) and 42 CFR 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice.

Special Transportation Services

Special transportation services must be provided by a vendor who is legally authorized to provide transportation services on the date the services are rendered. To be Medicaid reimbursable, special transportation services must be provided by a qualified Medicaid provider and attendance documentation (bus/transportation logs) is required. The need for special transportation must also be indicated on the student's IEP. The student's IEP must also state and how the transporting vehicle is modified to meet the needs of the individual student. Transportation must be to a Medicaid-eligible service or from a

Medicaid-eligible service. See Q&A #43-45 for additional information on special transportation services and specific exemptions.
[November 24, 2014]

20. Q. What does “under the direction of” mean?

A. “Under the direction of” means that the qualified practitioner:

- Sees the participant 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 beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and,
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment of each student.

[June 11, 2010]

Note: The response to Question #21 was revised December 10, 2012. Deletions are struck through and additions are underlined.

21. Q. Can a school psychologist make a determination that a child needs a psychological evaluation?

A. ~~This response is under development.~~ Yes. The determination whether a child needs a psychological evaluation must be made by an “appropriate school official or other official”. An appropriate school official or other official means any teacher, administrative personnel, Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE) chairperson or member, or other professional who is familiar with the needs of the individual student. A school psychologist is considered an appropriate school official for the purposes of making a determination that a child needs a psychological evaluation. [December 10, 2012]

22. Q. Who can conduct the psychological evaluation?

A. In order for Medicaid to reimburse for psychological evaluations, they must be provided by a professional acting within his or her scope of practice, and whose credentials are comparable to providers who are able to bill Medicaid for the provision of psychological evaluation services in the community. Psychological evaluations must be provided by:

- A New York State licensed and registered psychiatrist
- A New York State licensed and registered psychologist
[June 11, 2010]

23. Q. Are psychological counseling services in an IEP provided by certified school social workers and certified school psychologists eligible for Medicaid payment?

A. No. Professionals providing psychological counseling and/or evaluation services must have the same professional credentials as those who are permitted to provide psychological counseling and/or evaluations in the community.

In order to be Medicaid reimbursable, psychological services in an IEP must be provided by one of the following professionals, acting within his/her scope of practice:

- A NYS licensed and registered psychiatrist;
- A NYS licensed and registered psychologist;
- A NYS licensed and registered clinical social worker; or,
- A NYS licensed master social worker under the supervision of a licensed psychiatrist, licensed psychologist, or licensed clinical social worker.
[June 11, 2010]

Documentation Requirements to Support Medicaid Billing

General Requirements and Information

Note: The response to Question #24 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are underlined.

24. Q. What documentation is required to submit claims for Medicaid reimbursement?

A. The documentation that must be on file and made available upon request is as follows:

- The Individualized Education Program (IEP)

- New York State certification/licensure/registration of staff providing the service (certifications should include any external certifications needed to be a qualified Medicaid provider, such as a Certificate of Clinical Competence from the American Speech-Language-Hearing Association, or collaboration agreements between a nurse practitioner and a physician)
- Referrals for services as required
- Written orders for services as required
- Supervision or direction by a licensed professional where appropriate
- “Under the direction of” documentation when services are provided under the direction of a qualified provider
- Documentation of each encounter, dated and signed (session notes)
- Special transportation must be on the IEP, and bus logs must include daily entries for each child, on a one-way basis.

Note 1: ~~Each school district must maintain a record of the educational institution from which each physical therapist graduated for comparison with a list of CAPTE-approved programs. Effective July 24, 2013, all New York State licensed and currently registered physical therapists are qualified physical therapy providers under the New York State Medicaid program, including SSHSP. Therefore, each school district must maintain documentation of New York State licensure for physical therapists.~~

Note 2: There may be other documentation requirements, in addition to Medicaid requirements, that apply to students receiving special education services. For example, a written referral, signed and dated, to the Committee on Special Education and/or Committee on Preschool Special Education and quarterly progress notes are required. In addition, parental consent for release of information and a provider agreement and statement of reassignment are required for students with IEPs. [November 24, 2014]

Note: The response to Question #25 was revised July 21, 2015. Deletions are struck through and additions are underlined.

25. Q. What must be included in a session note?

- A.** Session notes specifically document that the service provider delivered certain evaluation and/or services to a student on a particular date. Session notes must be completed by all qualified service providers delivering preschool/school supportive health services that have been ordered by an appropriate practitioner and included in a student’s IEP for each service delivered. Session notes 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 person furnishing the service
- Dated signature and / credentials of supervising clinician as appropriate (signature date must be within 45 days of the date of service).

[July 21, 2015]

26. Q. What are the changes to the billing methodology?

- A. Effective with SPA #09-61, each service encounter must be documented for reimbursement. Current Procedural Terminology (CPT) codes must be used to identify the specific services provided during the encounter. [June 11, 2010]

27. Q. What is Medicaid reimbursement for SSHSP based on?

- A. The service CPT codes under SSHSP, except for transportation, were benchmarked at 75% of the 2010 Medicare fee schedule for the mid-Hudson region. For special transportation, one-way rates of payment have been set based on a statistically valid cost study that was conducted in 1999 to establish round trip transportation rates. The rates were trended forward based on changes in the Consumer Price Index and converted to one-way rates. [June 11, 2010]

28. Q. Where is the Centers for Medicare and Medicaid (CMS) Medicare fee schedule located?

- A. The Medicare fee schedule may be found at www.cms.gov [June 11, 2010]

29. Q. Where is the fee schedule for SSHSP located?

- A. The fee schedule with CPT codes for SSHSP will be posted separately on the SED Medicaid website at <http://www.oms.nysed.gov/Medicaid/>. [June 11, 2010]

30. Q. Does the Medicaid fee schedule for SSHSP cover those services that can be provided in group setting?

- A. Yes. There are different CPT codes for individual and group services, including speech therapy, physical therapy, occupational therapy, and psychological counseling services.
[June 11, 2010]

Evaluations

Note: The response to Question #31 was revised December 10, 2012. Deletions are struck through and additions are underlined.

31. Q. Are evaluations covered before a child has an IEP?

- A. ~~If an evaluation is used to identify a child's health-related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.~~ In addition, in order for reevaluations (triennial and other reevaluations) to be reimbursed by Medicaid, the need for the reevaluation must be documented in the IEP.

An initial evaluation is the evaluation(s) that is done prior to the development of a student's first Individualized Education Program (IEP). As stated in [Medicaid Alert #12-03](#), issued on March 1, 2012, effective April 1, 2012 (date of service), an initial evaluation for PT, OT, ST, or psychological counseling is not Medicaid reimbursable unless an IEP is developed which includes a recommendation for ongoing services in that same therapy type. 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 completed by a Medicaid qualified provider,
- The evaluation must be documented, and
- The evaluation must be included in the IEP.

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

Evaluations that are conducted upon referral to the Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) where the student is not found eligible for special education services, and an IEP is not developed, are not eligible for Medicaid reimbursement. [December 10, 2012]

Written Orders

Note: The response to Question #32 was revised November 24, 2014. Deletions are struck through and additions are underlined.

32. Q. Do the written orders need to be on a prescription pad form?

- A. No. However, the written order must include:
- The name of the child for whom the order is written;

- The complete date the order was written and signed;
- The service(s) that is being ordered;
- Note on frequency and duration: The frequency and duration of the ordered service must either be specified on the order itself or the order must 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 and registered and NYS Medicaid enrolled physician, a physician assistant, or a 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 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 services.

* 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. Refer to Medicaid Alert #12-11 for further clarification on written orders/referrals.

Referrals for psychological evaluations and counseling services may be made by an appropriate school official or other voluntary health or social agency. School officials are not allowed nor required to enroll as NYS Medicaid providers. [November 24, 2014]

Note: The response to Question #33 was revised December 10, 2012. Deletions are struck through and additions are underlined.

33. Q. Can/should frequency of services be included in the written order?

- A.** ~~The frequency of services may be included on the written order at the discretion of the ordering provider.~~ All written orders/referrals completed on and after 1/1/2013 must either include the frequency and duration of the service to be furnished or must adopt — by explicit reference to the IEP — the frequency and duration of the ordered service in the IEP. [December 10, 2012]

34. Q. (a) What is the proper way to indicate the time frame for which the order is written, for example “9/8/10-6/28/11” or “2010-2011 school year”? (b) If the written order says “2010-11 school year” and is dated 9/18/10, can the prescription be used for the summer 2011 services, since the summer is within the 12 month validity?

A. (a) The preferred format for dates is mm/dd/yyyy – mm/dd/yyyy. The school year begins July 1 of each year. A written order for services for the 2010-11 “school year” would be valid for the time period July 1, 2010 through June 30, 2011. (b) No, because the “school year” ends on June 30, 2011. For services on or after July 1, 2011 another order would need to be written and in place before July 1, 2011. Please note that the date of the written order must be prior to delivery of the services that are billed to Medicaid. [June 11, 2010]

Note: The response to Question #35 was revised December 10, 2012. Deletions are struck through and additions are underlined.

35. Q. Is it sufficient for the written order to state ... “per the IEP”?

A. ~~No.~~ According to 20 U.S.C. §1401(26)(A), related services “are ‘designed to enable a child with a disability to receive a free appropriate public education’ or ‘to benefit from special education.’” SSHSP services are a subset of IDEA-defined related services. The IEP determines which related services are needed to facilitate the student’s educational progress. It does not constitute medical necessity.

All written orders/referrals completed on and after 1/1/2013 must include frequency and duration of the service to be furnished or must adopt — by explicit reference to the IEP — the frequency and duration that will be delivered to the student. The use of the terminology “per the IEP” is acceptable on a written order/referral and means that the ordering provider is making an explicit reference to the frequency, duration, and other conditions of service delivery (e.g., individual vs. group) of the service detailed in the existing IEP. Regardless of how the ordering practitioner chooses to specify frequency and duration of the ordered service(s) the written order must contain all other required elements as stated in Q+A # 32. [December 10, 2012]

36. Q. If the IEP states physical therapy 3 times per week, and the written physician order states physical therapy 2 times per week, what services should be provided, and what services may be billed to Medicaid?

A. Because provided services are driven by what is included in the IEP, the district, county, or §4201 school should provide physical therapy services 3 times per week. However, because medical necessity has only been established for two of those days, Medicaid may only be billed for two times per week. If the services identified in the IEP are not the same as those ordered by the physician or other qualified

practitioner, Medicaid can only be billed for those services included in the written order. [June 11, 2010]

37. Q. If the physician/qualified practitioner does not date the order form, can it be used for the full IEP if it is received before services start?

A. No. A written order for services must include the complete date that the order was written and be signed by the appropriate practitioner and include service dates. [June 11, 2010]

38. Q. (a) Can receipt of a written order be established by a faxed date or a stamped-in date by the school district/county/§4201 school? (b) Is a practitioner's stamped signature acceptable?

A. (a) A date stamp or faxed date recorded by the school district/county/§4201 school is **not** acceptable. The written order must be dated and signed by the practitioner. If the order does not indicate a time frame, it may be considered valid for a period of one year from the date the order was written. (b) The use of a signature stamp or the signature of an administrator on written orders for services is not acceptable. The practitioner must sign the prescription or order. [June 11, 2010]

39. Q. Do occupational therapy, physical therapy and speech therapy services require individual written orders (scripts)? Currently most schools have all related services on one script.

A. No, individual written orders (scripts) are not required. The related services may all be on one written order, provided each student's need for each service is specifically determined and documented. [June 11, 2010]

Documentation of Service Delivery and Record Retention

40. Q. Where are services generally documented on the IEP?

A. On the State's model IEP form, services must be documented in the Recommended Special Education Programs and Services section of the IEP. [June 11, 2010]

41. Q. What constitutes contemporaneous as relates to record keeping or progress notes?

A. The duties of the provider are discussed in Social Services Law at 18 NYCRR Section 504.3(a). 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. [June 11, 2010]

42. Q. What is the current requirement for retaining Medicaid records and documentation for reimbursement under the School Supportive Health Services Program (SSHSP)?

A. The 2009 Settlement and Compliance Agreement between New York State and the federal agencies effectively ended the January 2002 SED directive that all Medicaid records since January 1, 1990 for reimbursement under SSHSP be held/retained until further notice. The normal retention policy now in effect is to retain the following records for a minimum of six years from the date that the services were paid:

- All documents relating in any manner to Medicaid reimbursement for services;
- All documents relating in any manner to referrals, prescriptions or orders for these services;
- All documents relating in any manner to the provision of these services; including but not limited to those showing dates that services were provided, the specific service that was provided, those that identify the professional providing the services or under whose direction the services were provided and their professional qualifications, progress and other notes, memoranda, correspondence, emails, reports, transportation logs, and other documents relating to services rendered; and,
- All Individualized Education Programs (IEPs) for Medicaid eligible students. Please note that you may need to retain some or all of these documents for a longer retention period than six years due to other retention requirements. When destroying old documents, school districts/counties are advised to adhere strictly to their own written policies regarding record retention and destruction, and to document the process they follow. [June 11, 2010]

Special Transportation Services

Note: The response to Question #43 was revised November 24, 2014. Deletions are struck through and additions are underlined.

43. Q. What criteria are used by the Committee on Special Education (CSE) or the Committee on Preschool Special Education (CPSE) to determine a child's need for special transportation?

