



COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human Services

MassHealth School-Based Medicaid Program

Direct Service Claiming (DSC) Program Guide

***Reimbursable Service Requirements and Guidelines for
Interim Claim Submission***

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Executive Summary

This guide is intended to provide local education agencies (LEAs) with instructions and information required 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 on 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) that is 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 therapists, etc.) to be included in the annual DSC cost report. The life cycle of a service is visually represented in Appendix D.

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 and special education 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 Direct Service Claiming (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 on 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, occupational, and physical therapies; psychological counseling; skilled nursing services; audiology services; personal care services; applied behavior analysis (ABA) services; medical nutritional counseling; certain physical and behavioral health screenings; and fluoride varnish treatment.

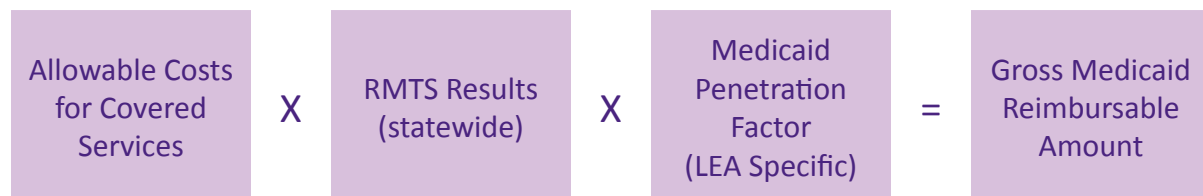
The document, Local Education Agencies Covered Services and Qualified Practitioners, is posted on the [SBMP Resource Center](#).

Interim Claims & 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 paid quarterly.

After the conclusion of the fiscal year, LEAs submit an annual DSC cost report that includes Medicaid-allowable costs, Random Moment Time Study (RMTS) results, and 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 Medicaid Reimbursable Amount



The total of each SBMP provider’s interim claims paid throughout the year is deducted from the gross Medicaid reimbursable amount based on the certified annual DSC cost report. 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 gross Medicaid reimbursable amount exceeds the interim claims paid throughout the year, a payment will be issued to the LEA. If the gross Medicaid reimbursable amount is less than the interim claims payments, 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 are 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 on the [SBMP Resource Center](#) (the document is called [SBMP Schedule SFYXX](#)).

This Direct Service Claiming (DSC) Guide provides instructions for the direct service reimbursement program, with a focus on reimbursable service requirement for interim claiming. 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 Direct Service Claiming 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 regarding the RMTS, please see the LEA RMTS Coordinator Guide for Random Moment Time Study (RMTS) available on 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 & 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 special education Chapter 766 schools or collaboratives for which the LEA is financially responsible.

If a student attends a charter, regional, vocational/technical, or agricultural school, only the LEA that the student attends 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 public school district 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 available by request from the SBMP help desk.

Eligible MassHealth Members

Claims are only reimbursable 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.

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 district'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 SBMP Instruction Guide for 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, occupational and physical therapies; psychological counseling; 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.

Educational and Other Non-Covered Services

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

- Educational, academic, vocational or social services
- 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.
- Telehealth/telepractice/teletherapy and virtual/online services
- Missed appointments/services
- Remedial education
- Daycare
- 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 counselor 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 due to 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, the following five requirements must be met, as described further in this section.

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

Regardless of the reason the service is being provided (i.e., IEP or school policy), as MassHealth providers, LEAs must ensure that such service meets program requirements before submitting claims. This guide does not dictate what LEAs should do or are required to do as an educational agency; rather, it 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 support for the five reimbursable services criteria in the event of a state or federal inquiry or audit may result in recoupment. The LEA should ensure 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.

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 only submit interim claims and may only include costs in their annual DSC cost report 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 on 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 are licensed (when required under state law) and providing services within their scope of practice as a 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 more information about scope of practice (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).

If a practitioner does not hold a current, active license for the practice specialty area for the services being provided, then the staff member does **not** meet practitioner qualifications for the SBMP.

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 (that is, by phone), if allowed under the individual licensing regulations.

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 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](#), as well as the specific medical necessity guidelines for [occupational therapy](#), [physical therapy](#), and [speech and language therapy](#). Other specialty-specific medical necessity guidelines are not available as of the date of publication. Educational necessity does not impact whether a service meets Medicaid medical necessity requirements.

Requirement of Medical Necessity

Per 130 CMR 450.204, “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.”

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” (130 CMR 450.204(A)(1)).

If the service does not meet this standard, it is not reimbursable. Services that are required under a student’s IEP or other 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.” (130 CMR 450.141).

Most Conservative and Least Costly Service

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” (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 a 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 and 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 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.

Professionally Recognized Standards Requirement

The “[m]edically 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” (130 CMR 450.204(1)(B)).

This means the amount, frequency, and duration of services must be 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 if 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 only be safely and effectively performed 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 due to school policy, rather than because the service requires the skill level of a nurse. For example, a registered nurse giving ibuprofen to a student without additional evaluation that requires clinical expertise.
- A licensed physical therapist reevaluates 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 therapist provides services three times a week as required in the student’s IEP. In the speech therapist’s clinical opinion, the student only needs the service 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 stated previously (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.
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFT) screening is administered as part of Screening, Brief Intervention and Referral to Treatment (SBIRT) by a licensed clinical social worker (after expansion is effective July 1, 2019). CRAFT is an EPSDT screening.

