MassHealth

COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human Services
MASSHEALTH SCHOOL-BASED MEDICAID PROGRAM

Direct Service Claiming (DSC) Program Guide

Requirements for Reimbursement of Medicaid-Covered Services through Interim Claim Submission and Random Moment Time Study Documentation

Effective July 1, 2019
[updated AUGUST 2020]

Contents

Executive Summary

This guide is intended to provide local education agencies (LEAs) with instructions and information to participate in the direct services reimbursement portion of the School-Based Medicaid Program (SBMP), particularly the reimbursable services requirement for interim claim submission and Random Moment Time Study (RMTS) moment responses. As MassHealth-contracted providers, LEAs are expected to follow all MassHealth rules and regulations.

LEAs should review the SBMP Program Guide for Local Education Agencies in the SBMP Resource Center before reviewing this guide. The Program Guide offers a higher-level overview of the entire program, including the administrative activity claiming (AAC) component, which complements the direct -service claiming (DSC) discussed in this document; and the RMTS, which is an integral component of the entire program.

LEAs are required to submit interim claims whenever a reimbursable service is provided to an eligible MassHealth-enrolled student for whom the LEA seeks reimbursement. Interim claims demonstrate to MassHealth that reimbursable services are being provided and are required to allow costs for each provider type (e.g., nurses, speech-language pathologists, etc.) and for the appropriate number of students to be included in the annual DSC cost report. The life cycle of reimbursable services is visually represented in Section 4: Interim Billing and Claims Submissions Rules.

LEAs are responsible for all costs submitted for reimbursement, including interim claims and RMTS moments marked as meeting program requirements. Regardless of whether an LEA contracts with a vendor to assist with claim submission, representatives from each LEA should review this guide and become familiar with program requirements. In addition to financial responsibility, LEAs must understand program requirements because the Centers for Medicare & Medicaid Services (CMS) and MassHealth frequently audit interim claims and RMTS moments.

This guide applies to many types of LEA staff, such as those listed below. These individuals should read and be familiar with the information in this guide.

- LEA staff who oversee interim claiming and/or direct-service practitioners;
- LEA health directors, special education directors, and student services directors;
- Lead nurses and other lead health practitioners;
- Anyone who works with electronic health records, including documentation and data; and
- LEA staff that oversee, work with, and/or draft contracts with vendors who assist with claim submission or other administration of SBMP.

This Direct Service Claiming (DSC) Guide is separated into five parts.

1. an overview of the Direct Service Claiming Program;
2. information about eligible MassHealth members;
3. requirements for reimbursable services—specifically practitioner RMTS participation, practitioner qualifications, Medicaid medical necessity, service authorization, and service documentation;

4. technical requirements related to interim billing and claims submission rules; and
5. other contractual obligations drawn from the SBMP Provider Contract.

Although this guide will be updated on an ongoing basis, the Executive Office of Health and Human Services (EOHHS) may from time to time release additional training materials or resources published related to the SBMP. LEAs should visit the SBMP Program website for the most up-to-date information. All terms and conditions of the SBMP Provider Contract and all program bulletins continue to apply.

Section 1:
Direct Service, Interim Claims, Cost Reporting Overview

The DSC Program is the mechanism through which LEAs seek federal reimbursement for the provision of medical services (as opposed to Medicaid administrative costs, which are captured in administrative activity claiming (AAC)). For more information about AAC, see the SBMP Program Guide for Local Education Agencies and the Administrative Activities Claiming Guide in the SBMP Resource Center.

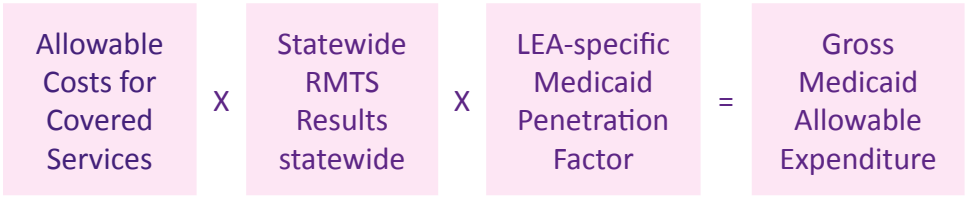
The SBMP covers the provision of Medicaid-covered medical services delivered in a school setting that meet Medicaid's definition of medical necessity and all other program requirements. Medicaid-covered medical services include speech-language pathology, occupational therapy, and physical therapy; mental and behavioral health services; skilled nursing services; audiology services; personal care services; applied behavior analysis (ABA) services for students with autism spectrum disorder; medical nutritional counseling; certain physical and behavioral health screenings; and fluoride varnish treatment. For additional information on licensure requirements for covered services, review the Local Education Agencies Covered Services and Qualified Practitioners Document posted on the SBMP Resource Center.

Interim Claims and Cost Report Overview

Throughout the year, LEAs submit interim claims for reimbursable services provided to eligible MassHealth-enrolled members through MassHealth's Medicaid Management Information System (MMIS). Providers must submit per-unit claims for all services for which they seek reimbursement in the annual DSC cost report due on December 31 each year. Interim claims are required to demonstrate that reimbursable services were provided to an eligible member. Interim claims that are adjudicated in MMIS and determined to be "paid" (regardless of interim billing fee) are the basis for which costs can be included in the Annual Cost Report and the basis for the number of students that can be counted in the Medicaid Percentage Rate calculation. The annual DSC cost report calculates total gross Medicaid allowable expenditures reimbursement, based on each LEA's actual incurred and allowable costs. Interim claims are paid quarterly.