A. Most students with disabilities receive the same transportation services as students without disabilities. The CSE and CPSE are responsible for determining whether a

student's disability prevents him or her from using the same transportation or manner in which to get to school as students without disabilities. In determining whether to include special transportation on a student's IEP, the CSE and the CPSE should consider and document the needs of the student. The IEP must include specific transportation recommendations to address each of the student's needs, as appropriate. Factors in the decision-making process include the student's mobility, behavior, communication skills, and physical and health needs.

Medicaid reimbursement for special transportation is limited to those situations where the child receives transportation to obtain a Medicaid-covered service (other than transportation), or from a Medicaid-covered service, and both the Medicaid-covered service, and the need for special transportation, and how the transporting vehicle is modified to meet the needs of the individual student are included in the child's IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one-way trip. [November 24, 2014]

Note: The response to Question #44 was revised November 24, 2014. Deletions are struck through and additions are underlined.

44. Q. What are the requirements for submitting claims for Special Transportation?

- A. Special transportation recommended by the Committee on Special Education (CSE) and Committee on Preschool Special Education (CPSE) and identified on the students' IEP ~~is~~ may be eligible for Medicaid funding.

With some exceptions, Medicaid reimbursable special transportation is limited to those situations where the student receives transportation in a vehicle modified to accommodate the student's disability to obtain a Medicaid-covered service (other than transportation), or returns from a Medicaid-covered service. See [Medicaid Alert #13-10](#) for additional information, including specific exceptions, effective September 1, 2013.

Note: 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 include the specific medical need for special transportation to accommodate the student's disability, specify the nature of the student's special transportation needs and an explanation as to how the transporting vehicle has been specially modified to serve the needs of that student with a disability must be documented in the IEP;

- 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 that was 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.

Providers are urged to maintain a record with all information listed above to support claims for Medicaid transportation services.

In addition, transportation departments must be made aware of the necessary documentation and record retention requirements for the claiming of Medicaid services.

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. [November 24, 2014]

Note: The response to Question #45 was revised November 24, 2014. Deletions are struck through and additions are underlined.

45. Q. How will transportation be billed under the new State Plan Amendment (SPA) #09-61?

- A. Special transportation will continue to be billed using a rate-based methodology. One-way rates of payment have been developed and will be made available on SED's website at <http://www.oms.nysed.gov/Medicaid/>. Special transportation can only be billed on a day that a Medicaid-reimbursable service was delivered and may only be billed at the rate for each one-way trip. See Medicaid Alert #13-10 for additional information, effective September 1, 2013. [November 24, 2014]

Training and Additional Resources

46. Q. Will training be available?

- A. Yes. Training will be provided on the compliance agreement between the federal Centers for Medicare and Medicaid Services and the state government to ensure compliance with Medicaid requirements; the Confidential Disclosure Policy; and on

the new requirements for SSHSP under SPA #09-61. Consult the SED Medicaid website at <http://www.oms.nysed.gov/Medicaid/> for updates. [June 11, 2010]

47. Q. Where can I get additional information about School Supportive Health Services?

- A.** Additional information about School Supportive Health Services is available on the Department of Health website and the State Education Department Medicaid website at <http://www.oms.nysed.gov/Medicaid/>.

Questions related to School Supportive Health Services may be sent via email to MedinEd@mail.nysed.gov. [June 11, 2010]

Relevant Employee Training

48. Q. Who is considered a relevant employee?

- A.** A relevant employee is anyone employed or contracted by a school district, county or 4201 school who is involved in the Medicaid in Education program. School district business officials, county finance officers, special education directors and Medicaid billing clerks must attend face-to-face compliance training. All other relevant employees must attend a face-to-face training or participate in the online training annually. [December 13, 2010]

Provider Qualifications

49. Q. Is a speech-language pathologist (SLP) (not currently licensed and registered) who holds a Certificate of Clinical Competence (CCC) issued by the American Speech-Language-Hearing Association (ASHA) considered to be a qualified Medicaid provider of SSHSP services?

- A.** No. An SLP who is ASHA-certified, but does not have a NYS license, may only provide Medicaid-billable speech therapy services if he or she is certified as a Teacher of the Speech and Hearing Handicapped (TSHH) or a Teacher of Students with Speech and Language Disabilities (TSSLD) and is working under the direction of a NYS licensed and currently registered SLP. [December 13, 2010]

Note: The response to Question #50 was revised July 21, 2015. Deletions are struck through and additions are underlined.

50. Q. Can individuals who are completing their 36 weeks of supervised experience as required for licensure in New York State and for certification by the American Speech-Language-Hearing Association provide Medicaid-reimbursable speech-language pathology services in the School Supportive Health Services Program?

A. Yes. 42 CFR Section 440.110(2)(iii) defines a "speech pathologist" as an individual who "has completed the academic program and is acquiring supervised work experience to qualify for the certificate." Individuals who are acquiring the supervised work experience to qualify for a New York State license as a speech-language pathologist must complete 36 weeks of acceptable supervised experience in accordance with Part 75 of the Regulations of the Commissioner, Section 75.2. The same supervised work experience is also required to obtain a Certificate of Clinical Competence issued by the American Speech-Language-Hearing Association (ASHA). This supervised work experience is also known as a Clinical Fellowship Year or CFY.

An individual completing their supervised work experience (CFY) in speech-language pathology who is supervised by a New York State licensed speech-language pathologist may provide Medicaid-reimbursable speech-language pathology services in the School Supportive Health Services Program as long as they have submitted the appropriate forms to the NYS Education Department identifying their supervisor and work setting and have received verification (Form 6) that their experience is approved. Please refer to the NYS Education Department's website at <http://www.op.nysed.gov/prof/slpa/speechforms.htm> for additional information.

The intensity and type of supervision is left to the discretion of the supervising speech-language pathologist. For purposes of the School Supportive Health Services Program, the supervising licensed speech-language pathologist must co-sign and date the supervisee's evaluation reports and session notes. All "under the direction of" requirements outlined in SSHSP guidance at http://www.oms.nysed.gov/medicaid/q_and_a/ in Q&A # 20 must be followed. In addition, the school district, county, or Section 4201 school must maintain documentation identifying the licensed speech-language pathologist who provides supervision to the individual completing their 36 weeks of supervised experience and/or CFY, as well as the terms of supervision. [July 21, 2015]

51. Q. Is Medicaid reimbursement available for services provided by student interns?

A. Medicaid reimbursement is available when individual or group therapy is being provided under the direct, face-to-face supervision of a New York State licensed and

currently registered practitioner acting within his or her scope of practice. To be Medicaid reimbursable, a session involving a student intern must be conducted with the licensed clinician in continuous attendance with the student intern and the child or children receiving the service. In addition, the qualified practitioner must be guiding the student intern in service delivery and cannot be engaged in treating another child, supervising another student intern, or doing other tasks at the same time. The qualified practitioner is responsible for the services that are furnished to the child, including writing a session note that reflects the service that was delivered, and signing all documentation. It is permissible, but not necessary, for the student intern to sign the session note. A separate note may be written by the student intern for educational purposes. For further information please visit the CMS website: <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> [December 13, 2010]

52. Q. The SPA does not include certified school psychologists within the list of qualified providers. Does this mean certified school psychologists may no longer conduct evaluations or provide services within the school setting?

A. Refer to the SSHSP guidance document ([Questions and Answers](#)), pages 7-8 and Questions #22 and #23. The State Plan Amendment specifies which providers must provide psychological evaluations and psychological counseling services in order to be Medicaid reimbursable. Services provided by certified school psychologists are not reimbursable under Medicaid. Certified school psychologists may provide psychological counseling services/evaluations; however, psychological counseling services/evaluations provided by school psychologists cannot be billed to Medicaid. [December 13, 2010]

Note: The response to Question #53 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are underlined.

53. Q. Regarding PT services: New York’s licensure laws allow for “individual evaluation” of license applicants through which individuals not having graduated from a CAPTE-approved program may be granted a license. The SPA does not require CAPTE approval, although guidance documents seem to suggest the requirement. Please clarify. How will SED/DOH treat individuals holding a New York State license through the “individual evaluations” process?

A. Individuals holding a New York State license in physical therapy who were subject to the “individual evaluations” (foreign educational program review) by the New York State Education Department’s Office of Professions Comparative Education Unit are considered no differently than individuals holding a New York State license in physical therapy who completed CAPTE-approved educational programs, these individuals are all licensed and currently registered NYS physical therapists and are qualified Medicaid providers.

Please see [Medicaid Alert #13-08](#), issued on July 24, 2013, for additional information.

~~SPA #09-61 requires the physical therapist to be New York State licensed and registered as well as being qualified in accordance with 42 CFR 440.110 and with applicable state and federal laws and regulations. Per 42 CFR 440.110 a “qualified physical therapist” is an individual who is —~~

~~(i) meets personnel qualifications for a physical therapist at 42 CFR § 484.4.~~

~~(i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and~~

~~(ii) Where applicable, licensed by the State.~~

~~Individuals without the CAPTE accreditation need to go through the Department of Education Office of the Professions and apply for an equivalency determination on a case-by-case basis.~~

~~Although the American Physical Therapy Association (APTA) does not directly approve any physical therapy education programs, CMS has determined that a CAPTE-approved program meets the regulation's credentialing requirement. The American Medical Association Committee no longer accredits physical therapy education programs. DOH is exploring the CAPTE requirement further. Additional information will be forthcoming.~~

~~Individuals applying for New York State licensure who graduate from programs outside of the United States that are not accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) must apply to the New York State Education Department's Office of Professions Comparative Education Unit for review of their education. Although a foreign-educated physical therapist may be licensed by New York State, CMS has determined that education equivalency rulings do not qualify physical therapists to bill for services provided under Medicaid. Therefore, at this time, only licensed physical therapists who have graduated from a CAPTE-approved program are qualified to provide services and be reimbursed by Medicaid. [November 24, 2014]~~

54. Q. Does Medicaid require that Occupational Therapist Assistants be registered with the National Board for Certification of Occupational Therapy (NBCOT)?

A. No. Occupational Therapy Assistants do not need to be certified by the NBCOT for Medicaid reimbursement purposes. They must be certified by the NYS Commissioner of Education. Please see [Medicaid Alert #10-2](#) posted on the Medicaid in Education website for additional information. [December 13, 2010]

55. Q. Does the equivalency determination from the NYS Attorney General apply to audiologists also?

A. No, the [equivalency determination](#) does not apply to audiologists. Therefore, audiologists must have both a NYS license and current registration and the Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA) in order to bill Medicaid. [December 13, 2010]

Evaluations and Services

56. Q. Evaluations are part of the definition of occupational therapy (OT), physical therapy (PT) and speech therapy services, per the SPA 09-61. a) Are OT, PT and speech evaluations claimable? b) Do these evaluations need a written referral? c) Who are the professionals who can refer the child to each of these evaluations?

A. a) Yes. OT, PT and speech evaluations are Medicaid reimbursable as long as there is documentation of the medical necessity and the evaluation is reflected in the IEP.
b) Yes, these evaluations require a written order/referral prior to the evaluation.
c) Refer to the "[Medicaid Qualified Providers & Medicaid Documentation Requirements](#)" handout for information pertaining to who can order and furnish services. Please note that services include evaluations and ongoing treatment. [December 13, 2010]

Note: The response to Question #57 was revised November 24, 2014. Deletions are struck through and additions are underlined.

57. Q. Is an evaluation that doesn't result in a recommendation for additional services Medicaid reimbursable if the student already has an Individualized Education Program (IEP) and is receiving other SSHSP services?

A. ~~Yes, as long as it is ordered properly, included in the IEP, conducted by a Medicaid approved provider, and documented properly.~~ No. The evaluation would only be reimbursable under SSHSP if the new service is subsequently included as an ongoing service in the student's IEP. [November 24, 2014]

58. Q. Who is the "appropriate school official" who may refer a student for psychological counseling services?

A. An appropriate school official or other official means any teacher, administrative personnel, Committee on Special Education (CSE)/Committee on Preschool Special

Education (CPSE) chairperson or member, or other professional who is familiar with the needs of the individual student. [December 13, 2010]

59. Q. Does the Individualized Education Program (IEP) establish medical necessity?

- A. No. According to 20 U.S.C. §1401(26)(A), related services are “designed to enable a child with a disability to receive a free appropriate public education” or “to benefit from special education.” SSHSP services are a subset of IDEA-defined related services. The IEP determines which related services are needed to facilitate the student’s educational progress. It does not constitute medical necessity.

The written orders or written referrals that are in the student’s record document medical necessity. See the “[Training on Compliance Agreement, Written Compliance Policies and Program Update](#)” PowerPoint posted on the Medicaid-In-Education website. In addition, refer to SSHSP [Questions and Answers #32](#) for the required elements of a written order. [December 13, 2010]

Skilled Nursing Services

Note: The responses to questions 60 through 70 were developed in conjunction with the Office of Student Support Services of the New York State Education Department.

60. Q. What are the different roles of an RN and an LPN?

- A. Per Section 6902 of Article 139 of the Education Law, a Registered Nurse (RN) is defined as being qualified to diagnose and treat human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner’s regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

Per Section 6902 of Article 139 of the Education Law a Licensed Practical Nurse (LPN) is defined as being qualified to perform tasks and responsibilities within the framework of casefinding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist, or other licensed health care provider legally authorized under this title and in accordance with the commissioner’s regulations.

