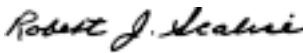


THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT

Date: May 23, 2003

To: Superintendents of Public School Districts and Approved Day Treatment Centers
From: Robert J. Scalise, Coordinator 
Medicaid Services Unit
Subject: Medicaid claiming for Health Related Support Services - Counseling Services at Day Treatment Centers.

School districts in New York State may claim Medicaid reimbursement for health related support services provided to Medicaid-eligible students with disabilities and indicated on an Individualized Education Program (IEP) under the School Supportive Health Services Program (SSHSP). The health related services eligible for Medicaid claiming are Speech, Physical Therapy, Occupational Therapy, Counseling and Skilled Nursing Services. Documentation requirements under the SSHSP are available through the Medicaid Guidebook located on the Medicaid Web Page at: <http://www.oms.nysed.gov/medicaid/>.

School districts place students with disabilities in approved Day Treatment Centers. Students placed in Day Treatment require extensive mental health services, i.e. counseling services, which are reimbursed by Medicaid directly to the Day Treatment Center. **School districts should not claim Medicaid for counseling services indicated on a students IEP, the Day Treatment Center will claim Medicaid directly for the counseling service.**

The Day Treatment Center, however, does not claim Medicaid for the other eligible health related services indicated on the IEP. **The school district may claim Medicaid reimbursement for Speech, Physical Therapy, Occupational Therapy and Skilled Nursing Services indicated on the IEP under the SSHSP. In addition the school district may claim Medicaid reimbursement for any corresponding evaluations as well as any TCM reviews provided the student if the following steps are in place:**

1. School Districts must request that the Day Treatment Center complete a Provider Agreement and a Statement of Reassignment (attached). These forms signed by the Day Treatment Center attest that the Day Treatment Center will not claim Medicaid for the Medicaid eligible services claimed by the school district under the SSHSP. In addition, the Day Treatment Center would attest that all the health related support services indicated on the IEP are provided in accordance with Medicaid regulations.
2. School districts must request that the Day Treatment Center document the delivery of service signed by the service provider monthly. The school district must provide the form used to document these services (attached). In addition, Part 200 of the regulations of the Commissioner require Progress Notes be provided to parents at the same frequency Progress Notes are provided to the parents of non-disabled students. The school district must indicate the frequency with which these progress notes are required. The form used to document the monthly delivery of service allows for a progress notation. Finally, the appropriate credential required for service providers are indicated in the Medicaid Guidebook available at the Medicaid WEB page, address above.

If you have any questions regarding the information above you may contact me at my email address: rscalise@mail.nysed.gov or at 518: 474-9341. Thank you for your cooperation in this matter.

cc: Theresa Savo
Thomas Hamel
Michael Albino

PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND
THE SERVICE PROVIDERS UNDER CONTRACT WITH THE SCHOOL DISTRICT
WHICH IS ENROLLED IN THE NEW YORK STATE MEDICAID
SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)

Based upon a request by the school district to participate in the New York State Medicaid SSHSP Program under Title XIX of the Social Security Act,

(Organization/Contracted Provider's Name)

will hereinafter be called the (outside contracted) Provider, agrees as follows to:

- A)
- 1) Keep any record necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medicaid Assistance.
 - 2) On request, furnish the New York States Department of Health, or its designee and the Secretary of the United State Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A)(1), and any information regarding any Medicaid claims reassigned by the Provider.
 - 3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B.
- B) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and/or marital status.
- C) Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York State Social Service Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York.

(Outside Contract) Providers Authorized Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date Signed: _____

Please list the School District(s) under contract with on the back of this form.

STATEMENT OF REASSIGNMENT

Name of the Outside Contracted Provider

By this reassignment the above-named outside contracted provider of services agrees:

1. to reassign all Medicaid reimbursements to your school district that you contracted with for providing medical services billed under the School Supportive Health Services Program (SSHSP).
2. to accept as payment in full the contracted reimbursement rates for covered services.
3. to comply with all the rules and policies as described in your contract with the school district.
4. to agree not to bill Medicaid directly for any services that the school district will bill for under the SSHSP program.

NOTE: Nothing in this "Agreement of Reassignment" would prohibit a Medicaid practitioner from claiming reimbursement for Medicaid eligible services rendered outside of the scope of the School Supportive Health Services Program (SSHSP)

(Date)

(Outside Contract Service Provider's Signature)

School District (under contract with): List additional ones on back of this form.)

