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

Updated July 2026

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Executive Summary

This guide is intended to provide local education agencies (LEAs) with instructions and information to participate in the direct service 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 which 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.) 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 understanding and complying with all program requirements as demonstrated through responsible and compliant management of the LEA's RMTS participation, accurate submission of interim claims, and compliance with requirements for including costs in Administrative Activity Claims and Direct Service Cost Reports. 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 qualifications, practitioner RMTS participation, Medicaid medical necessity, 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 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 and Cost Reporting Overview

The DSC Program allows LEAs to seek federal reimbursement for the provision of health-related 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 health-related services delivered in a school setting that meet Medicaid's definition of medical necessity and all other program requirements. Medicaid-covered health-related services include speech-language pathology, occupational therapy, and physical therapy; mental and behavioral health services; nursing services; audiology services; personal care services; applied behavior analysis (ABA) services for students with autism spectrum disorder and Down Syndrome; medical nutritional counseling; certain physical and behavioral health screenings; and fluoride varnish treatment. For information on licensure requirements for the practitioners who provide 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, whenever a LEA provides a reimbursable service to an eligible MassHealth-enrolled student for which the LEA seeks reimbursement the LEA must submit interim claims through MassHealth's Medicaid Management Information System (MMIS). Interim claims must be submitted within 90 days of the date of service. All claims adjudicated to a "paid" status in MMIS are accumulated to calculate the quarterly interim payments distributed to the LEAs. LEAs must submit claims for all services for which they seek reimbursement in the annual DSC cost report due on December 31 of each year. The annual DSC cost report calculates total gross Medicaid allowable expenditures, based on each LEA's actual incurred and allowable costs.

It is important to note that within SBMP, interim claims are primarily a mechanism for reporting reimbursable services and supporting the annual cost reconciliation. MassHealth does not make fee-for-service payments based on interim claims. Interim claims demonstrate that reimbursable services were provided to eligible members; are used to calculate a quarterly interim payment to the LEA; provide a path to produce supportive documentation in the event of a state or federal audit; and are the basis for which costs can be included in the annual Cost Report. This last point is of particular importance. LEAs may not include service types in the annual DSC Cost Report if no interim claims were submitted and paid for that service type during the quarter. If an LEA includes such costs, then MassHealth may disallow the costs, per the Provider Contract.

For example, if salary and benefit expenditures for 10 physical therapists are included in the annual DSC Cost Report for all four quarters of the fiscal year, but no physical therapy interim claims were submitted during Q1 and Q2 (July–December) of the fiscal year, all 10 physical therapists' costs will be disallowed for the first two quarters of the cost report.

Random Moment Time Study (RMTS) Participation

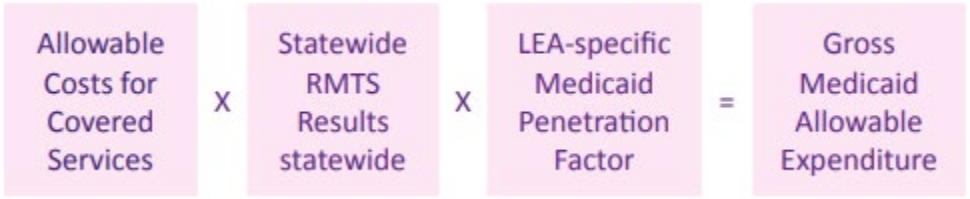
The RMTS determines what portion of LEA reported costs are Medicaid allowable costs—it is key to understanding SBMP reimbursement. For more detailed information, refer to the LEA RMTS Coordinator guide posted on the SBMP Resource Center under RMTS Resources. For a primer on the necessity of pools and cost allocation in Medicaid school-based services, please refer to this guide to cost pools developed by the federally funded School Based Services Technical Assistance Center.

LEAs may submit 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 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:

- Pool 1: Mental/Behavioral Health Services (includes ABA)
- Pool 2: Therapy Services
- Pool 3: Medical Services

After the conclusion of the fiscal year, LEAs submit an annual DSC cost report that includes costs to provide Medicaid-covered services; statewide 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.