For further information see <http://www.op.nysed.gov/prof/nurse/article139.htm>

An LPN cannot assess or triage, and therefore would not be able to document progress towards a goal(s). LPNs perform designated tasks, and report any data they collect to the RN for interpretation. [December 13, 2010]

61. Q. Is it the responsibility of the school nurse (RN) to supervise an LPN working in the same school?

A. Per Section 6902 of Article 139 an LPN must practice within their scope of practice “under the direction of a registered professional nurse, licensed physician, dentist or other licensed provider legally authorized under this title”... the RN, school nurse, in the building is not responsible to supervise the LPN unless that is in her job description; however he/she would be responsible for the provision of direction to the LPN and overseeing the quality of care the students receive. The district is responsible for providing supervision to both district employees and independent contractors or agency nurses that they pay to work in the district. The medical director, school nurse if there is one, and the board of education are responsible for insuring the students receive the appropriate care. [December 13, 2010]

62. Q. Must the Registered Nurse co-sign the Licensed Practical Nurse’s signature for every Medication Administration Record in order for the service to be Medicaid reimbursable?

A. No. The RN does not need to co-sign an LPN's signature in order for the service to be Medicaid reimbursable. [December 13, 2010]

63. Q. Since an LPN is assigned a National Provider Identifier (NPI) number for reimbursement by Medicaid as an independent practitioner, does that mean LPNs are able to function as independent practitioners?

A. No. An LPN's scope of practice is defined in Education Law §6902(2). The scope of practice states that the LPN is to work under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider designated in the Education Law or the Commissioner’s regulations. [December 13, 2010]

Note: The response to Question #64 was revised July 13, 2015. Deletions are struck through and additions are underlined.

64. Q. What documentation is needed to support Medicaid reimbursement for skilled nursing services?

A. In addition to documentation required for any Medicaid-covered service (e.g., written orders), session notes and/or Medication Administration Records are also needed to support Medicaid reimbursement for skilled nursing services. See Table 1 for clarification.

Table 1. Documentation Requirements for Skilled Nursing Services

SKILLED NURSING SERVICE	SESSION NOTE	MEDICATION ADMINISTRATION RECORD (MAR)
Health assessments and evaluations, including necessary consultation with licensed physicians, parents and/or staff regarding health care of student	X	
Medical treatments and procedures, including necessary consultation with licensed physicians, parents and/or staff regarding health care of student	X	
Administration of medication		X

Session notes

The required elements of a session note may be found in Questions and Answers issued June 11, 2010 (# 25 as revised 12/10/2012-7/21/2015) on the Medicaid-in-Education home page at http://www.oms.nysed.gov/medicaid/q_and_a/ [July 21, 2015]

65. Q. What information must be included in a Medication Administration Record (MAR)?

- A.** 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

School nursing personnel should maintain accurate records of the medication administered, any special circumstances related to the procedure, and the student’s reactions/responses.

A sample Medication Administration Record (MAR) is available at:
http://schoolhealthservicesny.com/tool_kit.cfm?subpage=326[December 13, 2010]

66. **Q. May initials be used on the medication log (MAR) instead of the full signature?**
- A. No. A full original signature is required by Medicaid in order to positively identify the licensee. Stamped signatures are not permitted on health care provider orders or school health documentation. [December 13, 2010]
67. **Q. Can the regularly employed School Nurse sign off on the Monthly Service Forms that a procedure/medication was done by a substitute School Nurse (documented on medication administration form)?**
- A. For purposes of Medicaid reimbursement, a monthly sign off is not necessary. Medicaid requires that the medication administration form be signed by the administering nurse at the time the service is rendered. It is recommended that a note is written periodically in the cumulative health record to summarize. [December 13, 2010]
68. **Q. Where can I find additional information on medication administration in the school setting?**
- A. The Education Department's *Administration of Medication in the School Setting Guidelines* is available at:
<http://www.schoolhealthservicesny.com/files/filesystem/NYSED%20Admin%20of%20Meds%20Guidelines%202002.pdf>. Additional questions may be directed to the Office of Student Support Services at 518-486-6090. [December 13, 2010]
69. **Q. In the questions and answers document issued 6/11/2010 under number 34 A(b), it indicates that orders need to be written within a given "school year." Within the document from SED "Administration of Medication in Schools 2002" the procedure indicates that orders need to be written "annually" or "when there is a change in medication." This time frame does not necessarily coincide with the July 1 - June 30 "school year." Can we continue with what we have always done in renewing on an annual basis?**
- A. Medication orders are valid for 12 months unless otherwise specified. For ease of documentation and tracking, orders for nursing services for a school year are recommended to start on or after 9/1 and end on 8/31 of the following year. Order changes would need to be dated as they occur. Unless the student will be attending summer school, parents/guardians should pick up medications at the end of the school year. [December 13, 2010]

70. Q. I am still not clear on the "up to 15 minute" billing time and what that includes. Is it just the actual face to face, skilled nursing time or does this time include the student coming to the office; travel time if the nurse is travelling between school buildings; paperwork; etc.?...

A. Only face-to-face time in skilled nursing services is Medicaid reimbursable.
[December 13, 2010]

Special Transportation

71. Q. Is transportation to another school district building alone a billable transportation service?

A. No. Medicaid reimbursement for special transportation is only available when a student is being transported to or from a Medicaid reimbursable service. In addition, special transportation must be included in the IEP and all other documentation requirements must be met. For more information on special transportation including documentation requirements, see #43 - #45 of the [Questions and Answers](#) posted on the Medicaid-In-Education website. [December 13, 2010]

72. Q. When completing the transportation log, is the full address, including street, city, and state needed for each trip or can they just include "home" and "school"?

A. 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. The transportation log must include the following elements for each trip:

- 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.

For more information see the SSHSP [Questions and Answers](#) document (#43 - #45) posted on the Medicaid in Education website.

*See question #73 for additional clarification. [December 13, 2010]

73. Q. a) **Must the special transportation provider document the pickup and drop off time of each student on the bus when completing a daily transportation log?**
b) **Does every Medicaid eligible student need their own daily transportation log?**

- A. a) This response is specific to the requirement to document pickup and drop off times referenced in question #72. 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.
b) No. It is not necessary for the provider to create a separate special transportation log for each Medicaid eligible student. [December 13, 2010]

Sessions (Individual, Group, Make-up, Frequency)

74. Q. **Are integrated (push-in) speech therapy services reimbursable by Medicaid? If a speech-language pathologist (SLP) goes into the classroom acting as a teacher aide; and in the course of instruction sits with various students or groups of students and makes sure to periodically include the student(s) that is receiving SSHSP services, can the SLP bill for these services? Often it will be in five-minute increments in the course of an hour spent in the classroom, possibly totaling 15 minutes. Can the minutes be totaled and billed as either group or individual as appropriate?**

- A. Therapy provided in this setting may only be billed to Medicaid if the servicing provider can document the occurrence of appropriate one-on-one or group (sized up to five students*) services provided and meet all other Medicaid billing documentation requirements. Classroom instruction is not a Medicaid reimbursable service, regardless of the amount of time spent instructing the Medicaid eligible student. The services of a teacher aide are not Medicaid reimbursable.

*Larger group sizes are permissible in NYC. Refer to Question #76. [December 13, 2010]

75. Q. **If the IEP only states group therapy, but both individual and group services were provided, what can the school district, county or §4201 school bill for?**

- A. You may only bill for ordered services that are included on the IEP. If only group therapy is indicated on the IEP, then Medicaid reimbursement is only available for group therapy. An example would be when a group of four students is scheduled, but only one student shows up. Because a group is defined for reimbursement

purposes as two or more, you may not bill this as group. Since this student's IEP only states group, you may not bill for the individual session either because it is not in the IEP. [December 13, 2010]

76. Q. Is there a limit on how many students can be in a group for related services (e.g., speech therapy, occupational therapy, physical therapy)?

- A.** Part 200.6(e)(3) of the regulations of the Commissioner of Education states *“When a related service is provided to a number of students at the same time, the number of students in the group shall not exceed five students per teacher or specialist, except that, in the city school district of the city of New York, the commissioner shall allow a variance of up to 50 percent rounded up to the nearest whole number from the maximum of five students per teacher or specialist.”*

The ratio of 5:1 for speech group therapy sessions is allowed per Part 200.6(e)(3) of the regulations of the Commissioner of Education. This ratio is also allowable for Medicaid billing purposes. Medicaid reimbursement is available for group therapy sessions involving two or more students. [December 13, 2010]

77. Q. Is Medicaid reimbursement available for therapy sessions that have to be made-up?

- A.** In order for a make-up therapy session to be Medicaid reimbursable it must be consistent with the written order/referral (medically necessary) and must:
- Be a service that is documented in the IEP
 - Occur within the week within which the missed visit occurred
 - Be documented (session notes must be kept for each session including made up sessions)
 - Be provided by a qualified Medicaid provider
 - Fit with the desired treatment outcome

Example:

The written order and the IEP specify three 30-minute physical therapy sessions per week must be provided. The student misses one session due to absence from school. If the session is made-up within the same week Medicaid can be billed for all three sessions because only the three sessions have been provided within one week. If the missed session is provided in a subsequent week Medicaid can only be billed for three of the four sessions provided that week because the IEP specified three therapy sessions per week, not four. [December 13, 2010]

78. Q. Can more than one therapist providing co-treatment bill for the same session?

- A.** Co-treatment consists of more than one professional providing treatment at the same time. Therapists, or therapy assistants, working together as a “team” to treat one or more individuals **cannot** bill separately for the same or different service provided at the same time to the same individual. For co-treatments only one

Current Procedural Terminology (CPT) code may be billed per session (untimed CPT codes) or per unit (timed CPT codes).

Where a physical and an occupational therapist (timed CPT code) both provide services to one individual at the same time, either one therapist can bill for the entire service or the PT and OT can divide the service units if applicable. If services are provided by a speech-language pathologist (untimed CPT code) and an occupational or physical therapist (timed CPT code), only one discipline per session may be billed. The session note should reflect the service provided by each practitioner during the session. [December 13, 2010]

Note: The response to Question #79 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are underlined.

79. Q. Many IEPs did not/do not list “psychological counseling”; but, rather, indicate “counseling” without modifier; or “social work”; or “family training.” Must all IEPs now describe those services as “psychological counseling”? How will IEPs implemented on and after 9/1/09 to the present be managed?

A. Effective 9/1/2009, in order for psychological counseling services to be Medicaid reimbursable, "psychological counseling" must be listed on the IEP. The service provided must meet the definition of psychological counseling services included in SPA #09-61 ("treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are severe enough to require treatment."). In addition, services must be medically necessary, provided by a qualified provider and fully documented. For more information on provider qualifications and documentation requirements, see the [Questions and Answers](#) (issued June 11, 2010 and revised 12/10/2012 and 11/18/2014) posted on the Medicaid in Education website. [December 13, 2010]

80. Q. How should a “consultation” between clinical and/or instructional staff be documented? Are “consultations” Medicaid reimbursed?

A. A consultation between clinical and/or instructional staff should be documented as the professional/clinician sees fit. Consultations between/among professionals are not Medicaid reimbursed under SSHSP. [December 13, 2010]

81. Q. Are there any SSHSP services Medicaid will reimburse if the student is not present?

A. Medicaid will not reimburse any SSHSP service when the student is not present. Activities associated with service delivery, such as writing evaluation reports or session notes, meeting with family members, or consulting with teachers or other professionals are not separately Medicaid reimbursable. [December 13, 2010]

Documentation

82. Q. Can providers use a signature stamp rather than manually signing each day's session notes?

A. The use of a signature stamp is not acceptable. [December 13, 2010]

Provider Credentials

83. Q. What documentation is acceptable proof of provider credentials for independent contractors? Is checking licensure on NYS Education Department's (SED) Office of the Professions website sufficient? Must the school districts, counties and §4201 schools have copies of each license for all "agency service providers" that they contract with?

A. Documentation of provider credentials is the responsibility of the school districts, counties and §4201 schools. There are several ways to check provider credentials. School districts, counties and §4201 schools should have a copy of each provider's credentials on file and must only bill Medicaid for services provided by qualified practitioners.

Districts/counties may be able to verify a provider's license using the NYS Office of the Professions website at <http://www.op.nysed.gov/opsearches>. It may also be necessary to verify the educational background, including the program from which an individual graduated, in some instances. [December 13, 2010]

84. Q. Should there be multiple copies of a provider's license and registration maintained—for example, one with the Committee on Special Education and one with the Business office?

