# **Medicaid 101: For LEA Direct Service Providers**

## **Slide 1: Introduction**

Welcome to the Medicaid one oh one [101] training series developed in partnership between MassHealth and the University of Massachusetts Medical School. Today’s training is Module eight in the series and is intended for Local Education Agency Direct Service providers.

## **Slide 2: Distributed April 2021**

This training was distributed in April of twenty twenty-one [2021] and was accurate at the time of distribution. As always, Local Education Agencies are responsible for reviewing information on the School-Based Medicaid Program website which can be found at mass dot gov slash MassHealth slash schools [www.mass.gov/masshealth/schools] to determine whether any subsequent guidance has superseded the content shared here. MassHealth does plan to update these trainings periodically as needed.

## **Slide 3: Introduction to Medicaid 101 Training Series**

The Medicaid one oh one [101] training series is designed to provide the essentials to understanding the School-Based Medicaid Program referred to as S-B-M-P. Some modules are designed for a broad, general audience. Other modules are targeted to the learning needs of a specific audience within each Local Education Agency or L-E-A.

I’m not going to read these all out as I’m sure that everyone in attendance today most likely is aware of the series, but the modules are shown here for your reference. And we encourage you to access any of the other modules in the series that might be helpful and appropriate for you and your responsibilities regarding the Medicaid program for your school district.

## **Slide 4: Introduction to Medicaid 101 Training Series**

And these are the additional modules in the series:

## **Slide 5: Training Agenda**

So, here’s today’s training agenda. Please note this module does assume that you have already reviewed the Introductory module in the Medicaid one oh one [101] series. Therefore, the agenda for this training builds upon that background knowledge.

* So, we will discuss the Training Objectives,
* And review What is the Direct Service Claiming or D-S-C portion of the program,
* We’ll cover the Reimbursable Services Requirements,
* Review Interim Claims and Billing Forms
* We’ll discuss the role of I-C-D Diagnosis and or Signs and Symptoms Codes,
* And go over some Random Moment Time Study Tips for Direct Service Practitioners.

## **Slide 6: Training Objectives**

So, we hope that, by the conclusion of the training, you will:

* Develop an understanding of what direct service claiming is and what types of services are reimbursable,
* And understand your role, from Medicaid’s perspective, as a clinically trained health care professional who is working in a school setting.
* Understand Medicaid’s requirements that have to be met for services you provide to be considered Reimbursable Services.
* And gain a better understanding of how your direct service work activities should be documented if you’re selected to respond in the Random Moment Time Study.

And, again, the note just that this is introductory one oh one [101] level. Every little detail you need to know is not going to be included here, but we really hope that this is a great place to start foundational knowledge. There is a lot here but not everything. So, we will provide some additional training opportunities and resources towards the end of the presentation, and there is an entire Direct Service Program Guide available on the S-B-M-P website as well.

## **Slide 7: What is Direct Service Claiming (DSC)?**

So, let’s begin with What is Direct Service Claiming?

* This is a program that L-E-As can use to seek federal reimbursement for the cost that your L-E-A, your school district, is incurring for providing direct services.
* The S-B-M-P the School-Based Medicaid Program covers direct medical services provided in the school-setting including things like speech, occupational and physical therapy, psychological counseling, skilled nursing services, audiology services, personal care services, and Applied Behavior Analysis therapy services when the Medicaid claiming requirements are met.
* The S-B-M-P program provides reimbursement for the provision of these Medicaid Covered Services when they meet Medicaid’s definition of medical necessity and all other program requirements, whether they are provided pursuant to a student’s I-E-P, or not.
* L-E-As, which is the Local Education Agency or school districts, submit interim claims for Covered Services provided to eligible MassHealth enrolled students through MassHealth’s M-M-I-S, that’s their claiming system. So, every time a service is provided to a MassHealth-enrolled student that is one of the reimbursable services, a claim is submitted.
* Providers must submit these per-unit or interim claims for all services that you’re seeking reimbursement for when the ultimate reimbursement actually comes through the Direct Services Cost Report. So, you file interim claims and then report your costs at the end of the year in a cost report.