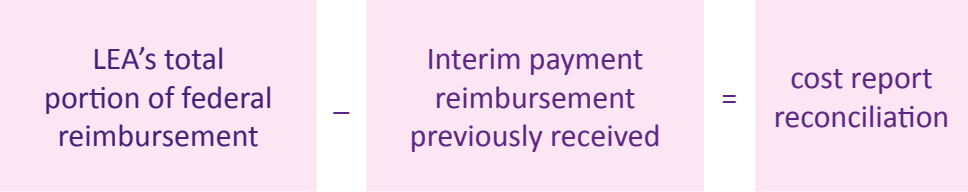
After the conclusion of the fiscal year, LEAs submit an annual DSC cost report that includes costs to provide Medicaid-covered services; statewide Random Moment Time Study (RMTS) results; and LEA-specific Medicaid eligibility statistics used to calculate Medicaid penetration factors. These inputs are used to determine the gross Medicaid reimbursable amount. This calculation is shown in Figure 1.

Figure 1: Annual DSC Cost Report Calculation to Determine Gross Expenditure Amount for Medicaid-Covered Services.



This gross Medicaid allowable expenditure amount is reported to CMS, and the state receives partial federal reimbursement. The total of each LEA's interim claims paid throughout the year is deducted from the LEA's portion of federal reimbursement, and the remaining amount is paid to the LEA. This is called the cost report reconciliation process. Figure 2 illustrates this process.

Figure 2: Annual DSC Cost Report Reconciliation Process



If the cost report reconciliation is positive, then a payment will be issued to the LEA. If the cost report reconciliation is negative, then MassHealth will recoup the overpayment from the LEA. Cost reports are due by December 31 each year and generally paid or recouped by the end of the following June. For example, for FY19 (July 2018–June 2019), cost reports were due 12/31/19 and reconciliations are anticipated to be paid or recouped by 6/30/20. A helpful list of dates and deadlines is available in the SBMP Resource Center (the document is called SBMP Schedule SFY20XX).

As a reminder, LEAs may bill up to the maximum fee specified in the SBMP Procedure Codes and Maximum Fees document. LEAs concerned that they may be in a recoupment state after cost report reconciliation should bill under the maximum fee. For example, an LEA that historically received an average of $150,000 in DSC revenue per year may target $100,000 in interim claiming revenue. Once $100,000 in interim claiming revenue is received, then the LEA would bill the interim claims at $0. In this scenario, the LEA could expect a $50,000 cost report settlement. The LEA should not stop billing interim claims after $100,000 in interim claims revenue. Because the SBMP is paid based on cost allocation, billing interim claims at $0 does not negatively impact annual revenue.

This Direct Service Claiming (DSC) Guide provides instructions for the direct-service reimbursement program, with a focus on reimbursable service requirements for interim claiming and documentation of RMTS moments. Please refer to the Instruction Guide for the Annual Direct Service Cost Report, available by request from the University of Massachusetts Medical School (UMMS), for additional details regarding the annual DSC cost report reconciliation process.

LEA Enrollment Overview

To participate in the DSC Program, LEAs must enroll with MassHealth. After enrollment is completed and the LEA has started to participate in its first quarter of the RMTS, the LEA may begin billing for direct services and may have its costs reimbursed if the reimbursable services requirements are met. For detailed instructions about the RMTS, please see the LEA RMTS Coordinator Guide for Random Moment Time Study (RMTS) available in the SBMP Resource Center.

To enroll as an SBMP provider, contact the MassHealth Customer Service Center at providersupport@mahealth.net or (800) 841-2900.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all LEAs must obtain a National Provider Identifier (NPI) and must include this 10-digit number on all claims and correspondence submitted to MassHealth. To register for an NPI, contact the National Plan & Provider Enumeration System (NPPES).

Section 2:
Eligible MassHealth Members and DESE Parental Consent Guidance

Definition of an Enrolled Student

LEAs may seek reimbursement from the SBMP for Medicaid-reimbursable services provided to MassHealth-enrolled students for whom the LEA is financially responsible. This includes all students who are enrolled by the LEA and those attending approved special education schools or collaboratives pursuant to an Individual Education Program (IEP), for whom the LEA is financially responsible.

If a student attends a charter, regional, vocational/technical, or agricultural school, only the LEA that the student attends (rather than the LEA in which they reside) can seek reimbursement for costs associated with the student. This includes counting that student in the LEA's Medicaid penetration factor calculation and submitting interim claims when Medicaid reimbursable services are provided to the student. The LEA should not include such students in the annual DSC cost report statistics or submit interim claims for services, regardless of financial responsibility. Additional details on determination of financial responsibility can be found in the Financial Responsibility Determination Chart shown in Appendix E.

Eligible MassHealth Members

Claims are reimbursable only if the services were provided to MassHealth-enrolled members between three and 22 years of age who are eligible for federal reimbursement for non-emergency services. Reimbursable eligibility types include CarePlus members and most Standard, CommonHealth, and Family Assistance members (not MassHealth Limited or the Children's Medical Security Plan (CMSP)).

MassHealth provides access to student Medicaid eligibility information for LEAs through two methods.

- The Provider Online Service Center (POSC) can be accessed to perform individual student eligibility inquiries. The POSC is updated daily and displays eligibility on a particular date (or month) of service, unlike the quarterly eligibility snapshot.
- The SBMP provides an online Student Medicaid Eligibility Matching verification system to all participating LEAs through the UMMS program website. This site is used by each LEA quarterly to identify MassHealth-enrolled students and calculate the LEA's Medicaid penetration factor used in AAC and in the annual DSC cost report. For additional information about the Student Medicaid Eligibility Matching system, please refer to the Step-by-Step Manual: Student Medicaid Eligibility Matching, available by request from the SBMP help desk.