A. Maintaining multiple copies of a provider's license and registration is not necessary. [December 13, 2010]

85. Q. Should school districts, counties and §4201 schools check licensure and registration yearly?

A. Yes. It is the responsibility of the school districts, counties and §4201 schools to verify NYS licensure and current registration at least on an annual basis. In addition, school districts and counties are responsible for checking the Federal and State exclusion lists. [December 13, 2010]

Exclusion Lists

- 86. Q. As a school district, county or §4201 school, are we required to check the exclusion status of any practitioner who prescribes or orders a service (e.g., physical therapy, occupational therapy, or speech therapy) that will be billed to Medicaid?**
- A. Yes. A person who is excluded from Medicaid cannot be involved in any activity relating to furnishing care, services, or supplies for which claims are submitted, or relating to claiming or receiving payment for medical care service or supplies. [December 13, 2010]
- 87. Q. Should school districts, counties, or §4201 schools check the exclusion lists for all employees of an agency with multiple contracts and services, or only those employees who work in programs involved in Medicaid/Medicare billing?**
- A. The billing provider should verify that all employees, contractors or service providers who are involved in generating a claim to bill for services or being paid by Medicaid (including if their salaries are included on a cost report submitted to the Medicaid program) are not on the excluded list. [December 13, 2010]
- 88. Q. Exclusion list checking – per OMIG compliance, we need to be checking the providers through three different websites for exclusion from the Medicaid/Federal programs. The compliance certifications didn't start until 12/31/09. Most counties are just beginning to do these checks, so would checking the websites now allow us to bill for services provided in September 2009 through June 2010?**
- A. Providers have always been required to check the PVR-292 (the list of excluded, restricted and terminated providers) when submitting a claim to Medicaid in order to ensure excluded individuals and entities do not participate in the Medicaid program. This check should be done before a claim is submitted. [December 13, 2010]
- 89. Q. Does every employee who works at the school district, county or §4201 school need to be checked? Even non-medical personnel such as bus drivers and transportation company owners?**
- A. A person who is excluded from Medicaid cannot be involved in any activity relating to furnishing care, services, or supplies for which claims are submitted, or relating to claiming or receiving payment for medical care service or supplies.

A provider should check the PVR-292 for any employee whose responsibilities could cause a claim to be made. When a provider uses a subcontractor to provide a service for which a claim would be submitted, we recommend the provider include language in the contract with subcontractor which would require the subcontractor to

check PVR-292 against the names of his employees whose responsibilities could result in a Medicaid claim. [December 13, 2010]

90. Q. How often must providers be checked?

- A. The OMIG recommends the PVR-292 (the list of excluded, restricted and terminated providers) be checked every 30 days. [December 13, 2010]

Written Orders and Referrals

Note: The response to Question #91 was revised November 24, 2014. Deletions are struck through and additions are underlined.

91. Q. Can school districts accept prescriptions for occupational therapy (OT), physical therapy (PT), speech therapy, and/or skilled nursing services from physicians, nurse practitioners or physician assistants who are located in a border state, but not registered with the New York State Office of the Professions?

- A. ~~Yes. Out-of-state practitioners (physician/physician assistant, nurse practitioner) who are licensed by the appropriate state agency in which they are located may prescribe medically necessary care/treatment for NYS Medicaid recipients.~~
In accordance with Article 31 section §6526 of the State Education Law, the only out-of-state practitioners that may prescribe medically necessary care/treatment are physicians licensed in a bordering state and who reside near the border of this state. The border vicinity is usually defined as less than 25 miles.

In addition, the out-of state ordering practitioner must be enrolled in the NYS Medicaid program. [November 24, 2014]

92. Q. If there is a change made to an IEP (service change) then is a new referral or order that covers that service type required?

- A. Yes. A written order/referral must be completed for each additional type of service, or change to an existing service, to be Medicaid reimbursable. [December 13, 2010]

93. Q. Can a doctor write and sign one script for several students, or would a script be needed for each student?

- A. No, this is not permissible; a separate order/referral is required for each student to protect each student's confidentiality. [December 13, 2010]

94. **Q. Can a NYS licensed and currently registered speech-language pathologist (SLP) who has not seen the student write a referral for speech therapy?**
- A. No. The SLP cannot write a referral if they have not seen the student. 18 NYCRR 505.11 states that a written order must contain a diagnostic statement and purpose of treatment. It is not acceptable under the Medicaid program for the ordering or referring professional never to have met with the child as it is incompatible with the obligations of the ordering practitioner to assure that the ordered care, services, or supplies will meet the recipient's needs and restore him or her to the best possible functional level. [December 13, 2010]
95. **Q. Can the old prescriptions received for 2009-2010 services, some of which may be 12-15 months old by this time, be returned to the physician with a request to annotate them to include the diagnosis code or treatment purpose without affecting the validity of the original prescription?**
- A. No, an original prescription cannot be altered. [December 13, 2010]
96. **Q. Can a statement signed and dated by the physician now, indicating the diagnosis or purpose of the treatment which was prescribed for the 2009-2010 school year on, for example 7/1/2009, be used as a supplement to the original prescription, allowing it to be used to meet the new prescription (written order/referral) requirements?**
- A. No, written orders for services must be prospective. [December 13, 2010]

Note: The response to Question #97 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are underlined.

97. **Q. What would a referral for Psychological Counseling consist of? Would it be an annual requirement or one referral at the start of counseling?**
- A. For clarification on “referral” for Psychological Counseling refer to the [Medicaid Qualified Providers & Medicaid Documentation Requirements](#) available on the Medicaid in Education website. Referrals for psychological counseling services may be made by an appropriate school official, such as a school administrator or the chairperson of the CSE/CPSE, or a NYS Medicaid enrolled licensed practitioner acting within his/her scope of practice. Referrals should coincide with the time frame reflected in the IEP. A copy of the referral should be included in the student’s record. [November 24, 2014]

Note: The response to Question #98 was revised December 10, 2012. Deletions are struck through and additions are underlined.

98. Q. Are ICD-9 diagnosis codes required on written orders/referrals?

- A. Diagnosis codes (ICD-9 codes) are not currently a NYS requirement on written orders or referrals for SSHSP, however, they may be included if available. The items that must be included in a written order/referral are listed in the [SSHSP Questions and Answers](#) (see question #32). ~~In the future,~~ Effective for dates of service on and after September 1, 2012, ICD-9 codes will be required ~~when submitting on claims submitted~~ to Medicaid for reimbursement. A [Medicaid Alert #12-04](#) ~~will be~~ was issued and posted on the Medicaid in Education website on March 1, 2012 prior to instituting this requirement. [December 10, 2012]

Session Notes

99. Q. What specific information is to be included in a “session note”? Do session notes only reflect start/end times of the face-to-face service; or (a) Are session notes to reflect the service as provided, or as set out in the IEP (for example, the IEP requires a group session, but 2 of the 3 group are absent, effectively resulting in an “individual session”)? (b) Is the “session” direct contact time only, or does it presume record keeping time within that “session”? If record keeping is not included within the “session,” how is that activity to be documented and is it a “Medicaid” service?

- A. The specific elements of a session note are included in guidance ([SSHSP Questions and Answers](#)) posted on the State Education Department’s Medicaid in Education web page. Please refer to [Session Notes and Progress Notes](#) handout posted on the Medicaid in Education website.
- (a) Session notes should reflect the service that was actually delivered. See Question #75 for guidance on billing for group versus individual sessions.
- (b) The session is direct contact time. There is no separate reimbursement for record keeping. [December 13, 2010]

100. Q. What is the suggested time frame for completing contemporaneous session notes?

- A. “Contemporaneous” means occurring at or about the same period of time. Sessions should be documented as close to the conclusion of the session as practicable. [December 13, 2010]

101. Q. a) Do Session Notes have to include a CPT Code(s)? Are these then forwarded to the billing clerk? b) Is there a prescribed form that should be

used—is it possible for school districts, counties and §4201 schools to make their own?

A. a) Session Notes do not have to include a CPT Code(s). The content of the note should support the CPT code or codes billed for the session. The specific place you record the CPT code(s) is at the discretion of the school district, county, or §4201 school in which you provide services. Yes, the CPT codes selected by the servicing provider need to be communicated to the billing clerk.

b) There is no prescribed format for session notes; required elements are listed in School Supportive Health Services Program (SSHSP) [Questions and Answers](#), #25. It may be beneficial for school districts, counties and §4201 schools to create discipline-specific forms that would capture the information the provider needs to supply the billing clerk/front office staff. [December 13, 2010]

102. Q. Can one session note work for the entire group?

A. No, this is not permissible. A separate session note is required for each student in the group for purposes of confidentiality and appropriate record keeping. [December 13, 2010]

103. Q. Can the provider just initial session notes instead of full signature?

A. No. The qualified provider must sign their full signature on each session note. [December 13, 2010]

104. Q. Some therapy sessions are billable in 15 minute increments. Is a separate session note required for each CPT code or each unit being billed?

A. Session notes must be written to reflect the services that were furnished during the session (encounter) whether the session encompasses one or several billing units. [December 13, 2010]

105. Q. How specific do we need to be when indicating the ‘setting’ the therapy took place in on a session note? Do we need to identify the precise setting where each therapy is delivered?

A. The setting indicated on session notes should be reflective of the actual location in which the services were delivered. Examples include:

- Public school,
- Board of Cooperative Educational Services (BOCES) classroom,
- Approved private day or residential school, or
- Private preschool or daycare setting. [December 13, 2010]

Billing and Claiming Guidance

106. Q. With regard to the 9/1/09 effective date of the SSHSP SPA 09-61 — how is “supporting documentation” to be managed “retroactively”? Assuming such documentation was not retained/maintained in accordance with recent protocols developed consistent with the SPA: specifically:

- (a) In what way should providers “modify” the “contemporaneous” documentation created prior to 9/1/09?**
- (b) What activities/services must be assigned a CPT code?**
- (c) Who “assigns” the CPT code?**
- (d) Must “session notes” be assigned a CPT code? Must “progress notes”?**
- (e) Are “session notes” required for each discrete service provided, even those activities / services which are not specifically identified on the IEP but are an integral component of the “approved” education program (i.e. music therapy)?**
- (f) Is there a standard duration of a “therapeutic session” for Medicaid? Must the duration be specified in the IEPs?**

- A.** (a) If providers/clinicians have the documentation specified in [SSHSP Billing/Claiming Guidance](#) to support the services they rendered during the 2009-2010 school year, claims for those services may be submitted to Medicaid. If the required documentation is not available to support the services furnished to students during the 2009-2010 school year, claims should not be submitted to Medicaid.
- (b) Refer to the list of [CPT codes for SSHSP](#). Each service covered under SSHSP provided to a student in accordance with his or her IEP by a qualified Medicaid practitioner should be assigned a CPT code. The ten covered SSHSP services are physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling services, audiological evaluations, medical evaluations, medical specialist evaluations, skilled nursing services and special transportation.
- (c) It is the responsibility of the clinician providing the service to assign the CPT codes.
- (d) No, neither session notes nor progress notes must be assigned a CPT code. There is no separate Medicaid reimbursement for preparation of session notes or progress notes.
- (e) Session notes are required for the SSHSP services for which Medicaid reimbursement is sought.
- (f) The duration of each related service is specified in the student’s IEP.
[December 13, 2010]

107. Q. Is the Preschool/School Supportive Health Services Program limited to the services defined on the CPT Codes list?

- A.** At this time Medicaid reimbursement is available for those services which can be billed using the [CPT code list](#) that has been posted online. Providers may write to MedinEd@mail.nysed.gov to request that additional codes be considered. The

provider would need to submit justification for the addition of new codes. [December 13, 2010]

Note: The response to Questions #108 was revised November 24, 2014. Deletions are struck through and additions are underlined.

108. Q. Do some of the CPT codes cross-over between Speech, OT, and PT?

- A. Yes, there is a cross-over among PT, OT, and some speech therapy CPT codes. Most of the Physical Medicine and Rehabilitation Services (PM&R) (97000-97999) codes can be used by occupational therapists and physical therapists and describe services that both occupational and physical therapists provide. Some of the Physical Medicine and Rehabilitation Services (PM&R) (97000-97999) codes can be used by speech therapists and describe services that speech therapists provide. For example 97532 Development of cognitive skills, each 15 minutes; and 97533, Sensory integrative techniques, each 15 minutes are two 15-minute treatment codes available for speech therapy. Service providers should refer to their professional associations for guidance on the use of the codes. Providers may write to MedinEd@mail.nysed.gov to request the inclusion of additional codes. The provider would need to submit justification for the addition of new codes. Please see Medicaid Alert #14-04 and #14-06 for additional information. [November 24, 2014]

109. Q. What CPT code do I use for an OT group?

- A. Most of the Physical Medicine and Rehabilitation Services (PM&R) (97000-97999) codes can be used by occupational therapists and describe services that occupational therapists provide. In some circumstances, codes outside of the PM&R section may appropriately describe occupational therapy services. You should consult with your professional organization (e.g., The American Occupational Therapy Association, Inc.) for additional guidance on codes to verify the appropriateness of using the code as a provider of occupational therapy services. [December 13, 2010]

110. Q. On the SSHSP CPT Code list some of the Session Time/Units have 15 minutes or 60 minutes while others say "1 per session". What is a session in this case?

- A. A session is an encounter. For billing purposes, some CPT codes are timed and some are not. Sessions that are billed using timed CPT codes require a unit(s). When the session length is in excess of the time described in the CPT code definition, multiple units must be billed. For example, a 30-minute physical therapy session can be billed as CPT code 97110 X 2 units. Sessions that are billed using untimed CPT codes cannot be submitted with more than one unit specified. For example, a 45 minute therapy session can be billed as CPT code 92507 (one unit specified because one code per session is billed). [December 13, 2010]

111. Q. Is there a minimum session length requirement for a speech therapy session when billing Medicaid with an untimed CPT code?

- A. A typical speech therapy session will last for 30-45 minutes. Medicaid reimbursement for speech therapy is only available for sessions lasting a minimum of 30 minutes. Because untimed CPT codes are billed using a one code per encounter logic, no additional 'units' can be billed when the therapy session exceeds 30 minutes. [December 13, 2010]

Note: The response to Question #112 was revised December 10, 2012. Deletions are struck through and additions are underlined.