## **Slide 8: Medicaid-Covered Direct Services**

So, what are the Medicaid-Covered Direct Services?

The services listed below are the MassHealth Covered Services. So, these are things that are MassHealth benefits to students enrolled in the MassHealth Program. So, it’s again:

* The A-B-A,
* Audiology,
* Dental Assessments or Screenings,
* Medical Nutritional Services,
* The Mandated Health and Behavioral Health Screenings,
* O-T,
* P-T,
* Speech Therapy,
* Psychological Counseling,
* Personal Care,
* Skilled Nursing,
* And some vision services.
* The full list of covered services and qualified practitioners is posted on the School-Based Medicaid website. That’s the link if you want to go there following the presentation or any other time: [<https://www.mass.gov/info-details/SBMP-resource-center>].

## **Slide 9: Reimbursable Services Requirements**

* So, an important concept is, how do we take something that’s a covered service and make it reimbursable in this program. There are requirements that have to be met when a Covered Service is delivered, which make that service eligible for reimbursement or make it a reimbursable service. The requirements are:

1. That the Practitioner who provided the service must participate in the Random Moment Time Study in the appropriate Direct Service Pool, if the services are being provided in district. Practitioners providing services to students out of district such as in one of the special education private schools or in an educational collaborative program are exempt from the R-M-T-S; however, all of the remaining requirements for reimbursement still apply to out-of-district services.
2. The Practitioner also has Licensure Qualifications that they need to meet for the type of service that they’re providing.
3. And the services need to meet Medicaid’s Definition of Medical Necessity. We’re going to talk about all of these things in this training.
4. The Service has been Authorized by a qualified practitioner.
5. And the Service has appropriate Documentation.

* L-E-As must ensure that each of these five requirements is met before submitting an interim claim for the service that was provided.

## **Slide 10: Reimbursable Services Requirements**

So, what does this look like in school-based practice?

* A large portion of the Medicaid-covered services provided in the school setting are provided pursuant to a student’s I-E-P.
  + I-E-P related services such as P-T, O-T, Speech therapy, A-B-A therapy, behavioral health counseling are common examples of services that can be reimbursable when the Medicaid program requirements are met.
* Additionally, some students receive Medicaid-covered services that have nothing to do with Special Education or an I-E-P. For example:
  + Health care services, such as nursing care or behavioral health counseling and others are often provided due to a student’s medical or behavioral health needs that has nothing to do with special education.
  + And many students receive the health screenings that occur in school, such as the vision screening, the hearing screening and others.
* All of these services are things that Medicaid covers and can be reimbursable when the reimbursement requirements are met.

## **Slide 11: Process for Medicaid Qualified Service Delivery**

* So, we’re going to talk about the process for Medicaid Qualified service delivery. We’re basically going to look at the service delivery process or cycle for I-E-P services first, since that’s the largest portion of services being delivered and reimbursed through the School Based Medicaid Program.
* And we’re going to use this as a framework to compare the I-E-P process, the work performed by an I-E-P team, and draw a parallel to the Medicaid Qualified Services Process performed by a qualified practitioner, who typically would be part of the I-E-P team in the case of I-E-P services.
* And we’re trying to illustrate that the I-E-P process is not the same thing as the Medicaid-Qualified Service Process, and it doesn’t substitute for it, but they actually work nicely in parallel. It’s actually pretty cohesive. So, we’re hoping that this is a helpful framework to understand how school-based practice fits with the way Medicaid looks at the world.

## **Slide 12: Health Care Services provided in a School Setting**

So, health care services provided in a school setting:

* As a related services provider, you are a clinically licensed health care professional working in a school setting, and you bring your clinical expertise to the rest of your school’s educational team and you all work together to support the needs of your students.
* Your school district hired you to perform your job because you have clinical skills and training that allow you to provide health care services that cannot be safely or effectively provided by other types of school staff.
* So, it’s really important to understand that educational needs and health care needs absolutely can and do overlap!
  + Medically necessary health care services have a clinical basis, but they also may help a student to achieve educational goals and access the curriculum.
* From MassHealth’s perspective, it’s your role in the I-E-P process, as the qualified practitioner, that MassHealth is focused on.