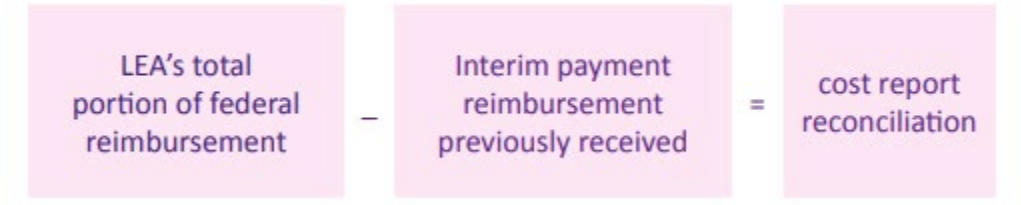
Figure 1: Annual DSC Cost Report Calculation to Determine Gross Expenditure Amount for Medicaid-Covered Services



Allowable Costs for Covered Services are multiplied by statewide RMTS Results statewide and LEA-specific Medicaid Penetration Factor to determine the LEA's Gross Medicaid Allowable Expenditure.

This gross Medicaid allowable expenditure 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



LEA's total portion of federal reimbursement minus Interim payment reimbursement previously received equals cost report reconciliation.

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 FY24 (July 2023–June 2024), cost reports were due 12/31/24 and reconciliations were paid or recouped by 6/30/25. A helpful list of dates and deadlines is available in the SBMP Resource Center (the document is called Dates & Deadlines FYXX).

LEAs may bill **up to** the maximum fee specified in the SBMP Billable Procedure Codes and Maximum Fees document posted to the SBMP Resource Center. LEAs concerned that they may be in a recoupment state after cost report reconciliation should bill less than the maximum fees indicated. Because reimbursement is based on cost allocation, billing interim claims below the maximum fee does not have a negative impact on annual revenue.

This Direct-Service Claiming (DSC) Guide provides instructions for the direct-service reimbursement program, with a focus on reimbursable service requirements, which apply to both interim claiming and documentation of direct service activities captured in RMTS moments. Please refer to ***the LEA Instruction Guide for the Direct Service Cost Report***, available in the SBMP Resource Center under Direct Service Claiming Resources, 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 under RMTS Resources

To enroll as an SBMP provider, refer to this technical assistance guidance on the Provider Application request. Contact the MassHealth Customer Service Center at provider@masshealthquestions.com or (800) 841-2900 with questions.

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). For technical assistance, refer to this guide on navigating the NPPES system.

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.
- 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 factors 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, for an LEA to be compliant with FERPA and IDEA, parental consent is required before an LEA can seek reimbursement from MassHealth for services provided to a student. For more information about parental consent, refer to the Administrative Advisory SPED 2013-1 (Updated July 16, 2018) or contact DESE's Office of Student and Family Support.

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) or Down Syndrome diagnosis when all Medicaid-claiming requirements are met.

The list of SBMP-covered services is outlined in SBMP Covered Services and Qualified Practitioners on the SBMP Resource Center under Direct Service Claiming Resources. 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 in the same section.

All costs claimed under SBMP must be consistent with state and federal laws and regulations. When a 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 not reimbursable.

- Services that are purely educational, academic, vocational, or social in nature and do not support the prevention, identification, evaluation or treatment of underlying physical, mental or behavioral health or developmental concerns for the student
- Consultations, which are defined as either professional-to-professional interactions to address a student need or aid or support. LEAs receive reimbursement for such activities through the administrative activity claiming portion of the SBMP
- Professional-to-student interactions that are limited in time and intensity and are primarily for monitoring purposes
- Missed appointments
- Remedial education
- Day care
- Health education when provided as an academic subject
- Review of records when not integral to the delivery of a direct service
- General student supervision and “duty” periods
- Parent consultation, contact, or training
- School/guidance counseling services

Reimbursable Services Requirements

A service is reimbursable only when the following conditions are met:

1) it was delivered by **qualified provider** who **participates in the RMTS** (as described in Section 1),

2) the service is **medically necessary** and the medical necessity is **documented in a care plan** (see page 15 for a discussion of exceptions), and

3) the provider **maintains service documentation**, as described further in this section.