112. Q. What is the 8-Minute Rule?

- A. The 8-Minute Rule is a Medicare billing construct that has to do with billing partial units when using timed CPT codes and does not apply to the NYS SSHSP. ~~The 8-Minute rule indicates that in order to bill for each additional time-based code, you must spend at least eight minutes of each unit providing direct service to the patient. In other words, in order to bill for a 15 minute code, the session must be at least eight minutes long. Note that if the total treatment time of timed codes is less than 8 minutes, then that treatment alone is non-billable. The first procedure must be at least 8 minutes, with each one thereafter billed in 15-minute increments. A minimum session length of twenty-three minutes is required in order to bill for two units. Only direct, face-to-face time with the patient is considered for timed codes.~~

~~However, because SSHSP services must be delivered in accordance with the student's Individualized Education Program (IEP). It is expected that the length of the session being billed would reflect the actual length of the therapy session that was furnished and be consistent with the time frame specified in the student's IEP.~~
[December 10, 2012]

113. Q. Where can I find additional guidance on Current Procedural Terminology (CPT) coding for therapy services?

- A. Additional information on coding of physical and occupation therapy services is available at the http://www.cms.gov/TherapyServices/02_billing_scenarios.asp

Further information regarding physical and occupational therapy is also available through these professional organizations:

<http://www.apta.org>
<http://www.aota.org/>

Additional information on coding of speech-language services is available at:

Written orders and referrals

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

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

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

See [Question and Answer #32](#) on the Medicaid in Education website for more information on required elements of a written order. [August 1, 2011]

Note: The response to Question #115 was revised November 24, 2014. Deletions are struck through and additions are underlined.

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

- A. Yes. Medicaid regulations at 18 NYCRR 505.18(c)(4) provide that psychological counseling services must be supported by a referral and that an individualized education program (IEP), which includes the recommendation for psychological counseling services, fulfills the requirement for prior referral. The referral requirement may be fulfilled by having an IEP that includes psychological counseling services, or by having a referral from the student's personal physician or clinic, or from an appropriate school official, such as the chairperson of the committee on special education. For psychological counseling services furnished prior to September 1, ~~2012~~ 2013, referral documentation could include one of the items just referenced. Effective September 1, ~~2012~~ 2013 and after, a separate referral for psychological counseling services from either the student's NYS Medicaid enrolled physician or a medical resource such as a clinic, an appropriate school official, or an official or voluntary health or social agency must be included in the student's record. The IEP will no longer serve as the referral on or after September 1, ~~2012~~ 2013.

Refer to SSHSP Billing/Claiming Guidance, posted on the State Education Department's Medicaid in Education website at http://www.oms.nysed.gov/medicaid/billing_claiming_guidance/BILLING_Claiming_guidelines_sept_2010.PDF for additional information and guidance on SSHSP billing and claiming. [November 24, 2014]

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

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

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

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

2. A copy of the prescribing/ordering practitioner's contemporaneous record, with an accompanying signed and dated statement from the prescriber that states that the record was, in fact, created on the date indicated in the record. [June 6, 2011]

Evaluations

Note: The response to Question #117 was revised November 24, 2014. Deletions are struck through and additions are underlined.

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

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

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

New York State Department of Health - Medicaid requirements:

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

To be Medicaid reimbursable a re-evaluation must be:

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

*Please note that for speech, occupational, and physical therapy the term "services" is defined to include evaluations and ongoing treatment. [November 24, 2014]

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

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

Re-evaluations ordered and performed by qualified providers and reflected in the student's IEP may also be eligible for Medicaid reimbursement. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Indications for a re-evaluation include new clinical findings, a significant change in the student's condition, or failure to respond to the therapeutic interventions outlined in the IEP. [June 6, 2011]

Services

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

- A. No, aides are not covered under the SSHS program. School districts, counties, and §4201 schools should explore other avenues such as Medicaid waiver programs through which the needed services may be provided. [June 6, 2011]

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

- A. Yes if the recommendation for “Skilled Nursing Services” is indicated on the IEP and the medication is administered by an RN (or LPN if within the scope of the Nurse Practice Act) and there is contemporaneous documentation of the service. See [Q+A # 64-66](#) on the Medicaid-in-Education website for additional information regarding Medicaid documentation requirements for medication administration. [June 6, 2011]

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

- A. No. Districts may only bill for skilled nursing services that are included in the student’s IEP. They may not bill for routine or emergency first aid. [June 6, 2011]

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

- A. Medicaid reimbursable treatments and procedures include, but are not limited to: continuous/intermittent nasal and oral care, and assessment of oxygen efficacy. Each service must be documented and billing is based on the time spent providing a covered service. Services that do not require continued administration by trained medical personnel are not Medicaid reimbursable. Services considered stand-by in nature are not Medicaid reimbursable. [June 6, 2011]

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

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

It is important to note that this does not preclude school districts, counties, and §4201 schools from contracting with a parent for transportation of their child when

appropriate and/or cost effective. However, Medicaid reimbursement is not available for transportation provided under these circumstances. [June 6, 2011]

Under the Direction of

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

- A. Yes, for Medicaid reimbursement, the qualified practitioner must see the student at the beginning of treatment. See [Question #20](#) of the Questions and Answers on the Medicaid-in-Education website. “Under the direction of” requires that the qualified practitioner sees the student at the beginning of and periodically during treatment. “At the beginning of treatment” is defined as the beginning of each IEP period. [June 6, 2011]

Documentation

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

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

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

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

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

line license verification page can be found at <http://www.op.nysed.gov/opsearches>.
[August 1, 2011]

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

A. Clinicians are responsible for contemporaneous documentation of the school supportive health services they furnish to students with disabilities. Such documentation includes recording the start and end times of therapy sessions and a session note. The clinician is also responsible for selecting the Current Procedural Terminology (CPT) code or codes that are consistent with the service(s) provided. In most cases, more than one CPT code cannot be reported for the same time period. An exception to this is CPT codes 97010 – 97028, which may be reported for the same time period as other therapy services at the clinician’s discretion. All other codes (timed and untimed) may not be reported for the same time period. It is not necessary to record the specific time in/time out for each CPT code billed for a single therapy session. See Question and Answer #135 for more information. [June 6, 2011]

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

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

A. ICD-9 codes are required on Medicaid claims. They are not explicitly required on written orders; however, including a diagnosis ICD-9 code on a written order can supply the reason/need for the service being ordered. [Question #32](#) discusses what written orders must include as of 9/1/09. Changes to the eMedNY system for HIPAA compliance necessitate the use of ICD-9 codes for SSHSP claims effective for dates of service on and after September 1, beginning in 2012. In the interim, there is nothing to prohibit a school district, county or §4201 school from requiring the use of an ICD-9 code. [December 10, 2012]

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

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

format, it must meet all applicable requirements for privacy, security and accessibility. [June 6, 2011]

129. Q. Are electronic signatures acceptable?

- A. Yes, electronic signatures are acceptable if adequate security is in place and confidentiality is maintained. The use of an electronic signature has the same validity as a signature affixed by hand. However, providers must be prepared to authenticate or prove that the record was electronically signed by the person authorized to sign the record. Electronic signatures affixed by someone other than the actual practitioner are not allowable. An exception to this rule would apply where the applicable statute or regulation specifically requires a hand-written signature. The provider's electronic medical record must have control features, such as pass codes, for electronic signatures. [June 6, 2011]

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

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

Confidentiality requirements mandated by Health Insurance Portability and Accountability Act (HIPAA) and other statutes are applicable to electronic records. These guidelines do not supersede requirements which mandate the maintenance and retention of records in the form in which they were originally created. [June 6, 2011]

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

- A. A faxed or photocopy image of a written order/referral is acceptable and the service is Medicaid reimbursable as long as all required elements are included in the order/referral. See [Question and Answer #32](#) on the Medicaid in Education website for all required elements of a written order. [June 6, 2011]

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

- A. The State's IEP form includes an Evaluation Results section as a place to document the results of evaluations that were conducted and considered in the development of the student's IEP. The Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE) could document its consideration of the evaluation and assessment results under the four need areas (academic achievement, functional performance and learning characteristics; social development; physical development; and management needs). [June 6, 2011]

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

- A. White out is not permissible when making corrections in session notes or any medical record. If a handwritten note must be corrected, the clinician must put a line through the ~~material to be deleted from the record~~ (JK) error and initial it. [June 6, 2011]

Billing and Claiming Guidance

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

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

For additional information on provider qualifications under the SSHSP, refer to [Handout #1](#) and for information about "under the direction of" and supervision requirements, refer to [Handout #2](#) under the Billing and Claiming tab on the Medicaid-in-Education website. [June 6, 2011]

Note: The response to Question #135 was revised November 24, 2014. Deletions are struck through and additions are underlined.

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

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

Please refer to [Handout #5 - Current Procedural Terminology \(CPT\) codes](#), on the NYS Medicaid In Education website. ~~Under Special Rules in Handout #5, for CPT codes 97010 – 97028, footnote #2 applies.~~

~~Footnote #2 reads as follows:~~ With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. The only exception involves a “supervised modality” defined by CPT codes 97010-97028, which may be reported for the same fifteen minute time period as other therapy services.

This means that CPT codes 97010 - 97028:

- Are untimed codes and are billed per session - not per unit;
- May be billed in conjunction with other timed or untimed codes and
- ~~Per footnote #2, †~~ These codes are defined as supervised modality codes, which may be reported for the same time period as other therapy services provided by the same clinician. [November 24, 2014]

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

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

- Included in the individualized education program (IEP);
- Medically necessary (written order in place prior to service delivery);
- Provided by a Medicaid qualified provider; and
- The session must be documented and reflect delivered services. [June 6, 2011]

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

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

- A. Medicaid can be billed for medically necessary services that are provided by Medicaid qualified personnel and documented properly. Related services must be delivered in the manner stated in the student's IEP. Medical necessity is established by the written order/referral. Medicaid reimbursement will be consistent with the frequency and duration of services specified on the written order, ~~or if not specified on the written order, with the frequency and intensity documented in the IEP.~~ Either the written order must include the frequency and duration of the service to be furnished or it must adopt — by explicit reference to the IEP — the frequency and duration that will be delivered in accordance with the IEP. See [Question and Answer #36](#) on the Medicaid in Education website for additional information. [December 10, 2012]

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

- A. Yes, billing for both individual (one-to-one) and group services provided to the same student in the same day is allowed, provided the Current Procedural Terminology (CPT) and Centers for Medicare and Medicaid Services (CMS) rules for individual and group therapy are both met. The Correct Coding Initiative (CCI) edits require the group therapy and the individual therapy to occur in different sessions, timeframes, or separate encounters that are distinct or independent from each other when billed on the same day. [June 6, 2011]

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

- A. The list of available SSHSP CPT codes includes two that are specific to a re-evaluation; 97002 (physical therapy re-evaluation) and 97004 (occupational therapy re-evaluation). Other disciplines (speech, psychology, and audiology) should report the appropriate evaluation code when claiming Medicaid reimbursement for a properly ordered and documented re-evaluation. [June 6, 2011]

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

- A. No. To be Medicaid reimbursable, the frequency and duration of the service furnished to the student must comply with both the recommendation on the student's IEP (special education policy) and the written order or referral (Medicaid policy). [June 6, 2011]

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

- A. No. Medicaid reimbursement for speech therapy is only available for sessions lasting a minimum of 30 minutes. The Current Procedural Terminology (CPT) code used under SSHSP for speech therapy services is an untimed code for which the Medicaid program has established a minimum session length of 30 minutes. Regardless of eligibility for Medicaid reimbursement, services must be provided as recommended on the student's IEP. [June 6, 2011]

Note: The response to Question #142 was revised November 24, 2014. Deletions are struck through and additions are underlined.

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

- A. A claim is submitted for each service provided. Claims must contain a Current Procedural Terminology (CPT) code with the appropriate number of units if applicable. Refer to the [SSHSP list of CPT codes](#) for more specific information. Services must be medically necessary, included on the IEP, ordered by a NYS Medicaid enrolled and qualified provider, delivered by a licensed RN or LPN, and documented (per the Nurse Practice Act). [November 24, 2014]

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

- A. The applicable CPT code for skilled nursing services is timed at "up to 15 minutes." Depending on the nature and complexity of the service being provided, a professional nurse may opt to bill one code for each of the three sessions furnished, or to bill a single unit to account for several less complex and less time-consuming encounters occurring in a single calendar day. When multiple visits occur on a single day, the total number of units billed to Medicaid must not exceed the total face-to-face time spent providing skilled nursing services to the student. [June 6, 2011]

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

- A. a) The phrase "Skilled Nursing Services" must be listed on the IEP.
b) The actual procedure need not be detailed in order to maintain the confidentiality of the student's treatment plan and medical records maintained by the school. Ideally, the student should have an Individual Health Care Plan (IHP or IHCP – see question # 145), maintained by the school nurse (RN). The IHCP is fluid and can

then be updated by the RN as needed without requiring a CSE meeting. You should not indicate the specific skilled nursing services or medications on the IEP. [June 6, 2011]

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

- A. a) The IHCP is a fluid nursing care plan that generally consists of the demographics of the student followed by the medical information, pertinent provider orders and the nurse's plan of care.
b) Generally, the school nurse (RN) is responsible for the development and implementation of the IHCP. An LPN may not develop or update an IHCP per the nurse practice act.
c) No, only documentation required to bill for services rendered is required for Medicaid billing purposes. The information on the IHCP is fluid and confidential and should remain with the student's other confidential medical records. [June 6, 2011]

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

- A. There are two CPT codes for skilled nursing services available for SSHSP billing; T1002 (RN Services, up to 15 minutes), and T1003 (LPN/LVN Services, up to 15 minutes). The list of [SSHSP CPT Codes](#) is available on the Medicaid in Education website. [June 6, 2011]

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

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

counseling services as defined in either SPA #09-61 or #92-42 were delivered, school districts may provide additional documentation, described below, to demonstrate that the services furnished met the definition of psychological counseling services under SSHSP.