## **Slide 13: Special Education Process Medicaid-Qualified Services Process**

So, let’s compare the Special Education Process to the Medicaid-Qualified Services Process. We’re trying to draw parallel to see that they’re quite similar and how they really neatly fit together, but it’s not exactly the same thing. They work in parallel. So, for example, I’m sure everyone is very familiar with the I-E-P process somehow or someway a student might be referred or identified as needing to be evaluated for Special Education.

So, there is an evaluation; there’s a determination of eligibility; an I-E-P is written; there’s a placement of a student who needs related services with a practitioner who is going to provide them; instruction occurs; and then there is an annual review process and so forth, and you have an I-E-P cycle that’s happening.

With Medicaid Qualified-Services, it’s really very, very parallel. So, initially, you might be aware of that the student needs to be looked at by a clinical professional from a variety of ways again, referral or identification methods to identify you have a kid you need to take a look at. But, a clinical evaluation by a qualified practitioner is going to be performed, and they’ll determine whether the student needs services. They’re going to write a plan of care to provide those services and assign this student to a practitioner’s caseload to receive the services. Then, the therapeutic interventions or services are provided, and at some point, the student will be reassessed, and they’ll determine the need for continuing services or alteration of services and so forth. So, it’s very much a similar cycle. All of these steps in the cycle could completely be performed by the same practitioner or different practitioners; it doesn’t matter.

## **Slide 14: Medicaid Qualified Practitioners**

* So, to qualify for Medicaid reimbursement, services have to be provided by qualified practitioners who have a clinical license where required under state law and are providing services within their scope of practice as that licensed clinician.
* The list of qualified practitioners again, it’s that same document, L-E-A Covered Services and Qualified Practitioners document. It’s at this link on the School-Based Medicaid website: [<https://www.mass.gov/info-details/SBMP-resource-center>], and it lists all of the different licenses Medicaid is looking for.
* Please note that, although School-Based Medicaid Program practitioners may also hold licenses through Department of Elementary and Secondary Education, for the purposes of the S-B-M-P, licensure status is based on the Massachusetts clinical licensing boards. The exception to that is the Department of Ed, the D-E-S-E-licensed psychologists, who are explicitly listed as qualified practitioners for the School-Based Program, and you’ll find them listed in that Qualified Practitioners document.
* L-E-As do need to monitor the license status of staff and make sure that only appropriately and actively licensed staff are:
  + Submitting interim claims or having claims submitted on their behalf.
  + And areincluded in one of the Time Study direct service practitioner pools.

## **Slide 15: Medicaid Qualified Practitioners**

So, the complete list again, it’s that document on the website but we just tried to create a little one-page summary to simplify here. So, the types of practitioners and the body the licensing body that Medicaid is looking for the license that makes you a Medicaid qualified practitioner are listed here:

## **Slide 16: Practitioner Qualifications**

So, let’s review some Practitioner Qualifications starting with Clinical Supervision.

* So, Medicaid qualified providers do need to follow their individual licensing regulations regarding any supervision requirements.
  + Supervision may be provided indirectly or telephonically something like that, if your licensing regulations allow that.
  + Andthe supervisor needs to document supervision according to your license regulations.
* Licensed practitioners whose licensing regulations require that they be supervised are not considered Medicaid Qualified unless that clinical supervision is in place and is being documented.
  + So, for example, an adjustment counselor who is also a Licensed Certified Social Worker (an L-C-S-W) requires clinical supervision per the regulations of the Massachusetts Board of Registration of Social Workers. Services provided by an L-C-S-W who was NOT being clinically supervised don’t meet Medicaid qualifications to be billable under Medicaid.

## **Slide 17: Practitioner Qualifications – Clinical Supervision**

It’s important to note that Direct supervision is not a substitute for licensure.

* For all service types, except Personal Care Services and A-B-A therapy provided by an autism specialist, if the L-E-A staff does not hold a current and active license for the practice specialty area for the services that are being performed, then the staff does not meet Medicaid requirements for reimbursement, even if they’re supervised by a licensed practitioner.
* So, for example, a paraprofessional carrying out activities recommended by a Licensed Occupational Therapist would not be reimbursable. The only reimbursable providers for occupational therapy services would be a Licensed Occupational Therapist or a Licensed Occupational Therapy Assistant.