DESE Guidance Regarding Parental Consent

The Department of Elementary and Secondary Education (DESE) is the state agency responsible for overseeing the Federal Educational Rights and Privacy Act (FERPA) and Individuals with Disabilities Education Act (IDEA) in Massachusetts. DESE has provided guidance that, in order for an LEA to be compliant with FERPA and IDEA, parental consent is required before an LEA can access a student's MassHealth benefits. This includes the submission of interim claims and the inclusion of students in the Medicaid eligibility statistics in the annual DSC cost report. For more information about parental consent, refer to the Special Education Mandated and Recommended Forms for the Implementation of Special Education Requirements or contact DESE.

Section 3:
Requirements for Reimbursable Services

Covered Services

The SBMP covers health services provided in the school setting, including speech-language pathology, occupational therapy, and physical therapy; mental and behavioral health services; skilled nursing services; audiology services; personal care services; medical nutritional counseling; certain physical and behavioral health screenings; fluoride varnish treatment; and ABA therapy services for students with an autism spectrum disorder (ASD) diagnosis when all Medicaid-claiming requirements are met.

The list of SBMP-covered services is outlined in Local Education Agencies Covered Services and Qualified Practitioners on the SBMP Resource Center. Additionally, the corresponding list of procedure codes, modifiers, and maximum interim billing fees can be found in the SBMP Billable Procedure Codes and Maximum Fees document.

All costs claimed under the School-Based Medicaid Program must be consistent with state and federal laws and regulations. When an SBMP-covered service is provided and meets all program requirements for reimbursement, that service is referred to as a reimbursable service.

Non-covered Services

As a reminder, as a health insurance program, MassHealth and the SBMP can reimburse only for certain Medicaid-covered health services. The following list includes examples of services that LEAs commonly provide that are **not** Medicaid-covered health services and are therefore neither covered nor reimbursable direct services.

- Services that are purely educational, academic, vocational or social in nature, or do not require the skill level of a qualified practitioner
- Consultation services, which are defined as either professional-to-professional interactions to address a student need or provide assistance or support; or professional-to-student interactions that are limited in time and intensity and are primarily for monitoring purposes. LEAs receive reimbursement for such activities through the administrative activity claiming portion of the SBMP.
- Missed appointments/services
- Remedial education
- Day-care
- Teaching parenting skills or life skills
- Review of records

- General student supervision
- Attending meetings, including individualized education program (IEP) meetings and IEP team meetings
- Parent consultation, contact, or training
- School/guidance counseling services

Qualified practitioners may provide educational or other non-health-related services in a school setting. For example, a speech-language pathologist may assist English language learners with speech, but unless the services are provided because of a medical condition or injury, the service is educational and not a health service. Therefore, the service would not be covered.

Reimbursable Services Requirements

For services to be reimbursable, five requirements must be met, as described further in this section. This may include services that are provided to help students access the curriculum when provided because of an underlying medical (physical or behavioral health) need. The five requirements are:

1. Practitioner RMTS participation
2. Practitioner qualifications
3. Medicaid medical necessity
4. Service authorization
5. Service documentation

LEAs must ensure that each of the five requirements is met before an interim claim is submitted to MMIS for adjudication. If an LEA designates this review to a billing vendor, then the LEA is still ultimately responsible for compliance and should take steps to ensure program integrity.

MassHealth does not dictate what LEAs should do or are required to do as an educational agency; rather, MassHealth provides guidance around requirements should LEAs wish to seek federal Medicaid reimbursement for services provided.

The LEA must maintain and produce upon request documentation of compliance with these requirements for each reimbursable service. Failure to produce documentation for the five reimbursable services requirements in the event of a state or federal inquiry or audit may result in recoupment. The LEA should ensure that student/patient privacy is maintained and all documentation is maintained securely per the SBMP Provider Contract, HIPAA, and other applicable state and federal privacy laws. LEAs are responsible for determining applicability and compliance with state and federal laws, including when tasks are carried out by a contractor or third-party billing vendor.

When responding to an RMTS moment, participants must meet reimbursable services requirements to respond that they were providing services in compliance with program guidelines.

1. Practitioner RMTS Participation

LEAs may submit only interim claims and may include costs in their annual DSC cost report only for employed or contracted staff who were included in the appropriate direct-service cost pool of the RMTS. LEAs may not submit an interim claim for practitioners in the administrative-only cost pool, even if those practitioners provided an otherwise reimbursable service.

Only Medicaid-qualified practitioners (as described next) who are reasonably expected to perform a reimbursable service may be included in a direct service cost pool in the RMTS. The direct-service pools appear in the following list. For additional information about pools and the RMTS, refer to the LEA RMTS Coordinator Guide for Random Moment Time Study (RMTS) available in the SBMP Resource Center.

Pool 1: Mental/Behavioral Health Services (includes ABA)

Pool 2: Therapy Services

Pool 3: Medical Services

2. Practitioner Qualifications

Services must be provided by qualified practitioners who have a clinical license (when required under state law) and are providing services within their scope of practice as a licensed clinician. The list of qualified practitioners can be found on the SBMP Resource Center in the Local Education Agencies Covered Services and Qualified Practitioners document. Please reference practitioners' licensing bodies for scope-of-practice regulations (including treatment plans where applicable) and supervision requirements (e.g., Massachusetts Board of Registration in Nursing, Massachusetts Board of Registration of Allied Mental Health and Human Services Professionals). Professional practice organizations may also provide scope-of-practice assistance (e.g., National Association of Social Workers, the American Speech-Language-Hearing Association).