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

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

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

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

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

Please note that IEPs developed on or after January 1, 2012 must include the term "psychological counseling" in order for those services to be Medicaid reimbursable. [June 6, 2011]

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

- A. Scheduling of related services on a per cycle basis is acceptable for Medicaid reimbursement purposes. [June 6, 2011]

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

- A. In order for a make-up therapy session to be Medicaid reimbursable it must be consistent with the written order/referral (medically necessary) and must:
- Be a service that is documented in the IEP
 - Occur within the cycle in which the missed visit occurred
 - Be documented (session notes must be kept for each session including made up sessions)
 - Be provided by a qualified Medicaid provider
 - Fit with the desired treatment outcome

Example:

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

Table 1: Sample Schedule Using a Six-Day Cycle

January 2011

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

[June 6, 2011]

National Provider Identifier (NPI)

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

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

when submitting SSHSP claims for NYS Medicaid reimbursement. See question and answer #151 – SSHSP claims will require an NPI number for both the billing provider (school districts, §4201 schools, counties) and the servicing provider effective January 2012. [June 6, 2011]

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

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

Although physical therapy assistants, occupational therapy assistants, and licensed master social workers are eligible to obtain an NPI number, only the NPI number of the physical therapist or occupational therapist providing direction (“under the direction of”) or the appropriately licensed and registered psychiatrist, psychologist, or licensed clinical social worker providing supervision – who has overall responsibility for the student’s medical care and treatment – is reported on the Medicaid claim for SSHSP services.

Effective January 2012, SSHSP claims will require the NPI number of the billing provider (school district, §4201 school, county) and the servicing provider, or clinician providing direction or supervision, as appropriate. Additional information will be forthcoming. [June 6, 2011]

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

- A. For purposes of the Preschool/School Supportive Health Services Program (SSHSP), the billing provider's NPI (school district, county, §4201 school) is currently used. In January 2012, the NPI of the attending (servicing) provider will also be required. Because you are not the billing provider in this instance, your agency is not required to obtain an NPI number for SSHSP purposes at this time. Questions about the provision of EI services should be directed to the Bureau of Early Intervention at (518) 473-7016 or bei@health.state.ny.us. [June 6, 2011]

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

- A. Recording the NPI on the session form is not necessary for Medicaid purposes. Medicaid requires the NPI number on claim forms. However, individual school

districts, counties, and §4201 schools may choose to record NPI number on session forms for their own administrative purposes. [June 6, 2011]

Exclusion Lists

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

- A. In addition to the Office of Medicaid Inspector General (OMIG) exclusion list, providers (school districts, counties, and §4201 schools) should check the Office of Inspector General (OIG) exclusion list and the General Services Administration (GSA) exclusion list. The OMIG exclusion list is accessible on the OMIG Web site (www.omig.ny.gov) on the home page. Once providers have checked the OMIG list once, they can then refer to the 30-day updates to check existing staff members. The OIG list is located at http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp. The GSA list can be found at <https://www.epls.gov/>. [June 6, 2011]

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. [December 5, 2011]

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, and 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. [December 10, 2012]

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. [December 5, 2011]

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. [December 5, 2011]

Note: The response to Question #159 was revised November 24, 2014. Deletions are struck through and additions are underlined.

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.~~

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.

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.

The NYS Medicaid Provider Enrollment Requirement for Providers who Order/Refer School Supportive Health Services were published in [Medicaid Alert #13-07](#), revised and re-issued on September 5, 2013. [November 24, 2014]

Session Notes

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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). [December 5, 2011]

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). [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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." [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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. [December 5, 2011]

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 discrete 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)

[December 5, 2011]

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. [December 5, 2011]

Random Moment Time Study (RMTS)

Note: The Random Moment Time Study (RMTS) is a component of certified public expenditures (CPEs). When the RMTS began, §4201 schools were enrolled as Medicaid billing providers. However, the Centers for Medicare and Medicaid Services (CMS) indicated that §4201 schools are not eligible for CPEs since they are not public agencies. Therefore, §4201 schools have been disenrolled as Medicaid billing providers; the last date of service that could be billed by §4201 schools was June 30, 2013. Refer to Medicaid Alert #13-06 for additional information. [November 24, 2014]

178. Q. What is a Random Moment Time Study (RMTS)?

- A. A Random Moment Time Study (RMTS) is a mechanism for identifying the amount of time SSHSP practitioners spend delivering Medicaid reimbursable activities. It is important to note that RMTS is not a management tool used to evaluate staff activities or performance. [March 16, 2012]

179. Q. How will RMTS affect SSHSP?

- A. Pending approval of State Plan Amendment #11-39 that outlines changes in the reimbursement methodology for SSHSP, the results of the RMTS will be used in determining the portion of costs related to direct medical services outlined in section 3.1(a) of the Medicaid State Plan. [March 16, 2012]

180. Q. What is each entity's role in RMTS?

- A. *State Education Department (SED)*
- Implementation
 - Special Education Policy
- Department of Health, Office of Health Insurance Programs (OHIP)*
- Medicaid Policy
 - Payment Methodology
- Regional Information Centers (RIC)*
- School district, county, and §4201 school support on SSHSP matters
- School districts, counties and §4201 schools*
- Implement SSHSP, participate in RMTS, file annual cost reports
 - Monitor Contractors
- Public Consulting Group, Inc (PCG) (DOH contractor)*
- Assist DOH, SED, and SSHSP providers in implementation of RMTS and support the preparation and submission of annual cost reports for each SSHSP provider actively billing Medicaid. [March 16, 2012]

181. Q. What is a staff pool roster?

- A. A staff pool roster (participant list) is each SSHSP Medicaid billing provider's list of all SSHSP qualified practitioners. [March 16, 2012]

182. Q. Who is responsible for the creation and/or certification of the participant list (staff pool roster)?

- A. Each school district and county, and §4201 school, as a Medicaid billing provider, is responsible for the creation and/or certification of its own participant list. To assist SSHSP billing providers in creating the initial list, SED and PCG utilized the "relevant employee" training database maintained by SED for the Medicaid Compliance Trainings. A file was distributed by PCG to a designee of each SSHSP billing provider with the expectation that the list would be reviewed and edited as needed. This ensures that PCG has the most up-to-date list of employees and contracted staff (SSHSP reimbursable clinicians) when creating staff pool rosters/participant lists. [March 16, 2012]

183. Q. Who should be included in a participant list?

- A. Only Medicaid qualified clinicians who perform direct service activities (including "under the direction of" and "under the supervision of" activities) should participate in the time study. These clinicians must be eligible per the requirements in section 3.1(a) of the Medicaid State Plan. Each school district, county, and §4201 school will certify its own participant list quarterly. The following clinicians (licensed, registered, and/or certified as required) should be included in the participant list:

- psychologist
- psychiatrist
- clinical social worker
- master social worker
- physician
- physician assistant
- nurse practitioner
- audiologist
- speech-language pathologist
- teacher of the speech and hearing handicapped
- teacher of students with speech and language disabilities
- physical therapist
- physical therapy assistant
- occupational therapist
- occupational therapy assistant
- registered professional nurse
- licensed practical nurse

[March 16, 2012]

184. Q. Which staff should be excluded from the participant list for RMTS?

- A. Staff who are not licensed/registered and/or certified and who do not provide SSHSP Medicaid reimbursable services must not be included in the participant list. These include:
- Non-paid temporary staff such as interns
 - School psychologists
 - Administrative and facility-related staff/contractors who do not provide direct medical services (e.g., receptionists, billing clerks, janitors).

[March 16, 2012]

185. Q. Which agencies need to certify their participant list for RMTS?

- A. School districts, counties, and §4201 schools that participate in the Medicaid program must certify participant lists for the RMTS. [March 16, 2012]

Note: The response to Question #186 was revised November 24, 2014. Deletions are struck through and additions are underlined.

186. Q. Should school districts, counties, and §4201 schools include direct service contractors in their participant list?

- A. ~~Yes, at this time, school districts, counties, and §4201 schools must include both employed and contracted clinicians that perform direct service activities billed to Medicaid in the participant list.~~ School districts and counties must include all employees providing direct medical service activities in their participant lists. In addition, school districts and counties must provide names of all contracted direct service providers on supplemental rosters. [November 24, 2014]

187. Q. PCG's email states that "each provider must designate a state employee as its SSHS Program Coordinator." The school districts, counties, and §4201 schools have no State employees. Does that mean the requirement does not apply?

- A. The email inadvertently stated that "**each provider must designate a state employee as its SSHS Program Coordinator**". Instead, the Random Moment Time Study Coordinator (RMTS Coordinator) and Assistant RMTS Coordinator are selected by the school district, county, or §4201 school. Individuals filling this role may include, but are not limited to: clinicians, Medicaid Compliance Officers, representatives from the Committee on Special Education (CSE), school principals, or billing clerks, for example. Therefore, the requirement for selecting a designated state employee does not apply. [March 16, 2012]

188. Q. Does every school district, county, and §4201 school need a "Random Moment Time Study Coordinator" and can it be anyone the school district, county or §4201 school selects?

- A. Yes, every school district, county, and §4201 school participating in the Medicaid program needs to assign a RMTS Coordinator and a designated Assistant RMTS Coordinator to serve as back up. Individuals filling this role may include, but are not limited to: clinicians, Medicaid Compliance Officers, representatives from the Committee on Special Education (CSE), school principals, or billing clerks, for example. [March 16, 2012]

189. Q. Who must receive RMTS training provided by PCG?

- A. RMTS Coordinators must participate in web-based RMTS training. The Assistant RMTS Coordinator and clinical staff identified in the participant list are strongly encouraged to attend one of the web-based sessions; however, there is an acceptable alternative to attending a web-based session. Assistant RMTS Coordinators and staff identified in the participant lists may receive RMTS training from their RMTS Coordinator who attended the web-based training.

This supersedes and clarifies information included in PCG's Medicaid Director letter dated March 7, 2012 that indicated both RMTS Coordinators and RMTS participants must receive web-based RMTS training prior to April 1, 2012. [March 16, 2012]

190. Q. How will school districts, counties, and §4201 schools receive training on RMTS?

- A. Medicaid billing providers may receive required RMTS training through various web-based sessions sponsored by PCG. PCG will also be available during many Phase III Compliance training sessions. [March 16, 2012]

191. Q. What is the schedule for face-to-face trainings that "Random Moment Time Study Coordinators must attend"?

- A. At this time, there are no face-to-face RMTS trainings available. Therefore, RMTS Coordinators must attend the web-based training.

PCG provided a schedule of web-based training seminars for RMTS Coordinators and RMTS participants. (See Attachment B, which was included with PCG's Medicaid Director letter dated March 7, 2012.) You may also refer to Question #192 for more information. All RMTS Coordinators must attend one of the web-based training sessions. [March 16, 2012]

192. Q. How do the RMTS Coordinators sign up/register for web-based training?

- A. Morning and afternoon sessions are available beginning Monday March 12th and continuing through March 27th. Each RMTS Coordinator must attend RMTS training prior to April 1, 2012. Assistant RMTS Coordinators and SSHSP practitioners may also attend this RMTS training prior to April 1, 2012. It is not necessary to register for this training.

To start or join an online meeting that begins at **9:00am** go to

<https://pcgus.webex.com/pcgus/j.php?ED=163872467&UID=481393857&PW=NNTJkZmMyZjJI&RT=MIMxMQ%3D%3D>

and call

1- 888-866-0650 (Conference ID: 0198159) for the audio conference.

To start or join the online meeting that begins at **1:00pm** go to:

<https://pcgus.webex.com/pcgus/j.php?ED=163872542&UID=481393857&PW=NMTExY2Q4YWQz&RT=MIMxMQ%3D%3D>

and call

1-888-866-0650 (Conference ID: 0198159) for the audio conference. [March 16, 2012]

193. Q. Will there be additional RMTS training separate from the web-based training?

- A. At most face-to-face Phase III Mandatory Compliance Training, representatives from PCG will be available. Further information regarding online RMTS training opportunities will be forthcoming. [March 16, 2012]

194. Q. What is the date for the district to start rolling out RMTS information to their providers?

- A. It is the responsibility of the school districts, counties, and §4201 schools to inform their clinicians (those included on staff pool rosters/participant lists) of the need to participate in available RMTS trainings as soon as information is available. It is expected that clinicians on the participant list will be included in the RMTS sampling process that will begin on April 1, 2012. [March 16, 2012]

195. Q. How can school districts, counties, and §4201 schools be expected to include contracted employees in their list of participants since most are employed by BOCES, private schools, or independent agencies?

- A. On September 12, 2011, Medicaid Alert #11-03 notified school districts, counties, and §4201 schools participating in the Medicaid program of the requirement to include National Provider Identifier (NPI) numbers for attending providers on SSHSP claims. This requirement went into effect for services rendered on and after January 1, 2012.