## **Slide 18: Evaluations**

So, regardless of referral source or how it was that it came to be that you identified that a student needs to be evaluated, both the I-E-P Process and the Medicaid-Qualified Services Process start with an evaluation by a qualified practitioner.

* So, in the I-E-P Process, there might be several I-E-P team members who have a role in evaluating a student’s needs for various types of services that might encompass educational, social services, and health-related services and supports.
* In the Medicaid process, we’re looking at a clinical evaluation which, for Medicaid’s purposes, we’re looking at the evaluation for health care services that is performed by a Medicaid Qualified practitioner whose scope of their license allows them to determine a student’s needs for that type of health-care service. The extent and type of an evaluation needed is consistent with clinical standards of practice that is set by the licensing board.

## **Slide 19: Determination of Need for Health Care Services**

All covered services must meet medical necessity standards. There is a state regulation if you’re interested in it that goes into, in regulatory terms, medical necessity standards. So, what does this look like?

In the I-E-P Process, again, an I-E-P team comes together and determines whether a student qualifies for special education and makes the determination about that student’s I-E-P.

* In Medicaid’s view of what is happening, there is a determination by a qualified practitioner, through their evaluation process, who’s determining whether it is **Medically Necessary** to provide health care services to the student. That signed evaluation report substantiates the medical need that a qualified practitioner determined there is medical need, not the I-E-P.

## **Slide 20: Medicaid Medical Necessity**

* All covered services must meet medical necessity standards to be reimbursable.
* And, of course, MassHealth does not pay for services that are not medically necessary.
* So, that means that the service must be reasonably calculated to prevent, diagnose, or prevent the worsening of, alleviate, correct conditions in the student that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, result in illness or infirmity.
  + If the service does not meet the standard, it is not reimbursable.
* So, all of that means there is an underlying cause. It could be a physical health cause. It could be a mental behavioral health cause. There is an underlying issue and a skilled intervention is required to address that underlying issue.
* Services that are required under a student’s I-E-P or health plan, or provided at the request of a third party, aren’t automatically considered medically necessary. Just because something is an I-E-P or just because something’s requested doesn’t make it medically necessary, right?

## **Slide 21: Medicaid Medical Necessity**

Let’s talk about Skilled Services. This is so important, I think.

* To be a Medicaid reimbursable service, the service must be skilled. So, that means it requires the clinical expertise of the licensed practitioner.
  + If the student themselves or an untrained lay person could provide the care, then it doesn’t meet the Medicaid medical necessity standard because it is not a skilled service if an unskilled person can do it.
  + The only exception to this requirement is personal care services, which are routinely provided by paraprofessionals and, by definition, do not require clinical skills to provide them.

## **Slide 22: Medicaid Medical Necessity**

The Professionally Recognized Standards Requirement

* This says that medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records that evidence that the medical necessity and quality was there.
* This means that the amount, frequency, and duration of services that are provided would be considered reasonable by professionally recognized standards of practice for the clinical service specialty and they require the skill level of a qualified practitioner to provide them.
* Practitioners are responsible for understanding their own standards of care and scope of license, including whether the clinical standards of practice differ from educational standards of practice.
* For services to be within the scope of a practitioner’s license, the student’s condition must require treatment of a level of complexity and sophistication that can be safely and effectively performed only by such a licensed practitioner. In other words, only someone qualified with the appropriate skills and training can effectively address the issue.

## **Slide 23: ICD Diagnosis and/or Signs and Symptoms Codes**

So, the clinical evaluation performed by a qualified practitioner is often the first source of identifying the reason that a health care service is medically necessary.