Licensed practitioners must comply with all supervision requirements of the practitioners' licensing body. See the LEA Covered Services and Qualified Practitioners document. Practitioners are responsible for understanding their scope-of-practice and supervision requirements.

Supervision may be provided indirectly (by phone or videoconference) if allowed under the individual licensing regulation.

Practitioners must have a current, active license for the practice specialty area for the service area being provided, and supervision is not a substitute for licensure. For all service types, except personal care services and ABA therapy provided by an autism specialist, if the practitioner does not hold a current, active clinical license for the practice specialty area for the services being provided, the staff member does not meet practitioner qualifications, even if supervised by a licensed practitioner. For example, a paraprofessional providing occupational therapy services under the supervision of a licensed occupational therapist would not be reimbursable. The staff person would need to be licensed as an occupational therapy assistant (OTA) for their services to meet the practitioner qualifications requirement.

3. Medicaid Medical Necessity

All covered services must meet medical necessity standards under 130 CMR 450.204 to be reimbursable. The following excerpts from the regulation provide additional explanation for certain school settings. Providers are required to comply with the full regulation.

Requirement of Medical Necessity

Per 130 CMR 450.204, MassHealth does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service where such service is not medically necessary.

The service must be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.

If the service does not meet this standard, it is not reimbursable. Services that are required under a student's IEP or health plan, or provided at the request of a third party, are not automatically considered medically necessary. Providers must follow the guidelines as set forth by 130 CMR 450.204 (A)(1) to determine medical necessity.

For screenings and visits under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the periodicity is established in Appendix W of all Provider Manuals, available on the MassHealth All Provider Manual Appendices page. All periodic screenings and visits under the EPSDT benefit consistent with Appendix W meet the requirement standard. Per Appendix W, interperiodic screenings and visits may be medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition. (See 130 CMR 450.141.

Most Conservative and Least Costly Service

For the service to be medically necessary, there must be no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. (See 130 CMR 450.204(A)(2).)

One implication of this regulation is that the service must require the clinical expertise of the practitioner. If the student or an untrained lay person could provide the care in another setting, then there is another medical service or site of service that is more conservative or less costly to the MassHealth agency; therefore, the service does not meet Medicaid medical necessity requirements.

For example, if a nurse provides basic first aid, which a parent, teacher, or another lay person could do in another setting, the service does not meet the Medicaid medical necessity requirement. Generally, if the task can be delegated to a non-qualified practitioner such as a paraprofessional or nurse aide, then the service does not require the skill level of the qualified practitioner. Although they do not have clinical expertise, personal care service providers are an exception who provide assistance with activities of daily living and are considered qualified practitioners.

Professionally Recognized Standards Requirement

The medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. (See 130 CMR 450.204(1)(B).)

This means that the amount, frequency, and duration of services must be considered reasonable by professionally recognized standards of practice for the clinical service specialty and require the skill level of the qualified practitioner.

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.

Examples That Do Not Meet Medicaid Medical Necessity Requirements

This list has additional examples of services that would not meet Medicaid medical necessity requirements and cannot be claimed.

- Services that could be delegated to a nurse aide or paraprofessional do not require the skill level of a qualified practitioner (for example, taking a student's temperature without any additional evaluation).
- Services that are provided by a nurse because of school policy, rather than because the service requires the skill level of a nurse (for example, if a registered nurse gives ibuprofen to a student without additional evaluation that requires clinical expertise).
- A licensed physical therapist reevaluating a student at the request of a parent. (In the physical therapist's clinical opinion, the student does not need the evaluation, and therefore the evaluation is inconsistent with standards of practice.)
- A licensed speech-language pathologist providing services three times a week as required in the student's IEP. (In the speech-language pathologist's clinical opinion, the student needs the service only once per week. In this situation, the first time per week that is medically necessary and consistent with standards of practice would meet the Medicaid necessity requirement and could be billed. The other two instances per week would not, and therefore should not be billed.)

Examples That Do Meet Medicaid Medical Necessity Requirements

The following list has examples of services that would meet Medicaid medical necessity requirements. For services to be reimbursable, the other four requirements (i.e., practitioner RMTS participation, practitioner qualifications, service authorization, and service documentation) would also need to be met.

- A licensed occupational therapist provides needed occupational therapy with frequency and duration consistent with standards of practice.
- A licensed physical therapy assistant provides physical therapy pursuant to an IEP that is under "stay put," meaning a prior year's IEP is being followed because an updated IEP has not been signed by all required parties. The practitioner is supervised according to licensure requirements, and the services are still considered medically necessary by the supervising physical therapist and provided in accordance with physical therapy standards of practice (including treatment plans and goals as appropriate).
- A nurse administers a hearing screening, which is an EPSDT screening.

4. Service Authorization

Service authorization must be written documentation by an appropriately licensed and qualified practitioner that documents the medical necessity of the service, and the clinically appropriate plan of care. Some exceptions are listed near the end of this section. Determination of medical necessity and the development of a clinically appropriate plan of care typically occur following an evaluation. Some exceptions are listed near the end of this section. SBMP service authorization requirements are consistent with clinical standards and requirements of practitioners' licensing bodies. There is no prior authorization requirement for SBMP services.

Practitioners whose clinical scope of practice includes the ability to practice without supervision may authorize the services. For example, a licensed independent clinical social worker (LICSW) can provide services without supervision and therefore can authorize behavioral health services, whereas a licensed clinical social worker (LCSW) requires supervision and cannot authorize services. Please note that although SBMP practitioners may also hold DESE licenses, for the purposes of the SBMP, licensure status is based on the Massachusetts clinical licensing boards (except for DESE-licensed psychologists, who are explicitly listed in the CSQP).