LEAs must ensure that each of the three requirements is met before an interim claim is submitted to MMIS for adjudication. The LEA is ultimately responsible for compliance and should take steps to ensure program integrity even if they delegate tasks to a billing vendor.

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 demonstrating compliance with the three above-listed requirements for each reimbursable service. Failure to produce documentation demonstrating compliance with the three requirements in the event of a state or federal inquiry or audit may result in recoupment of payments. The LEA should ensure that student/patient privacy and that all documentation is maintained securely, per the SBMP Provider Contract, HIPAA, and other applicable state and federal privacy laws. Please review the record-retention guidelines in the SBMP Provider Contract for rules on how long documentation must be maintained. 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.

Provider Qualifications

Clinical services must be provided by qualified providers 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 under Direct Service Claiming Resources within the *SBMP 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). For non-clinical persons providing PCA assistance with ADLs and IADLs or autism specialists providing ABA services, there are no clinical license requirements.

Licensed practitioners must comply with all supervision requirements of the practitioners' licensing body, including but not limited to requirements for documentation of appropriate supervision or supervisory visits. Supervision may be provided indirectly (by phone or videoconference) if allowed

under the individual licensing regulations. LEAs seeking reimbursement for direct services are responsible for ensuring that their employed and contracted practitioners understand their scope-of-practice and supervision requirements. 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.

Medicaid Medical Necessity

All covered services must meet medical necessity standards under 130 CMR 450.204 to be reimbursable.

Requirement of Medical Necessity

130 CMR 450.204: *Medical Necessity* states that "The MassHealth agency 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 or for admitting a member to an inpatient facility where such service or admission is not medically necessary."

130 CMR 250.204(A) defines medical necessity as follows: "A service is medically necessary if

1) it is 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; and
2) there is 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. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: Potential Sources of Health Care, or 517.007: Utilization of Potential Benefits."

Further, under 130 CMR 450.204(B), "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."

If the service does not meet the standard outlined in 130 CMR 450.240, 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) and (B) to determine medical necessity.

For screening, prevention and treatment services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for MassHealth members under age 21, the periodicity is established in Appendix W of all Provider Manuals, available on the MassHealth All Provider Manual Appendices page. 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.)

Examples That Do Not Meet Medicaid Medical Necessity Requirements

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

- Services that are provided by an LEA because of school policy or IDEA requirements when the qualified practitioner has determined that the student has met all treatment goals and recommends discontinuing services.
- Evaluations performed at the request of a parent when the qualified school-based practitioner and/or IEP team does not agree with the need for further evaluation.
- 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.)

Documenting Medical Necessity within a Plan of Care

Typically, medical necessity must be documented within a plan of care by a qualified practitioner. The licensing bodies and standards of practice for most SBMP-covered services already require a plan of care and therefore should not require any separate or additional documentation created solely for Medicaid purposes. In the context of the SBMP, the term "plan of care" (POC) is a general term that may cover a variety of plans and is not necessarily synonymous with the Individualized Education Program (IEP) or the Individualized Family Service Plan (IFSP). The IEP or IFSP may serve as a POC if all required elements of a POC are included. Other examples of POCs include, but are not limited to, behavior intervention plans, treatment plans, individualized health plans, and emergency action plans. The POC should be developed and maintained consistent with licensing bodies' standards of practice, including the licensure requirements for the person developing the plan of care and the frequency of revision.

MassHealth does not require prior authorization for SBMP services. MassHealth considers practitioners whose clinical scope of practice includes the ability to evaluate or assess a student and determine the need and plan for services/interventions/treatment to be qualified to determine medical necessity of that service/intervention/treatment.

For example, per 258 CMR 12.00, a licensed independent clinical social worker (LICSW) can provide behavioral health services without supervision and therefore can determine the medical necessity of those services, whereas a licensed clinical social worker (LCSW) requires supervision and cannot independently determine medical necessity.