* The reason needs to be translated for claiming purposes into a clinically appropriate I-C-D code.
* Per hip pah [HIPAA] requirements, every claim has to include a clinically appropriate I-C-D code that is supported by the clinical documentation and all it does is explain WHY the child needs the service.
* The L-E-A may opt to utilize an I-C-D code that relates to the presenting signs and symptoms instead of, or maybe in addition to, a formal diagnosis.
* Every interim claim includes at least one I-C-D code, and you know, someone at the school is responsible for ensuring that there’s at least one clinically appropriate I-C-D code that explains why the service was necessary on each claim.
* When appropriate, an I-C-D code that is provided by a qualified practitioner that’s not employed or contracted with the L-E-A, such as if you get an order from a physician or nurse practitioner outside of the school, if they identify an I-C-D code, you can report that on a claim. You just need to maintain written and signed documentation of where that diagnosis came from.

## **Slide 24: Plan of Care Medicaid Service Authorization**

So, let’s talk about the Plan of Care and how that relates to Medicaid Service Authorization.

So, in the Medicaid Program, qualified services have to be authorized by a qualified practitioner through a written plan of care or treatment plan or order. They can be called a number of things.

* So, if we’re again trying to look as a parallel to help provide a framework in the I-E-P process, the I-E-P team documents a student’s disability and identifies the comprehensive program of services and supports that the school is going to provide to address the student’s needs so that the student can succeed in school.
* For Medicaid purposes, as part of that I-E-P team, there is a qualified practitioner who, following an evaluation or assessment of the student’s health care needs, writes a Plan of Care and defines the course of skilled treatments or interventions that the child needs to achieve a specific clinical treatment goal or goals. The clinician-signed plan of care authorizes services pursuant to that plan.

## **Slide 25: Plan of Care Medicaid Service Authorization**

* So, service authorization or plan of care must be written documentation signed by an appropriately licensed and qualified practitioner that documents the medical necessity of the service and the Plan of Care.
  + A signature on a Plan of Care can never be back-dated.
  + And any services provided prior to the signature date on the Plan of Care are not authorized and not billable.
* Determination of medical necessity and the development of a clinically appropriate plan of care typically are going to occur following an evaluation or some form of appropriate clinical assessment, and the extent and type of assessment needed to support that medical necessity and to develop or revise a plan of care just needs to be consistent with clinical standards of practice. That’s really saying it needs to fit what the student needs and what the treatment is so far, and the student’s needs, and standards of clinical practice.
* Service authorization requirements are consistent with clinical standards and requirements of each practitioner’s licensing bodies.
* The licensing bodies and standards of practice for most S-B-M-P-covered services require a plan of care.
* The plan of care should be developed consistent with those standards of practice, including ensuring that the license requirements for the person who develops the plan of care, and the frequency under which that plan of care might be revised and so forth are just consistent with the standards of practice of the license.

## **Slide 26: Plan of Care Medicaid Service Authorization**

So, as with all documentation, the Plan of Care, which is authorizing services, must directly include all of this information or incorporate supplemental information by reference. So:

* the name of the student whom the services are going to be provided to;
* the student diagnosis or presenting signs and symptoms and or a relevant I-C-D code;
* the services that are being authorized. This would be the description of services to be provided, and it should be written at an appropriate level of detail, again according to clinical standards of practice of what level of detail is necessary to make the plan (the treatment plan) clear.
* the complete date that the plan of care was written and signed;
* the frequency of services would be in a plan;
* the duration of services, if appropriate;
* and then a clinical rationale or justification for why the services are necessary. This, again, you should be writing this at an appropriate level of detail following clinical standards of practice for your clinical discipline area.
* The plan of care is going to indicate the time period for which these services are being authorized;
* the printed name, legible signature, signature date of the licensed practitioner who is writing the plan of care within his or her scope of license, including the type of license held, the license number, and again the note you can never backdate a signature;
* and then the authorizing practitioner’s contact information should be on the plan.

## **Slide 27: Plan of Care – Medicaid Service Authorization**

The Plan of Care, which authorizes services, must directly include information or incorporate supplemental information by reference. So, I just wanted to go over that just a little bit more because that sometimes causes confusion. So:

Information that must be directly in the Plan of Care:

* Any information identifying the student.
* The description of services being authorized, including frequency duration.
* Time period for the services being authorized, and.
* The authorizing practitioner’s information everything about them, including:
* The Practitioner signature and signature date that must be in the plan of care.

