School Supportive Health Services Program
Preschool Supportive Health Services Program

Questions and Answers
Issued December 13, 2010

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

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

Note: The responses to Questions #98 and #112 were revised December 10, 2012.

Note: The responses to Questions #53, #57, #64, #79, #91, #97, and #108 were revised November 24, 2014.

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

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.

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.

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 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.

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

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.

Note: The response to Questions #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) 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.~~

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Note: The response to Question #64 was revised November 24, 2014. Deletions are ~~struck through~~ and additions are <u>underlined.</u>

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 <u>as revised 12/10/2012</u>) on the Medicaid-in-Education home page at http://www.oms.nysed.gov/medicaid/q_and_a/.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

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 <u>and revised 12/10/2012 and 11/18/2014</u>) posted on the Medicaid in Education website.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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).

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.

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.

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:
http://www.asha.org/practice/reimbursement/coding/