For personal care services only, because the rendering practitioner is not a licensed practitioner, a physician, physician assistant, or nurse practitioner must authorize the services.

The licensing bodies and standards of practice for most SBMP-covered services require "plans of care." In this context, plans of care refer to any type of care plan—for example, a treatment plan, intervention plan, or behavior intervention plan. The plan of care should be developed consistent with licensing bodies' standards of practice, including licensure requirements for the person developing the plan of care, and the frequency of plan of care development and revision. When all the information listed below is included in the plan of care, then the service authorization requirement is met. If a plan of care does not include all listed elements below, then the LEA may choose to add the required information to the plan of care or supplement the plan of care with the required information.

This authorization requirement is distinct from IEP requirements. Decisions made about the provision of services as part of an IEP do not substitute for written service authorization by an appropriate practitioner as described previously.

The following elements must be included in service authorization:

- the name of the child to whom the services will be provided;
- the patient diagnosis and/or relevant ICD-10 code;
- the service(s) being authorized;
- the complete date that the care plan was written and signed;
- the frequency of the service (including unit of frequency—e.g., 2x30/week or 3x45/month);
- the duration of the service, when appropriate;
- clinical rationale/justification for service(s). This should follow standards of clinical practice for each clinical discipline as defined by clinical licensing boards and professional practice organizations. At a minimum, this should be 1-2 sentences that describe why the service is medically necessary, along with an appropriate level of detail required to describe the plan of care to be provided to treat the medical (physical or behavioral health) issue(s);

- the time period for which services are being authorized;
- the printed name and legible signature of practitioner who is licensed, registered, and/or certified as the relevant licensed professional acting within his or her scope of license, including his or her type of license and license number; and
- the authorizing practitioner's contact information, including school address and phone number.

Exceptions: Unplanned services, screenings, and evaluations. In this event, the service authorization requirement is met in the following way.

- 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. Standing orders are defined as physician orders used in urgent or emergent scenarios in which immediate actions must be taken to support a patient, because any delay in care may be detrimental. Nurses may provide services following these predetermined standards of care, as long as the standing orders have been reviewed and approved at least annually; and the responsible physician signs the service documentation as soon as possible after execution of the nurse-initiated order(s) and before the service is billed to Medicaid.
- Unplanned behavioral health interventions cannot be pursuant to a plan of care by nature of being unplanned. Medical necessity should be supported through service documentation; and the service is considered authorized when such documentation is signed by a qualified practitioner. If unplanned behavioral health interventions are provided by a practitioner who is not qualified to authorize services, but is being supervised by a qualified practitioner (e.g., an LCSW who is supervised by an LICSW), then the supervising practitioner must review and sign the service documentation as soon as possible after the delivery of the service, and before the service is billed to Medicaid.
- EPSDT screenings that are listed in the SBMP Billable Procedure Codes and Maximum Fees document (as published and updated in the SBMP Resource Center) are automatically considered to be authorized.
- Since evaluations are performed to determine whether services are necessary, the evaluations do not require service authorization. The documentation of the evaluation must support medical necessity and include a description of the clinical reasons that the evaluation was appropriate and necessary.

5. Service Documentation

Service documentation substantiates that the previously described requirements for reimbursement were met. LEAs are responsible for ensuring that practitioners complete sufficient clinical documentation for all covered services provided to students for whom the LEA seeks reimbursement. Documentation may be completed using a paper form, chart, or medical record; or an electronic health record of the LEA's choosing, as long as all requirements for clinical documentation and practitioner signature/electronic signature are met. MassHealth does not endorse any particular clinical documentation form, process, or system.

Note: Service documentation is not the interim claim record. For information about the requirements for data to be included in an interim claim, please see Section 4 of this guide.

Service documentation may be in the format of the LEA's choosing, but, at a minimum, the following data elements must be included in the documentation. (Multiple services delivered by the same practitioner to the same student may be documented on a single form.)

- Student name
- Student date of birth
- Student's MassHealth ID, if known, and State Assigned Student Identifier (SASID)
- School district name and school name (if different)
- Date(s) service(s) were provided
- Time of service and duration of service in minutes
- Individual or group indicator
- IEP or non-IEP indicator
- Diagnosis or relevant ICD-10 code
- Telehealth information: If services were provided via telehealth, documentation must indicate that the service was provided via telehealth and must name the location of the practitioner (e.g., "Kennedy High School," "Therapy Services, Inc. main campus," "therapist's home") and of the student (e.g., "Kennedy Elementary," "Easthampton Residential Program," "student's home").
- Activity/Procedure note: The practitioner must write a brief description of the service provided to the student that sufficiently documents the extent and duration of the service provided, including identification of the treatment goals being addressed in the session, where appropriate. Service documentation notes should be consistent with the standards of clinical practice for the practitioner's clinical license (including outcomes, as appropriate). This documentation should support the determination that the service met Medicaid medical necessity standards.
- Printed name and legible signature of practitioner and legible, printed name and signature of supervising provider, where applicable. The practitioner's type of license and license number must be listed.
    - If practitioner or supervisor cannot be determined, then the service documentation may be considered invalid, and payment may be subject to recoupment. Electronic signature is acceptable. LEAs that allow electronic signatures must develop policies and procedures to ensure appropriate use of electronic signatures. These policies should
        - recognize the potential for misuse or abuse when using electronic signatures and should establish standards, determined by the LEA to be consistent with state and federal electronic signature requirements;
        - include security provisions to prevent the use of an electronic signature by anyone other than the licensed provider to whom the electronic signature belongs;
        - include procedures that follow recognized standards and laws that protect against modification of electronic signatures; and
        - protect the privacy and integrity of all documentation, including signatures.