Supplemental information that could potentially if it was appropriate be incorporated by reference might be:

* The clinical rationale or basis for medical necessity. That might come from somewhere else, such as:
* An evaluation, student diagnosis or presenting signs and symptoms, and/or the I-C-D code.
  + Again, that information might be contained in an evaluation report, which could be referenced by the plan of care. You would want to include the name of the evaluator, the date of the evaluation.
  + That information might be contained in documentation that came in from a community provider, which again, you could reference in the Plan of Care including the provider’s name and the date of the provider’s order or whatever the document is.

## **Slide 28: Services Not Pursuant to an IEP**

* As we mentioned at the beginning of the presentation, the S-B-M-P does provide reimbursement for health care services that are completely unrelated to special education and not pursuant to an I-E-P.
* The requirements for reimbursement of I-E-P and non I-E-P services are the same.
* There are a few situations that occur when you’re not talking about I-E-Ps that will need to meet the Service Authorization requirement in a slightly different way than with normal I-E-P services.

## **Slide 29: Medicaid Service Authorization for Non-IEP Services**

So, the examples here: Unplanned services, screenings, and evaluations are categories of services that aren’t going to be resulting from an evaluation, writing a plan of care and delivering services.

* So, when unplanned nursing services are provided pursuant to a physician’s standing order, rather than a plan of care, the standing order may serve as the authorization.
* Unplanned behavioral health interventions can’t really be pursuant necessarily to a plan of care because they were unplanned, but medical necessity should be supported through service documentation; and the service is considered authorized when the documentation signed by a qualified practitioner is indicating that the service was necessary.
* The E-P-S-D-T screenings that are listed in the School-Based Medicaid Program Billable Procedure Codes document are considered automatically because they’re necessary health screenings considered to be authorized. So, no additional authorization is required for those.
* And, since evaluations are performed to determine whether services are necessary, the evaluations themselves don’t require a separate authorization. The documentation of the evaluation would support that it was medically necessary to evaluate and would include a description of the clinical reasons that it was appropriate to and necessary to evaluate the child.

## **Slide 30: Service Delivery and Documentation**

So, let’s talk about Service Delivery Documentation.

All Medicaid-qualified services must be documented.

* So, in terms of instruction, I-E-P services are provided to students to address the educational goals that are in the student’s I-E-P.
* Therapeutic intervention for Medicaid purposes is the qualified practitioner documenting the specific skilled treatments or interventions they provided to the student during each service session. So, these signed clinical treatment notes document that the treatment provided was consistent with the Plan of Care and was working toward achieving specific clinical treatment goals.

## **Slide 31: Service Documentation**

* Service documentation substantiates that the previously described requirements for reimbursement were met.
* So, L-E-As are responsible for ensuring that practitioners complete sufficient clinical documentation for any covered services provided to students if you’re seeking reimbursement for that service.
* Documentation can be completed using a paper form, a chart, medical record, or an electronic health record whatever you choose as long as requirements for clinical documentation and your practitioner’s signature or electronic signature requirements are met.
* And MassHealth doesn’t endorse any particular clinical documentation form or process or system. You don’t want MassHealth to dictate that. That is for you to decide what works at your L-E-A and should meet your clinical standards of practice for clinical documentation.

Just a note that service documentation is not the interim claim record, and it’s not a billing form. We’re going to talk about that a little more a little bit later.

## **Slide 32: Service Documentation**

So, service documentation again can be in the format of your school district’s choosing, but, at a minimum, these are data elements that should be directly in the documentation. Multiple services delivered by the same practitioner to the same student could be documented in a single form if that’s what you use. But, you are going to include:

* The student’s name,
* Date of birth,
* MassHealth ID number, if known,
* Some other student I-D number or the sass sid [SASID],
* School district name school name if different,
* The date of service or services,
* The time and duration of services,
* An indication whether it was an individually delivered service or in a group setting,
* An indication whether it was pursuant to an I-E-P or not,
* The diagnosis or presenting signs and symptoms information that translates to a relevant I-C-D code,
* Information that indicates if it was Telehealth; if it was provided virtually, that needs to be indicated.
* And an activity or procedure note: The activity or procedure note should be written at a clinically appropriate level of detail again following the clinical standards of practice for the clinical discipline that’s involved.
* Printed name, legible signature, signature date of the practitioner. We need a legible, printed name and signature of a supervising provider, if it was applicable, and the practitioner’s type of license and license number.