However, under 130 CMR 422.000, only a physician, physician's assistant, or nurse practitioner can determine the medical necessity of personal care services (activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that are necessary physical assistance services for a member with a chronic or permanent disability or impairment).

For special education students with an IEP, IFSP, or 504 plan, those documents can serve as the plan of care that documents medical necessity if all required elements are included.

The following minimum elements are required to document medical necessity in a plan of care:

- the name of the child to whom the services will be provided;
- the patient diagnosis and/or reason for the service 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 must 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 health (physical or behavioral health) issue(s) including identification of measurable treatment goal(s);
- the time period for which services are being authorized; and
- the printed name and legible signature or compliant e-signature of practitioner who is licensed, registered, and/or certified as the relevant licensed professional acting within their scope of license, including their type of license and license number.
- the authorizing practitioner's contact information, including school address and phone number
- If a plan of care does not include all listed elements above, then the LEA may choose to add the required information to the plan of care or instead incorporate supplemental information into the plan of care by reference. For example, if the basis for medical necessity was determined through an evaluation, the evaluation report could be referenced in the plan of care (including name of the evaluator, and date of the evaluation).

There are three exceptions to the requirement that medical necessity must be documented in a plan of care: 1) unplanned services, 2) screenings, and 3) evaluations. "Unplanned" refers to situations in which there is not a student specific plan in place related to the presenting issue. In those instances, medical necessity must be supported through service documentation of the intervention and signed by a qualified provider.

1. Unplanned Services
    - *Unplanned nursing services* refer to in-the-moment interventions that are required by situations and do not require a plan of care or physician order. They include assessment, treatment and/or referral for illness/injury or onset of symptoms.
    - *Unplanned behavioral health services* refer to in-the-moment interventions such as crisis de-escalation. Though a POC is not required, the LEA must maintain documentation of the service, according to the qualified practitioner's licensing board requirements and practice standards.
2. Screenings that are performed to detect conditions that may require further evaluation and treatment. The documentation of the screening itself supports medical necessity.

3. Evaluations that are performed to determine whether services are necessary. The documentation of the evaluation itself supports medical necessity and when it includes a description of the clinical reasons that the evaluation was appropriate and necessary.

Service Documentation

LEAs are responsible for ensuring that practitioners complete sufficient clinical documentation for all covered services provided to students for which 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, if 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
- Student's State Assigned Student Identifier (SASID) or LEA assigned unique student ID
- School district name
- Date(s) service(s) were provided
- Time of service began and either time service ended or duration of service in minutes (which can include calculation of duration based on start time of service to the next student in cases of brief encounters such as conducting grade-level screenings)
- Individual or group indicator
- IEP or non-IEP indicator
- Diagnosis, reason for the service, 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.

- Legible, printed name and signature of practitioner and legible, printed name and signature of supervising provider, where applicable, or compliant e-signature. The practitioner's type of license and license number must be listed.
    - If practitioner or supervisor cannot be determined (due to illegibility or other deficiency), then the service documentation may be considered invalid, and payment may be subject to recoupment. Electronic signatures are 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 medical necessity 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.

See Appendix E **Documentation Requirements by Type and Purpose**, which lists typical sources of documentation that LEAs maintain to support service provision.

Section 4:
Interim Billing and Claims Submission Rules

Interim Billing and Payment Overview

CMS requires that interim claims be submitted. This means that every time a Medicaid-qualified practitioner (who has been included in the appropriate direct service 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 for reimbursable services 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.

Step 1. LEA: Qualified practitioner provides a service that meets the following requirements for billing a reimbursable service provided to a MassHealth-enrolled student.

- Practitioner Qualifications (including supervision requirements)
- Practitioner RMTS Direct-Service Pool Participation
- Documented Medicaid Medical Necessity
- Service Documentation

Step 2. LEA: Service prepared for billing.

Examples: submitting documentation of service to billing vendor/billing staff; identifying the dollar amount up to maximum fee to be billed.