This process necessitated establishing and maintaining a list of current employees and/or contracted staff for which school districts, counties, and §4201 schools can bill Medicaid. School districts, counties, and §4201 schools can use these lists as a starting point in developing their staff pool/participant lists for the RMTS. Those lists can then be forwarded to PCG for use in the RMTS process. [March 16, 2012]

196. Q. Do school districts have the ability to decline any clinician (from a contracted agency) who did not appear on the original list submitted?

- A. School districts, counties, and §4201 schools must include all clinicians (employees and contracted staff) that provide Individualized Education Program (IEP) services for which they intend to bill Medicaid. [March 16, 2012]

197. Q. BOCES, school district and agency school calendars may differ from one another, is this being taken into account?

- A. Yes, this has been taken into account in the development of the RMTS. [March 16, 2012]

198. Q. Is this a federal or State mandate?

- A. Pending Centers for Medicare and Medicaid Services (CMS) approval of the New York State Plan Amendment (SPA) # 11-39, this is a New York State requirement. [March 16, 2012]

199. Q. Will PCG be doing any webinars after hours, etc. to accommodate staff accordingly?

- A. In addition to the trainings already scheduled, PCG will conduct additional training beginning at 4pm on Monday March 26 and Tuesday March 27. Please see the links to the webinar trainings being conducted for the remainder of the month below.

To start or join an online meeting that begins at **4:00pm** go to

<https://pcgus.webex.com/pcgus/j.php?ED=164221447&UID=481393857&PW=NZTAyZiMzZDM0&RT=MIMxMQ%3D%3D>

and call

1- 888-866-0650 (Conference ID: 0198159) for the audio conference. [March 16, 2012]

200. Q. Will school districts, counties, and §4201 schools be reimbursed under ‘administrative costs’ for the time being spent to develop/update participant lists and the cost reports?

A. No. At this time, there is no Medicaid reimbursement to school districts, counties, or §4201 schools for administrative costs, also referred to Medicaid Administrative Claiming (MAC). However, implementation of a MAC program is under consideration for the future. Should Medicaid Administrative Claiming be implemented for SSHSP, Medicaid providers would be informed of the specific program requirements. [March 16, 2012]

201. Q. How can clinicians participate in the RMTS without interruption to services provided to students?

A. Responding to an RMTS email should not cause an interruption in the provision of services to students. Clinicians will have five (5) business days to respond to a random moment inquiry. Additionally, not all clinicians will receive a moment each quarter. Based on the size of the staff pools/participant lists in New York State, the expectation is one moment per clinician per year. [March 16, 2012]

202. Q. Will the school district, county, or §4201 school fiscal officer be expected to maintain a roster of providers included in the RMTS in order to determine eligible Medicaid costs for the cost reports.

A. The district, county, or §4201 school must maintain the staff pool/participant roster because costs associated with only those direct service providers eligible to participate in RMTS can be included in the cost report. [March 16, 2012]

203. Q. Can the state use the efficiency information in the RS-2 form or the SED-4 form in lieu of participating in the RMTS?

A. No. The Centers for Medicare and Medicaid Services (CMS) requires the use of a federally accepted method for tracking staff time and activities of the billing providers that is a verifiable, statistically valid random sampling technique that produces accurate labor distribution results. Use of the federally accepted RMTS sampling will greatly reduce the amount of staff time needed to record an individual time study participant’s activities. [March 16, 2012]

ACA – O/P/R/A

204. Q. Must the ordering practitioner be enrolled in the NYS Medicaid program at the time he/she writes the order?

- A. It is the billing provider's (school district or county) responsibility to ensure that all required documentation is in place prior to submission of a Medicaid claim, including checking the status of the ordering provider. The ordering provider's enrollment status may be checked by accessing the following link: <https://www.emedny.org/info/opra.aspx> or by calling CSC at 1-800-343-9000. [September 5, 2013]

205. Q. Will a claim be valid if the enrollment happens subsequent to writing the order?

- A. The billing provider is responsible to ensure that all required Medicaid documentation is in place prior to submission of a Medicaid claim. In addition, it is important to note that in order to bill Medicaid for preschool or school supportive health services, written orders must be in place prior to provision of services. [September 5, 2013]

206. Q. Must the ordering practitioner request retroactive enrollment?

- A. As eMedNY's Provider Enrollment FAQs indicate, after receiving their enrollment approval letter, the provider may request retroactive enrollment by contacting the Bureau of Provider Enrollment at ffspe@health.state.ny.us. This is the recommended approach for SSHSP providers.

As the response to eMedNY FAQ #13 indicates, most enrollments are completed within 30 days of receipt of a complete application. Practitioners are encouraged to complete this process as soon as possible if they have not already done so.

Additional information in the form of Frequently Asked Questions on ordering/prescribing/referring/attending provider enrollment is available on the eMedNY website at

https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/Core_OPRA_FAQs.pdf

[Medicaid Alert #13-07](#) discusses the NYS Medicaid provider enrollment requirements for providers who order/refer in the SSHS Program. [September 5, 2013]

207. Q. Are new orders/referrals necessary for psychological evaluations and psychological counseling services that were ordered by licensed psychologists and Licensed Clinical Social Workers for the upcoming school year?

- A.** SSHSP billing providers must ensure that all required documentation is in place prior to the submission of a Medicaid claim. If the psychological evaluation or psychological counseling services are ordered by an enrollable ordering provider (a licensed physician, psychiatrist, physician assistant, nurse practitioner or a licensed psychologist for purposes of the SSHSP), that provider's NPI number must be included on the Medicaid 837I claim form in the referring provider field.

If the psychological evaluation or psychological counseling services are referred by an individual who is not eligible to enroll as an ordering/referring provider in the SSHSP (e.g., a school official, classroom teacher, or other licensed provider such as an LCSW or LMSW), the Medicaid 837I (institutional) claim form must include the NPI of the billing provider in both the billing and referring provider fields. [September 5, 2013]

208. Q. According to the March 2013 Medicaid Update, physical therapists, occupational therapists and speech therapists (among others) must enroll in the state Medicaid program if they provide services to children for which FFS Medicaid is billed even if the billing is done by the County or School District. Am I correct in assuming that this requirement applies to our PT's, OT's, and ST's who provide these services to children for which Medicaid is billed?

- A.** The March 2013 Medicaid Update article titled "Expedited Enrollment for Ordering, Prescribing, Referring & Attending Practitioners" is specific to practitioners who are ordering services. In the School Supportive Health Services Program, speech-language pathologists can order services, as can physicians, physician assistants and nurse practitioners. Occupational therapists and physical therapists cannot order services, therefore they do not have to enroll as ordering providers for the SSHSP. However, if physical therapists and occupational therapists are working for other provider types (e.g., hospital, clinic, other), they may be required to enroll. [September 5, 2013]

209. Q. Providers who refer children for services which are billed to Medicaid must also enroll in the Medicaid program. Is this correct?

- A.** See the response to #208 as well as SSHSP Handout #1 on Provider Qualifications and Documentation Requirements, which is available at http://www.oms.nysed.gov/medicaid/training_materials/home.html . Speech-language pathologists who provide written referrals must enroll in the Medicaid program. In addition, if an SSHSP service is ordered by a provider in the community (physician, physician assistant, or nurse practitioner), that provider must be enrolled

in Medicaid in order for the service to be Medicaid reimbursable. [September 5, 2013]

210. Q. When our physical therapists attempt to enroll in Medicaid, they are being told they (or we as the school) must be Medicare enrolled in order for them to enroll in Medicaid. Is this true? Is there a mechanism for them to enroll in Medicaid without being Medicare enrolled?

A. See the response to #208. For purposes of SSHSP, it is not necessary for physical therapists to enroll in Medicaid as ordering practitioners. However, if physical therapists are working for other provider types (e.g., hospital, clinic, other), they may be required to enroll.

Additional information on provider enrollment requirements specific to the SSHSP - [Medicaid Alert #13-07](#) and supplemental instructions - are available on the NYS Department of Education website at these links:

http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2013/13_07_ordering_referring_enrollment_6_24_13.pdf

http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2013/13_07_instructions_to_verify_ordering_referring_status_7_11_13.pdf

http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2013/13_07_medicaid_enrollment_directions_for_referring_slp_7_11_13.pdf

Additional information on provider enrollment is available on the eMedNY website at <https://www.emedny.org/info/ProviderEnrollment/index.aspx> [September 5, 2013]

211. Q. I understand that PTs/OTs do not have to enroll in Medicaid as ordering practitioners because they cannot order/refer. Must OTs/PTs who provide SSHSP services which will be billed to Medicaid be enrolled in Medicaid, even though another entity (school district/county) will be billing?

A. No. Physical and occupational therapists providing SSHSP services that are billed by the school district or county are not required to enroll in the Medicaid program. However, if physical therapists and occupational therapists are working for other provider types (e.g., hospital, clinic, other), they may be required to enroll. [September 5, 2013]

212. Q. Must an employee of a school district complete the “Ownership in Applicant” section of the application form?

A. No, if the practitioner is an employee of a school district or county, he or she is not required to complete the “Ownership in Applicant” section. That section is only required for businesses or agencies. [September 5, 2013]

- 213. Q. Are supervisors and administrators of the applicant considered to be Managing Employees in Section 5?**
- A. Yes, administrators, supervisors, office managers of the applicant would be considered managing employees. [September 5, 2013]
- 214. Q. In a school/agency setting for Section 5, Managing Employees, please clarify, is it the immediate supervisor of the applying therapist? Is it also necessary to list the district superintendent or agency director as a managing employee?**
- A. It is recommended that applicants refer to and read the regulatory references included on the Ordering, Prescribing, Referring and Attending Practitioner application form. If the office manager or administrator, or a supervisor of the applying therapist within the school or county exercises operational or managerial control over the day to day operations of the provider (service provision) then that individual(s) should be reported in Section 5 of the application. [September 5, 2013]
- 215. Q. On the Signature and Affirmation page, what information is the individual provider expected to disclose about a school district/county/private agency business transactions that total \$25,000 or more? And, what constitutes a "significant" business transaction?**
- A. Information to be included on the signature and affirmation must be obtained from the Office of the Medicaid Inspector General (OMIG) as this is related to compliance rulings. Refer to OMIG Compliance Alert - 2012-01, which is available at this link: http://www.omig.ny.gov/images/stories/compliance_alerts/compliance_alert%202012_01_annual_certification.pdf [September 5, 2013]
- 216. Q. When it says that providers agree to notify the Department of changes in the agreement, does that include if the provider/applicant changes employers?**
- A. All providers are required to notify the Department of Health of any changes in their status when they are enrolled in Medicaid. This includes change of address, employer, and the like. [September 5, 2013]
- 217. Q. What is the process for this notification? Is there a form, website, etc?**
- A. If you need to change your address there is a form on the Provider Enrollment site on eMedNY. There is also an eMedNY Call Center for inquiries and a contact form that can be accessed on the site for provider questions at <https://www.emedny.org/info/ProviderEnrollment/changeaddress.aspx>. [September 5, 2013]

218. Q. I am a speech-language pathologist enrolling in Medicaid as an ordering provider only. Will my contact information be made public after I enroll?

A. Your name, license number and NPI will be on the Search feature on the eMedNY website so that servicing providers will know you are eligible to order/refer. [September 5, 2013]

219. Q. When searching for OPRA verification, would the results only pick up individuals who filled out the expedited enrollment (ordering practitioners only), or would the results also show those who are enrolled and bill Medicaid directly?

A. The search results would include both individuals who filled out the expedited enrollment (ordering, prescribing, referring, and attending practitioners) and those who bill Medicaid directly. [September 5, 2013]

Special Transportation

220. Q. We are a non-transporting district. The only special education students who ride the bus are those who qualify for special transportation due to asthma, emotional disturbance, autism or physical disabilities. They may not be on a modified vehicle but the only reason we use the vehicle is because they need to be transported to and from their program. Is it correct based on the special circumstances 1st paragraph that they qualify?

A. A non-transporting district is one in which all students live in close enough proximity to the school that transportation is not provided. In order for special transportation to be Medicaid reimbursable, the student must have a medical need documented in the IEP and the student must be traveling to or from a Medicaid reimbursable service. This is the first special circumstance where transportation is Medicaid reimbursable regardless of the type of vehicle used – see page 2 of [Medicaid Alert #13-10](#). [November 25, 2013]

221. Q. Is a vehicle with a 5-point harness considered specially modified?

A. No. A five-point harness is considered a component of a seat belt. Seat belts are not considered modifications to the school bus. [November 25, 2013]

222. Q. If the student attends a full time academic program at BOCES, for example, and receives SSHSP services at that same location, does that transportation qualify as reimbursable?

A. No, this does not meet either of the two exceptions in [Medicaid Alert #13-10](#) because the student is not being transported for the exclusive purpose of receiving a direct medical (SSHSP) service. In order to be Medicaid reimbursable, the vehicle

that is transporting the student to this day program would need to be specially modified. To summarize, to be Medicaid reimbursable, the IEP must include the medical need for special transportation and the specific modification to the vehicle that meets the needs of that student, and the student must be traveling to or from a Medicaid reimbursable service. [November 25, 2013]

223. Q. If the student is transported to a specialized program outside of his/her home school district in a vehicle specially modified to meet that student's needs (a program that provides both educational and SSHSP services can that be reimbursed?