Following the record-retention guidelines in the SBMP Provider Contract, LEAs must retain written documentation of the service delivery and service authorizations to support all interim claims. LEAs must produce these records in the event of an audit, upon request by MassHealth or other state or federal compliance agency. This includes services provided to students by subcontractors or in an out-of-district placement pursuant to an IEP. It is the responsibility of the LEA to ensure that all subcontractors, including approved special education schools, and collaboratives maintain this documentation.

Section 4:
Interim Billing and Claims Submission Rules

Interim Billing and Payment Overview

CMS requires that interim claims be submitted for all services and for each student for whom LEAs seek reimbursement. This means that every time a Medicaid-qualified practitioner (who has been included in the appropriate direct-services cost pool of the RMTS) provides a reimbursable service to a MassHealth-enrolled student for whom the LEA seeks reimbursement, an interim claim must be submitted. Only claims submitted with billable procedure codes provided to eligible MassHealth-enrolled members (see Section 2 earlier in this document) will be adjudicated for payment in MMIS. All submitted claims should meet the definition of reimbursable services described previously.

LEAs are responsible for monitoring their interim billing activity and ensuring that claims are submitted and paid for all reimbursable services provided. This includes the responsibility to resubmit denied claims when the denial is because of a clerical or billing error.

The life cycle of a service, from service delivery to disbursement.

1. **LEA:** Qualified practitioner provides an authorized service that meets the following requirements for billing to a MassHealth-enrolled student.
   - Practitioner RMTS Direct-Service Pool Participation
   - Practitioner Qualifications (including supervision requirements)
   - Medicaid Medical Necessity
   - Service Authorization
   - Service Documentation
2. **LEA:** Service prepared for billing.

   Examples: submitting documentation of service, authorization, etc. to billing vendor/billing staff, reviewing authorization; identifying the dollar amount up to maximum fee to be billed.
3. **LEA:** Interim Claim submitted to MMIS for processing.
4. **MassHealth:** MMIS processes claim ("paid," "denied," or "suspended").
5. **LEA:** Claim monitoring:
   - Denied and suspended claims are reviewed and resubmitted.
   - Paid claims are tracked to update projections, interim billing compliance monitoring.
6. **MassHealth:** Quarterly claims report pulled to inform federal claiming and federal revenue claimed from CMS.
7. **MassHealth:** MassHealth disburses federal revenue payments to LEAs.

Payment

Payment for interim direct-service claims is made quarterly. All claims adjudicated through MMIS and approved for payment are accumulated quarterly and payments are disbursed to LEAs approximately 90 days after the close of each quarter. LEAs can track their payments by accessing the Massachusetts Office of the Comptroller's VendorWeb website.

Definition of a Unit

LEAs should bill units based on rounding to the nearest whole unit.

For example, for per-service billing in 15-minute increments, LEAs should follow the CMS "8 Minute Rule" as shown in this table.

Time Range and Number of Units
8–22 minutes would equal 1 unit
23–37 minutes would equal 2 units
38–52 minutes would equal 3 units
53–67 minutes would equal 4 units
68–82 minutes would equal 5 units
83 minutes would equal 6 units, and so on.

Procedure Codes and Modifiers

Modifiers give MassHealth crucial information about billed services. A detailed list of billable procedure codes, modifiers, and interim billing rates can be found in the SBMP Billable Procedure Codes and Maximum Fees document in the SBMP Resource Center. Modifiers may be listed on the claim in any order.

The following modifiers are used in the SBMP.

- TM: indicates services provided pursuant to an IEP
- TR: indicates services provided not pursuant to an IEP
- GO: indicates OT services provided in a group setting
- GP: indicates PT services provided in a group setting
- U1: indicates services provided in an out-of-district residential placement
- U2: indicates ABA therapy provided in a group setting
- U3: indicates services provided in an out-of-district day placement

Claims can contain up to five modifiers.

1. TM or TR (required)
2. GO or GP (required for certain codes only)

3. U1 (required if services were provided in an out-of-district residential placement)
4. U2 (optional)
5. U3 (required if services were provided in an out-of-district day placement)

LEAs must track and bill appropriately, using modifier TM or TR to indicate IEP or non-IEP respectively. As with all information included on interim claims, the use of TM or TR should be supported by documentation.

As a reminder, LEAs must submit interim claims for all services provided to claim fully on the annual DSC cost report. Expenditures for staff costs, out-of-district tuition costs, and equipment/supply/purchased services costs may not be claimed in the annual DSC cost report if unsupported by interim claims.

Place of Service Codes

Generally, LEAs use Place of Service code 03 to indicate that services were provided in a school. If an LEA is providing services using telehealth in a location different from the student, then place of service code 02 should be used instead. For example, if a speech-language pathologist is located at the middle school building and provides services via a telehealth modality to a student at the high school, then place of service code 02 should be used.

ICD-10 Diagnosis Codes

Per HIPAA requirements, all claims must include a clinically appropriate ICD-10 diagnosis code that is supported by service documentation and explains the reason for the service. LEAs are responsible for submitting at least one clinically appropriate ICD-10 code on each interim claim.