Step 3. LEA: Interim Claim submitted to MMIS for processing.

Step 4. MassHealth: MMIS processes claim (“paid,” “denied,” or “suspended”).

Step 5. LEA: Claim monitoring:

- Denied and suspended claims are reviewed and resubmitted.
- Paid claims are tracked to update projections, interim billing compliance monitoring.

Step 6. MassHealth: Quarterly claims report pulled to inform federal claiming and federal revenue claimed from CMS.

Step 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 the Office of Comptroller's Vendor Web .

Definition of a Unit

LEAs should bill services based on each encounter/visit with a student, except evaluations which are billed per evaluation and continuous personal care and 1:1 nursing services which are billed per day. See the SBMP Billable Procedure Codes and Maximum Fees document in the SBMP Resource Center for additional information.

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 under Direct Service Claiming Resources. 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
- 95: indicates services provided remotely in a real-time audio/visual telehealth visit
- 93: indicates service provided remotely with audio only

Claims can contain up to four modifiers on one service line.

- TM or TR (required for all claims)
    - LEAs must use 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.
- GO or GP (required for certain codes only)
- U1 (required if services were provided in an out-of-district residential placement)
- U2 (optional)
  U3 (required if services were provided in an out-of-district day placement)
- 93 or 95 (required if services were provided via telehealth)

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 (telehealth in school) or 10 (Telehealth in home) 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.

American ICD-10-CM Codes

Per HIPAA requirements, all claims must include a clinically appropriate code from the International Classification Diseases, Functioning, and Disability-Clinical Modification, commonly known as the ICD-10. The selected code should be supported by service documentation that 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, an ICD-10 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, if the LEA maintains written and signed documentation indicating the provider's determination of the appropriate code. Alternatively, or in addition to that code, the LEA may utilize an ICD-10 code related to signs and symptoms or screenings. Signs and symptoms and screening ICD-10 codes do not require a formal diagnosis to be used. For more information about the ICD-10 coding system and to download the complete list of codes, descriptions, and guidelines, see the National Center for Health Statistics division of the CDC at https://www.cdc.gov/nchs/icd/icd-10-cm/index.html . Some LEAs work with their billing vendor, professional coders, or utilize software or online resources to identify appropriate 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) or Down Syndrome diagnosis, and an appropriate ASD or Down Syndrome ICD-10 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

(https://www.doe.mass.edu/specialeducation/policy/dese/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 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 free online 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: https://www.mass.gov/doc/masshealth-standard-companion-guide-health-care-claim-professional-837p-0/download.

Remittance advice 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 on a weekly basis (for each week that claims were processed for the LEA) to the entity or organization that submitted the claim(s). To monitor claim payments and denials, LEAs should review remittance advice. If another entity, such as a billing vendor, submits claims on behalf of the LEA, the LEA is responsible for requesting remittance advice from the entity. Reviewing remittance advice is required to ensure that claims submissions are being adjudicated and paid appropriately. Additionally, for LEAs who utilize the POSC DDE option for free online individual claim submission, the POSC offers real-time adjudication of claims and will inform the biller of the adjudication status (paid, denied or suspended) immediately with an on-screen message.

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 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 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. Please review your provider contract in full, with particular attention to the following sections: *Excluded Persons or Entities*, *Recordkeeping and Retention*, and Appendix A: *Data Management and Confidentiality*. A model SBMP contract is available on the SBMP Resource Center for reference.

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 Chan Medical School 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, please refer to this Technical Assistance document on the Provider Application process posted under General Program Information on the SBMP Resource Center.
- 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

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

RMTS—Random Moment Time Study

SBMP—School-Based Medicaid Program

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

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	Commonwealth Virtual 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	Commonwealth Virtual School	Sending Public SD	Sending Public 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 SBMP.

Appendix E: Documentation Requirements - by Type and Purpose

A downloadable version of this chart is available under Tools for SBMP Success section of the LEA SBMP Professional Learning Community on the SBMP Program website. It is referred to as the SBMP Self-Audit Checklist.