A. Yes, if the following criteria are met:

- The specific medical need for special transportation is documented in the student's Individualized Education Program (IEP) and;
- An explanation as to how the transporting vehicle has been specially modified to serve the needs of the student with a disability is documented in the IEP; and
- The student is traveling to or from a Medicaid reimbursable service other than transportation. [November 25, 2013]

224. Q. My question is would the following still be considered a "medical need" as per the 2005 memo?

- **Mobility – e.g., nonambulatory wheelchair bound.**
- **Behavior – e.g., fearful in noisy environments; self-abusive; runs away; cries frequently.**
- **Communication – e.g., hard of hearing; nonverbal; limited understanding of questions and directions; non-English speaking.**
- **Physical – e.g., needs assistive devices to maintain a sitting position; needs assistance walking and going up and down stairs.**
- **Health needs – e.g., has seizures; fatigue – may fall asleep on bus, requires oxygen equipment; use of an inhaler.**

A. Special transportation is Medicaid reimbursable when it is medically necessary and included in the student's IEP. The IEP must specify the student's medical need for special transportation and the specific vehicle modification that will be used to meet that student's needs. In addition, the student must be traveling to or from a Medicaid reimbursable service other than special transportation. The only instances where the vehicle would not have to be specifically modified are the two exceptions noted in [Medicaid Alert #13-10](#).

[Medicaid Alert #13-10](#) clarified that the 2005 memo referenced in this question reflects special education policy and cannot be used to determine if or when special transportation is Medicaid reimbursable. If a Medicaid eligible student's medical need is such that an accommodation other than a specific vehicle modification is required (e.g., nursing care or personal care during transport), the school district may make arrangements outside of the SSHSP, either through the Medicaid

program (fee-for-service) or through the student's Medicaid managed care plan. [November 25, 2013]

225. Q. We have a number of children who are attending private programs specializing in treatment of autism. The children receive multiple Medicaid eligible services every day. In some instances such services comprise most of the day. Due to their disability transportation cannot be provided with the general student population. It is provided on a bus with additional staff to who attend to the children during the trip.

- A.** If the student receives his/her education in the private program, and that is the primary reason for the trip, transportation to and from that program is the responsibility of the school district. In order for the transportation to be Medicaid reimbursable, as indicated in [Medicaid Alert #13-10](#), the following three conditions must be met:
- The specific medical need must be documented in the IEP,
 - The IEP must also have an explanation of how the vehicle has been modified to serve the needs of that student with a disability, and,
 - The student must be traveling to or from a Medicaid reimbursable service other than special transportation. [November 25, 2013]

226. Q. On page 2 of [Medicaid Alert #13-10](#) there are 2 special circumstances listed where transportation is reimbursable regardless of the type of vehicle used. Aren't these 2 bullets separate scenarios?

- A.** Yes, these two bullets are separate scenarios. [November 25, 2013]

Non-Medicaid Encounter Data for Cost Reporting

227. Q. What documentation is needed by billing providers for those encounters, not submitted for Medicaid reimbursement, that are included in the annual cost report's total of encounters for each service type?

- A.** The types of data that support the number of encounters are different than the data necessary to support a Medicaid claim for an encounter. Documentation that establishes an encounter was Medicaid-eligible, such as consent for release of information, provider agreements and statements of reassignment, clinician credentials, medical orders and referrals, and signed session notes and CPT coding, is not necessary. Documentation which is appropriate to support the reported total number of encounters will demonstrate the type, frequency and duration of services. There are multiple sources of data that a school district or county could maintain to support the total number of encounters they report. School districts and counties can determine if this information is found in special education data reports, billing and fiscal reports, or other documentation. [February 11, 2015]

Medicaid Eligibility and Client Identification Number (CIN)

228. Q. How can school districts/counties verify a student's Medicaid eligibility?

- A. To verify a student's Medicaid eligibility a provider must have either a CIN or a social security number. The Department of Health understands that State and federal education laws and regulations severely limit a school district's ability to obtain social security numbers for its students and limit the use of such personal information (These laws and regulations include, but are not limited to, the NYS Personal Privacy Protection Law (Public Officers Law Article 6-A), Commissioner's Regulations on enrollment (8 NYCRR 100.2(y)), and the federal Tax Reform Act of 1976 (42 USC Section 405 (c)(2)(C)(i)).) While the Medicaid program does not employ a similar limitation, SSHSP providers should use the CIN for Medicaid eligibility verification purposes. [February 11, 2015]

229. Q. What are some steps a school district/county should take to find out a student's CIN?

- A. School districts/counties have several opportunities to obtain a student's CIN once parental consent to bill Medicaid has been granted, including but not limited to the following:
- Request the student's CIN when the Parental Consent Form is signed; record the CIN on the Parental Consent Form.
 - Request that Medicaid cards are brought to CSE/CPSE meetings.
 - Request that the ordering practitioner include the student's CIN on written orders/referrals for SSHSP services when they have that information in their patient records.
 - If the school district/county billed in the past, pull CIN from previous billing records or web reports.
 - Explore opportunities to work with local Social Services or Medicaid Offices to identify students' CINs. [December 9, 2016]

230. Q. Given that the CNYRIC student matching process will no longer be available after March 31, 2017, what actions are the Department of Health and State Education Department taking to assist providers in determining whether a student is Medicaid eligible?

- A. To check eligibility, Medicaid providers, including school districts and counties, must have either a client identification number (CIN) or a social security number. Following discussions among the State Education Department (SED), the Department of Health (DOH), and Medicaid Data Warehouse representatives, the SED and DOH are pursuing a systems project that will result in a limited matching process. Additional information on this process will be forthcoming in 2017. This limited matching process (exact matches) is intended to supplement, not supplant, the steps SSHSP providers will take to obtain CINs and to ensure they have

current eligibility information for students receiving SSHSP services. [December 9, 2016]

231. Q. How can SSHSP providers verify students' Medicaid eligibility?

- A. There are three ways to verify Medicaid eligibility with a CIN (or social security number):
- ePACES: Free Internet-based application
 - Audio Response Unit: (touch-tone telephone method) 1-800-997-1111
 - Alternate access: Batch and Real-time 270/271 Eligibility Inquiry & Response [December 9, 2016]

232. Q. Will SSHSP providers be able to do batch eligibility checks?

- A. Yes. SSHSP providers can purchase HIPAA compliant software which batches and submits the eligibility verification request to eMedNY (via a 270 request transaction). A HIPAA compliant response (via a 271 response transaction) is then received back from eMedNY. Additional information may be accessed online at: https://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Batch_Auth/FTP%20Batch%20Instructions%20Manual.pdf [December 9, 2016]

Service Bureaus, Trading Partner Agreements, and Electronic Transmission Identification Number (ETIN)

233. Q. Who must enroll as a service bureau, vendor, electronic media biller, or billing service?

- A. Per [18 NYCRR §504.9](#) - (a)(1) Persons submitting claims, verifying client eligibility or obtaining service authorizations for or on behalf of providers, except those individuals employed by providers enrolled in the medical assistance program, must enroll in the Medical Assistance Program in accordance with this Part and must meet the appropriate additional requirements set forth in this section. [December 9, 2016]

234. Q. Must BOCES enroll as a service bureau?

- A. If BOCES access the State's Medicaid Management Information System (MMIS) to submit claims or verify student eligibility for or on behalf of a school district or county, they must enroll as a service bureau. ePACES (claim entry) and eMEVS (eligibility verification) are features of the MMIS. Refer to [18 NYCRR §504.9](#) for more information. [December 9, 2016]

235. Q. Who needs to complete a Trading Partner Agreement?

- A. The Trading Partner Agreement addresses certain requirements applicable to the electronic exchange of information and data associated with health care

transactions. All trading partners who will be submitting claims or other electronic transactions to NYSDOH need to have a Trading Partner Agreement (TPA) on file. The TPA form must include the Electronic Transmitter Identification Number (ETIN) as assigned by NYS DOH and other identifying information as noted on the form.

School districts and counties must complete and submit a **Trading Partner Agreement for each ETIN** the provider uses for electronic transactions.

The NYS Medicaid Trading Partner Agreement is available at eMedNY.org:

- a. Select Provider Enrollment tab
- b. Click on Provider Maintenance Forms
- c. Under Miscellaneous Maintenance Forms, Click on **Trading Partner Agreement**. [December 9, 2016]

236. Q. What is an Electronic Transmitter Identification Number (ETIN) used for?

- A.** An ETIN is used to submit claims to eMedNY and to enroll in ePACES. It allows for any claim processing information (REMIT data) to be returned electronically (or PDF if selected) to the submitter's ETIN on file for that claim.

Medicaid claims may be submitted by or on behalf of a billing provider by more than one Medicaid Service Bureau, in addition to by the billing provider itself. The claiming data includes an ETIN so Medicaid knows who submitted the claim, and where the processed claim data is to be returned to. To enroll in ePACES, you must first have an ETIN. [December 9, 2016]

237. Q. Who must have an ETIN?

- A.** Whoever submits claims to Medicaid (school districts, counties, Medicaid Service Bureaus) must have their own ETIN.
- If an SSHSP provider wants to submit claims directly to eMedNY it must have its own ETIN.
 - If an SSHSP provider contracts with a vendor to submit claims on their behalf, that vendor must have an ETIN of their own. The SSHSP provider must be added to the vendor's existing ETIN by submitting a Certification Statement.

Best practice: Get your own ETIN even if you contract with a vendor to submit claims on your behalf. This gives you the option to submit a claim(s) if you need to. It costs nothing. [December 9, 2016]

238. Q. Can school districts or counties continue to use the same ETIN they have been using?

- A.** ETIN 6N8 belongs to the Central New York Regional Information Center (CNYRIC). To continue billing after CNYRIC ends services, SSHSP providers

must apply for their own ETIN or complete a Certification Statement to link their MMIS billing provider number to a Medicaid Service Bureau's ETIN. SSHSP providers are strongly encouraged to apply for their own ETIN. Counties may have their own ETIN already in place as they submit claims for services provided outside of SSHSP. The county will need to decide whether to use an existing ETIN or to get a new one that is specific to SSHSP. You should continue to recertify the 6N8-CNYRIC ETIN through May 2017 to allow REMIT information to be returned to CNYRIC. [December 9, 2016]

239. Q. How long does it take to get an ETIN?

A. It takes about three months. Best practice – apply for an ETIN as soon as possible if you have not already done so. [December 9, 2016]

Billing and Claiming

240. Q. If a claim submitted by CNYRIC is denied at eMedNY, after the CNYRIC system ceases operation may the district/county submit a new claim for that same service themselves or through their new vendor?

A. Yes. Once changes are made, a new claim may be submitted as long as it is within 60 days of notification of the denial. It may be submitted by the SSHSP provider directly or through a vendor. [December 9, 2016]

241. Q. If a district/county wants to adjust or void a claim that was previously paid by Medicaid and processed through CNYRIC, may the district submit that adjustment or void themselves or through their new vendor?

A. Yes, the SSHSP provider may submit an adjustment or void to Medicaid. It may be submitted by the SSHSP provider directly or through a vendor. [December 9, 2016]

242. Q. If a district/county contracts with a vendor, does that mean that they may not submit claims directly themselves?

A. No, SSHSP providers may submit claims directly, even if they do contract with a vendor to submit claims on their behalf, as long as they have their own individual ETIN. This can be advantageous for claim adjustments, voids, and when submitting claims which could soon be time-barred.

Best practice: Discuss any plans to submit claims, adjustments or voids with vendors to assess systems or record-keeping implications. Understanding just what services are provided by the vendor will also assist the district/county in determining if there is any advantage to submitting claims directly. [December 9, 2016]

243. Q. Will the 12-month billing window remain in place for the SSHSP after the transition to direct billing?

- A. Yes, the 12-month billing window for the SSHSP will remain in place after the transition to direct billing. SSHSP providers are permitted to use Delay Reason Code 3 on claims submitted more than 90, but less than 366, days after the service was rendered. Do not use delay reason code 3 on claims submitted within 90 days of the service date because eMedNY will deny the claims. [December 9, 2016]

Training and Getting Help

244. Q. Is additional information and training regarding direct billing available for districts/counties?

- A. Yes. Webinars and seminars are available, register online at: [eMedNY Webinars](#)
- i. Relevant to SSHSP –
 1. How to Check Eligibility
 2. Navigating the eMedNY Website
 3. ePACES for SSHSP

Providers should check eMedNY.org website for dates/times of upcoming webinars and seminars.

ePACES Enrollment Reference sheet is available at:

https://www.emedny.org/HIPAA/QuickRefDocs/ePACES-Enrollment_Overview.pdf

eMedNY Provider Quick Reference Guide is available at:

<https://www.emedny.org/contacts/telephone%20quick%20reference.pdf>

Help documents and pages that will help providers and users conduct business with eMedNY are available at:

<https://www.emedny.org/selfhelp/index.aspx>

Additional resources available on the [Billing Transition](#) page of the Medicaid-in-Education website:

- ePACES Quick Claim Guide
 - Step by step instructions for creating and submitting electronic claim through ePACES, and retrieving remittance statements.
- SSHSP Medicaid Eligibility Verification System (MEVS) Responses Chart
 - Chart of Medicaid eMedNY member coverage codes and benefits, highlighting codes/benefits that include coverage of SSHSP services. [December 9, 2016]