When appropriate, a diagnosis code provided by a qualified practitioner not employed by or contracted with the LEA, such as a physician or nurse practitioner, may be reported on an interim claim, as long as the LEA maintains written and signed documentation of such diagnosis. Alternatively, or in addition to that diagnosis code, the LEA may utilize an ICD-10 diagnosis code related to signs and symptoms or screenings. Signs and symptoms and screening ICD-10 codes do not require a clinical diagnosis in order to be used. For more information about the ICD-10 coding system and to download the complete list of codes, descriptions, and guidelines, see https://www.cdc.gov/nchs/icd/icd10cm.htm. Some LEAs work with their billing vendor or professional coders to come up with a list of common ICD-10 codes. Some professional practice organizations may have a public-facing or member-only list of common ICD-10 codes.

As a reminder, ABA therapy is covered only when provided to students with a documented autism spectrum disorder (ASD) diagnosis, and an appropriate ASD diagnosis code must be included on the claim. The diagnosis documentation must support that the diagnosis was made by a licensed practitioner who is qualified to diagnose ASD within the scope of their clinical license.

Billing Forms

LEAs may choose to utilize a billing form or system for the purpose of facilitating interim claiming. Examples include an electronic billing system purchased directly from a software company or through a billing vendor, or an LEA- or vendor-developed paper form. **This is separate from service documentation.**

DESE has developed a billing documentation form specifically for students in out-of-district placements. This information is available in a Special Education Administrative Advisory (http://www.doe.mass.edu/sped/advisories/2019-3.html), titled Updated State Mandated Form for Documentation of Medicaid Service Delivery in Out-of-District Programs (28M/12), dated May 19, 2019. As described in the advisory, "this form is 'mandated.' … Out-of-district programs and public school districts may only use a different format for submitting information for reimbursement if it is mutually agreed upon and if it contains all required elements."

Electronic Claim Submission

Interim claims must be submitted to the Medicaid Management Information System (MMIS). LEAs are responsible for ensuring that claims are submitted to MMIS. Billing forms submitted in internal documentation systems or sent to vendors to be sent to MMIS does not meet this requirement. The interim claim must actually be submitted to MMIS.

The interim claim must be submitted in electronic format in accordance with HIPAA guidelines, using the 837P claim format or through direct data entry (DDE) via the POSC. LEAs may bill by

1. using the POSC DDE option;
2. purchasing software to generate the required 837P claim files*; or
3. contracting with a third party to bill on behalf of the LEA.

* Testing may be required before sending claims to the production environment. An Electronic Data Interchange (EDI) enrollment request must be made before submitting an electronic batch claim file.

LEAs are responsible for ensuring compliance with all SBMP program requirements related to all billing activities, even if a third party bills on the LEA's behalf. LEAs should develop internal controls for quality assurance of submissions made by their vendor or by LEA internal billing staff.

For information about 837P file requirements, please refer to the MassHealth Companion Guide to HIPAA Compliant Electronic Data Interchange Transactions document that is available from the MassHealth Customer Service Center.

Remittance advices detailing the adjudication status of all electronically submitted claims are available through the POSC and through the HIPAA 5010 electronic remittance advice files in 835 format. These remittance advices are made available to the entity or organization that submitted a claim file weekly. To monitor claim payments and denials, LEAs should review remittance advices. If another entity, such as a billing vendor, submits claims on behalf of the LEA, the LEA is responsible for requesting the remittance advices from the entity. Reviewing remittance advices is required to ensure that claims submissions are being adjudicated and paid appropriately. As a reminder, claims that are submitted, but not adjudicated as "paid" in MMIS, do not meet the interim billing requirement and may result in costs or students being unallowable on the annual DSC cost report.

Timely Filing Requirement

Interim claims must be submitted within 90 days of the date of service. For services delivered over multiple days, such as a psychological evaluation, the service time should be totaled across all days to calculate the correct units to bill, and the service should be billed using the day the evaluation was completed as the service date.

Section 5:
Other Contractual Obligations

Provider obligations are outlined in the School-Based Medicaid Program Provider Contract. This section details several obligations from the contract about to the Direct-Service Claiming Program. For a comprehensive list of provider obligations, please refer to the SBMP Provider Contract directly. A model SBMP contract is available on the SBMP Resource Center for reference.

Excluded Persons or Entities

As per the Provider Contract, the LEA must search the U.S. Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Exclusions database in the System for Award Management (SAM) (https://www.sam.gov/SAM/pages/public/extracts/samPublicAccessData.jsf) for the names of agents or managing employees of the provider at least monthly to ensure that EOHHS does not pay for services provided by excluded persons or entities. The LEIE exclusions database can be accessed online at the website of the Office of Inspector General of the U.S. Department of Health and Human Services.

Recordkeeping and Retention

As per the Provider Contract, LEAs must make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all Direct Services provided to Members, including, but not limited to, the records described in 130 CMR 450.205 and the records described in federal regulations at 42 CFR § 431.107. All such records shall be created at the time Direct Services are delivered, and shall be retained by the LEA for at least six years following the date of filing of the annual DSC cost report for the period which included the date the medical services were provided, as required under 130 CMR § 450.205.

Data Management and Confidentiality

As per the Provider Contract, Appendix A, all LEAs must comply with obligations relating to the privacy, security and management of personal and other confidential information, including compliance with the Privacy Rule defined by the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164. The LEA must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PI, and that prevent the use or disclosure of such data other than as specifically required for the operation of the School-Based Medicaid Program per the terms of the SBMP Provider Contract. All obligations to protect the privacy and security of Protected Information from unauthorized release or disclosure apply to the LEA, its employees and agents, and to any subcontractors of the LEA, including any contracted staff or contracted billing agent engaged in the performance of any activities on behalf of the LEA related to the SBMP.