Massachusetts School-Based Medicaid Program

Documentation Requirements - by Type and Purpose

In compliance with 42 CFR 438.230(c)(3)(iii), records of services must be retained for not less than six (6) years after the date of service. Documentation in those records must be complete, accurate, readily accessible and systematically organized to facilitate retrieval and compilation of information upon request of state or federal auditors. The LEA must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval).

		Documentation retained by the LEA					Information shared with MassHealth
	Data Element	Evaluation Record or Report	Plan of Care (See note 1 below)	Service/ Session Note or Log	Screening Record	"Unplanned" Service/ Session Note or Log	Interim Claim (Billing Record)
Identify the Student							
1	Student's First Name	Yes	Yes	Yes	Yes	Yes	Yes
2	Student's Last Name	Yes	Yes	Yes	Yes	Yes	Yes
3	Student's Unique ID (See note 2 below)	Yes	Yes	Yes	Yes	Yes	
4	Student's Medicaid ID						Yes
Identify the LEA							
5	Local Education Agency Name	Yes	Yes	Yes	Yes	Yes	Yes
6	Local Education Agency NPI						Yes
Identify the Service Date(s)							
7	Start date of session/service	Yes		Yes	Yes	Yes	Yes
8	End date of session/service	Yes		Yes	Yes	Yes	Yes
9	Start & Stop times of activities performed			Yes	Yes	Yes	
Identify the Service Provided							
10	Type of Health Service (See note 3 below)	Yes	Yes	Yes	Yes	Yes	
11	Description of assessment procedures	Yes					
12	Description of therapeutic activities performed			Yes		Yes	
13	Identification of screening or assessment tools/tests used	Yes			Yes		
14	Description of history related to the presenting issue	Yes	Yes				
15	Findings/Results of any tests/instruments	Yes					
16	Individual or Group indicator	Yes		Yes	Yes	Yes	Yes
17	IEP or Non-IEP Service indicator	Yes		Yes	Yes	Yes	Yes
18	Telehealth indicator	Yes		Yes	Yes	Yes	Yes
19	Procedure code & modifier code(s)						Yes
Identify the Diagnosis, Clinical Impression, and/or Reason for the Service(s)							
20	The specific diagnosis or presenting clinical issue or clinical impression	Yes	Yes	Yes		Yes	
21	Reason for screening				Yes		
22	ICD-10 code						Yes
Identify the Service(s) Recommended / Planned							
23	Effective/Start Date for Recommended Services		Yes				
24	End date for POC (when applicable)		Yes				
25	Prioritization of problems/needs		Yes				
26	Specific skill(s) and measurable treatment goal(s)		Yes				
27	Description of treatment/interventions planned for achieving each goal		Yes				
28	Estimated timeframes for achievement of each goal		Yes				
29	Description of the therapeutic value of recommended service		Yes				
30	Baseline data used to determine current functional level(s)		Yes				
Identify Response to Treatment, Recommendations, Follow-up Needs							
31	Response to treatment and performance relative to treatment goal(s)			Yes			
32	Recommendations & follow-up			Yes	Yes	Yes	
Practitioner Signature(s)							
33	Signature of Servicing Practitioner	Yes	Yes	Yes	Yes	Yes	
34	Signature of Supervising Practitioner (when applicable)			Yes	Yes	Yes	
35	Date the document was written and signed	Yes	Yes	Yes	Yes	Yes	

Notes:

(1) In the context of the School-Based Medicaid Program, the term "Plan of Care" (POC) is a general term that may cover a variety of plans and does not replace the Individualized Education Program (IEP) or the Individualized Family Service Plan (IFSP). The IEP or IFSP may serve as a POC if all required elements of a POC are included. Other examples of POCs include behavior intervention plans, treatment plans, individualized health plans, emergency action plans, etc.

(2) Student's unique identification number (such as the LEA's student ID number or SASID) which has been matched to the student's Medicaid ID number OR the student's Medicaid

(3) Examples of the Type of Health Service include: PT, OT, SLP, Nursing, Counseling, etc.