For more details on service documentation, the Direct Service Program Guide that is up on the Resource Center provides more details.

## **Slide 33: Re-Assessment**

So, in the I-E-P process, there’s an annual review of the various components of an I-E-P and an opportunity to make changes to the I-E-P as needed. For the S-B-M-P, re assessment for the purpose of determining whether changes are needed to a Plan of Care occur at clinically appropriate intervals.

* So, again, trying to parallel the two in the annual review process in the I-E-P process, there might be several I-E-P team members who have a role in reviewing the student’s progress towards achieving their I-E-P goals and continuing needs for the various types of services that they are receiving pursuant to that I-E-P. We’re talking about the healthcare services.
* So, for Medicaid’s purpose, the reassessment is what Medicaid is looking at, and the interval between assessments or reassessments and potential revisions to the Plan of Care are going to be determined by the needs of the individual student and the clinical standards of practice for the type of service. The extent and type of assessment needed to support medical necessity or to revise a plan of care again should be consistent with your clinical standards of practice and what the student needs.

## **Slide 34: Interim Claiming is Required**

* Whenever an L-E-A provides a Reimbursable Service (for which the L-E-A seeks reimbursement) to an eligible MassHealth enrolled student an interim claim must be submitted!
* EVERY time a qualified practitioner who participants in a Direct Service R-M-T-S pool provides a MassHealth Covered Service with the required authorization and service documentation that meet Medicaid’s definition of Medical Necessity (in other words is a Reimbursable Service) to a MassHealth-enrolled student, an interim claim must be submitted.

## **Slide 35: Billing Forms**

A note on billing forms:

* So, L-E-As can choose to utilize a billing form or system for the purpose of facilitating that interim claiming.
* Examples include things like electronic billing systems purchased directly from a software company or through a billing vendor, or an L-E-A or vendor-developed paper form perhaps. This is typically separate from service documentation that we’ve been talking about throughout this training module.
* And how this is implemented in each L-E-A is going to vary. So, your L-E-A may utilize a system or software that fully integrates clinical documentation with the Medicaid billing process, or this documentation and information may stand alone. Your L-E-A’s process might be paper-based, computer-based, a little bit of both.
* As a participating direct service practitioner, it’s your responsibility to seek guidance from your clinical leadership or your Medicaid coordinator at your school district regarding your L-E-A’s internal procedures for meeting all of the Medicaid program requirements.

## **Slide 36: Billing Forms Out-of-District Programs**

There is a billing form specific for out-of-district services.

* So, practitioners who work in a private special education school or collaborative program, Department of Elementary and Secondary Education dess see [DESE] has developed a billing documentation form specifically for students in the out-of-district placements.
* And the form is available on dess sees [DESE’s] website. That’s the link to where the form is located on dess sees [DESE’s] site: [<http://www.doe.mass.edu/sped/advisories/2019-3.html>]. It was fairly recently updated in May of twenty nineteen [2019].
* As described in this advisory, the form is ‘mandated.’ Out-of-district programs and public schools should only be using a different format for submitting information if it’s mutually agreed upon between the school district that sent the child or placed the child and the private school and contains all of the required data elements.

## **Slide 37: Procedure Codes and Service Units**

A little note on procedure codes and service units:

* So, depending on the billing forms and processes in place in your L-E-A, practitioners may need to indicate which procedure code should be billed for services performed.
* The School-Based Medicaid Program uses a limited set of procedure codes for interim billing purposes. So, there is a complete list again on the website if you want to see the complete list: [<https://www.mass.gov/info-details/SBMP-resource-center>].
* For Medicaid billing purposes, each service must be billed in units, which in most cases translates to service duration, but in other cases, some of the services are billed sort of per encounter or per visit. So, for example:
  + Individual speech therapy is billed with the C-P-T code nine two five oh seven [92507], and it’s billed in increments of fifteen [15]-minute units.
  + A vision screening is billed with nine nine one seven three [99173], and it’s just billed per screening; it’s always billed as one [1] unit. It doesn’t matter how long it takes to complete the screening.
* So, we recommend that everyone refer to any specific instructions at your L-E-A about the billing forms or electronic or paper or whatever they may be that are in process and in use at your L-E-A.