Appendix A: Contact Information

- For SBMP information, including where to find this and other guides, please visit the MassHealth School-Based Medicaid Program page.
  - Please direct questions to the University of Massachusetts Medical School (UMMS) School-Based Help Desk at schoolbasedclaiming@umassmed.edu or at (800) 535-6741, Monday through Friday, 7:30 a.m.–7:30 p.m.
- To enroll as an SBMP provider, as well as for information about MMIS claims (including remittance advices), please contact the MassHealth Customer Service Center at providersupport@mahealth.net (for non-member-specific questions only) or (800) 841-2900, Monday through Friday, 8 a.m.–5 p.m.
  - Please record the date and time of the call and the case number assigned to the call, in case additional follow-up is needed.
- For general MassHealth information, including regulations, please visit the MassHealth website.
- For all education-related questions, including parent/guardian consent, contact the Massachusetts Department of Elementary and Secondary Education (DESE).
  - Individualized Education Program (IEP) questions can be directed to Special Education Planning & Policy at (781) 338-3375 or specialeducation@doe.mass.edu.
  - Consent questions can be directed to the Office of Student and Family Support at (781) 338-3010 or achievement@doe.mass.edu.
- To request a professional claims (837P) Companion Guide, or if you are interested in submitting electronic batch claim files, please contact the MassHealth Customer Service Center at (800) 841-2900 or edi@mahealth.net.

Appendix B:
Commonly Used SBMP Terms

ABA—applied behavior analysis, a service type covered for students with an autism spectrum diagnosis

AAC—administrative activity claiming

CHIP—Children's Health Insurance Program

CMS – Centers for Medicare & Medicaid Services, the federal agency that gives MassHealth, including the School-Based Medicaid Program, the authority to operate and claim federal dollars

Cost Report—the annual submission of an LEA's actual incurred costs related to the provision of Medicaid reimbursable services, which determines the total Medicaid-allowable costs the LEA incurred that year

Covered Service—services for which there is an SBMP-corresponding procedure code. The SBMP covers direct medical services provided in the school-setting, including speech-language pathology, occupational therapy, and physical therapy; psychological counseling; skilled nursing services; audiology services; personal care services; and ABA therapy services, when all Medicaid-claiming requirements are met. When a covered service is provided and meets the requirements for reimbursement, including medical necessity, it is referred to as a "reimbursable service."

CPE—certified public expenditure

DESE—Massachusetts Department of Elementary and Secondary Education

DSC—direct-service claiming

FERPA—the Family Educational Rights and Privacy Act

HIPAA—the Health Insurance Portability and Accountability Act

IEP—Individualized Education Program

LEA—local education agency

MassHealth—in Massachusetts, the program that combines Medicaid and the Children's Health Insurance Program (CHIP)

MMIS—Medicaid Management Information System

POSC—Provider Online Service Center

Reimbursable Service—a covered service that has been provided and that meets the requirements for reimbursement. The five requirements are (1) practitioner RMTS participation; (2) practitioner qualifications; (3) Medicaid medical necessity; (4) service authorization; and (5) service documentation.

RMTS—Random Moment Time Study

SBMP—School-Based Medicaid Program

UMMS—the University of Massachusetts Medical School, which administers the School-Based Medicaid Program on behalf of MassHealth

Appendix C:
SBMP Guides and Other Resources

Most written guidance is available in the SBMP Resource Center. The following documents were discussed in this guide.

- Administrative Activity Claiming (AAC) Guide
- Instruction Guide for the Annual Direct Service Cost Report
- LEA RMTS Coordinator Guide for Random Moment Time Study (RMTS)
- Local Education Agencies Covered Services and Qualified Practitioners
- Massachusetts School-Based Medicaid State Plan Amendment
- Model SBMP Provider Contract
- SBMP Billable Procedure Codes and Maximum Fees
- SBMP Schedule SFYXX
- School-Based Medicaid Program: Program Guide for Local Education Agencies

Appendix D: Financial Responsibility Determination Chart

Table 3: Financial Responsibility Determination for Claiming Costs under the SBMP

Sending LEA	Receiving LEA	LEA with Financial Responsibility	LEA Claiming the Student under Medicaid (including for Eligibility Statistics)
Public School District (SD)	Public SD (School Choice)	Sending Public SD	Sending Public SD
Public SD	Charter School *	Sending Public SD	Charter School
Public SD	Home School	Sending Public SD	Sending Public SD
Public SD	Private School [Special Education (SPED) placement] **	Sending Public SD	Sending Public SD
Public SD	Private School (parentally placed) **	Private School **	N/A **
Public SD	Regional SD (School Choice)	Sending Public SD	Sending Public SD
Public SD	Regional Voc/Tech	Sending Public SD	Regional Voc/Tech
Regional SD	Public SD (School Choice)	Sending Regional SD	Sending Regional SD
Regional SD	Charter School *	Sending Regional SD	Charter School
Regional SD	Home School	Sending Regional SD	Sending Regional SD
Regional SD	Private School (SPED placement)**	Sending Regional SD	Sending Regional SD
Regional SD	Private School (parentally placed) **	Private School **	N/A **
Regional SD	Regional SD (School Choice)	Sending Regional SD	Sending Regional SD
Regional SD	Regional Voc/Tech	Sending Regional SD	Regional Voc/Tech
Public SD	Any METCO	Receiving METCO SD	Receiving METCO SD
Regional SD	Any METCO	Receiving METCO SD	Receiving METCO SD

* Horace Mann charter schools are part of a public school district and can be considered part of an LEA for this table.

** Private schools are not eligible to participate in the School-Based Medicaid Program.