## **Slide 38: What Exactly is on the Interim Claim Submitted to MMIS?**

We do often get the question of what exactly is on the interim claim that is submitted to M-M-I-S Submitted to the Medicaid Claim Processing System.

So, the information on an S-B-M-P interim claim record is:

1. Who received the service? Which is identifying the Medicaid-enrolled student by name, date of birth, or Medicaid I-D number.
2. Who provided the service? This is identifying the L-E-A or school district submitting the claim.
3. When was the service provided? That’s the date of service.
4. What service was provided? That’s identified by the procedure code and modifier the modifier indicates whether it is pursuant to an I-E-P or not or provided in-district or out-of-district.
5. How many services were provided? That’s that unit sometimes that’s a time indication it might just be per encounter.
6. Why was the service provided? That’s the I-C-D code that tells you why the service was necessary.
7. Where the service was provided? There is a ‘place of service’ code on the claims it either indicates in-school or remotely via telehealth.
8. And the amount of payment the L-E-A is requesting for the service.

So, just a really important note that most of the documentation that we’ve talked about throughout this presentation is retained by the L-E-A to support the claim in case of audit. Most of that never actually goes to MassHealth.

## **Slide 39: Random Moment Time Study Tips for Practitioners**

And then just to wrap us out the Random Moment Time Study:

As a direct service practitioner, you’re going to apply your understanding of reimbursable service requirements when you answer a random moment, if selected.

So, if you happen to be providing a direct health care service or preparing to provide a direct health care service, or documenting that you provided a health care service at the time of a randomly-assigned moment, you’re going to have to answer questions that say:

* Was it medically necessary?
* Was it authorized?
* Was it within your scope of clinical practice?
* And, we’re always going to ask whether it was pursuant to an I-E-P or not?

You will never be asked to identify any student specifically, and you’ll never need to know whether the student that you were working with was actually enrolled in MassHealth or not that doesn’t matter when you’re responding to a random moment.

## **Slide 40: Random Moment Time Study Tips for Practitioners**

* L-E-As/school districts also receive reimbursement for Medicaid Administrative work activities performed by a variety of L-E-A staffing, including the Direct Service practitioners.
* So, if anyone is interested in learning more about the Medicaid Administrative portion of the School-Based Medicaid Program and how that works in the Random Moment Time Study, there is a module posted online. Module nine focuses on the Administrative Activities Reimbursement part of the program.

## **Slide 41: Next Training Steps**

So, again, just the refresher: These are the modules in the series, and some of these may be of interest to you for further information.

## **Slide 42: Contact Information and Resources**

And, of course, contact information and resources:

Mass dot gov slash MassHealth slash schools [[www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)] That is the School Based Medicaid Program website where all the official guidance and all kinds of information that we referred to today is posted online.

Some of the specific items we talked about that are there:

* The Direct Service Claiming Guide.
* The Covered Services and Qualified Practitioners document and,
* The list of the procedure codes and fees interim rates for those codes

As always, if you have questions or need assistance, the U-Mass Medical School School-Based Program Help Desk is available for you at school based claiming at U-mass med dot E-D-U [[SchoolBasedClaiming@umassmed.edu](mailto:SchoolBasedClaiming@umassmed.edu)], and there is our eight hundred [800] number [1-800-535-6741].

We are here Monday through Friday, from seven thirty [7:30] to seven thirty [7:30] to help you answer your questions, et cetera. So, don’t ever hesitate to reach out to us.

And thank you so much for attending today. We all appreciate everything you’re doing to try to understand this program and make this all work, and we’re trying to help and support you in that way. So, let us know what we can do to help and support you in any way that we can.

Thank you so much.