4. Service Authorization

The services must be prescribed by, referred by, recommended by, ordered by, provided under the direction of, or otherwise authorized in writing, by an appropriate practitioner with a current and active license as described next.

A physician, nurse practitioner, or physician assistant may authorize any covered service. In addition, speech-language pathologists may authorize speech-language therapy services; physical therapists may authorize physical therapy services; occupational therapists may authorize occupational therapy; applied behavior analysts and psychologists may authorize ABA therapy services; and psychologists, psychiatrists, licensed independent clinical social workers, licensed marriage and family therapists, and licensed mental health counselors may authorize psychological counseling. Personal care services **must** be authorized by a physician, nurse practitioner, or physician assistant. Please see Appendix B for a list of allowable service authorizers.

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

Pursuant to the record retention guidelines in the SBMP Provider Contract, LEAs must retain written documentation of service authorizations to support all interim claims. LEAs must produce these records in the event of an audit or upon request by MassHealth or other state or federal compliance agency.

The following elements must be included on written authorization.

- The name of the child for whom the order is written;
- The complete date the order was written and signed;
- The service(s) being ordered;
 - The frequency and duration of the ordered service must be either specified on the order itself or the order can explicitly adopt the frequency and duration of the service in the treatment plan by reference;
- The time period for which services are being ordered;
- The ordering provider's contact information, including address and phone number;
- The printed name and legible signature of practitioner who is licensed, registered, and/or certified, as the relevant, physician, physician assistant, licensed nurse practitioner, or other licensed professional acting within his or her scope of license; and
- The patient diagnosis and/or reason/need for ordered service(s).

5. Service Documentation

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. Mass Health does not provide, maintain, or endorse any particular clinical documentation form, process, or system.

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

In the event of an audit or other review by MassHealth, CMS, or another state or federal agency, the LEA will be expected to produce the service documentation. Failure to do so may result in a recoupment and/or termination from the program as described in the SBMP Provider Contract.

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.

- School district name and school name (if different)
- Date(s) service(s) were provided
- Time of service
- Student name
- Student date of birth
- Student's MassHealth ID, if known, and State Assigned Student Identifier (SASID)
- Duration of service, in minutes
- Individual or group indicator
- IEP or non-IEP indicator
- Diagnosis
- 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. 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.

LEAs must document covered services provided to all students for whom the LEA seeks reimbursement, including students serviced by subcontractors or placed out-of-district pursuant to an IEP. It is the responsibility of the LEA to ensure that all subcontractors, including Chapter 766 private schools, and collaboratives, maintain this documentation. The Department of Elementary and Secondary Education (DESE) has developed a service 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.

Section 4: Interim Billing & Claims Submission Rules

Interim Billing and Payment Overview

CMS requires that interim claims must be submitted for all services for which 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 due to a clerical or billing error.

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	Number of units
8–22 minutes	1 unit
23–37 minutes	2 units
38–52 minutes	3 units
53–67 minutes	4 units
68–82 minutes	5 units
83 minutes	6 units

Procedure Codes & Modifiers

Modifiers tell 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 on 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 were provided in a group setting
- GP: indicates PT services were provided in a group setting
- U1: indicates services provided in an out-of-district residential placement
- U2: indicates ABA therapy was 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)

Although services are covered for both IEP and non-IEP services, LEAs must track and bill appropriately using modifier TM or TR. 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.

Diagnosis Codes

Per HIPAA requirements, all claims must include a clinically appropriate ICD-10 diagnosis code that is supported by service documentation. LEAs are responsible for submitting the appropriate diagnosis code based on authorizing practitioner's clinical judgment. ICD-10 diagnosis codes exist for signs and symptoms and may be used as appropriate (e.g., no clinical diagnosis has been made, diagnosis not known to LEA). For more information about ICD-10 coding system and to download the complete list of codes, descriptions, and guidelines, see <https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202019%20release%20of%20ICD-10-CM>.

As a reminder, only ABA therapy provided to students with a documented autism spectrum disorder (ASD) diagnosis is covered and an appropriate ASD diagnosis code must be included on the claim.

Electronic Claim Submission

Claims 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.

For information regarding the 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, which are made available to the entity/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.

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 relevant to the Direct Service Claiming Program. For a comprehensive list of provider obligations, please refer to the SBMP Provider Contract directly.

Excluded Persons or Entities

As per the Provider Contract, the LEA shall 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, "Pursuant to the terms of the School-Based Medicaid 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 (PI) 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, please contact 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.
- 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: Service Authorization

Any services may be authorized by a physician, physician assistant, or nurse practitioner. Alternatively, services may be authorized as described in the following chart.

ABA Therapy	<ul style="list-style-type: none">• Licensed Applied Behavior Analysts• Psychologists
Occupational Therapy	<ul style="list-style-type: none">• Licensed Occupational Therapists
Personal Care Services	<ul style="list-style-type: none">• Physicians, nurse practitioners, or physician assistants ONLY
Physical Therapy	<ul style="list-style-type: none">• Licensed Physical Therapists
Psychological Counseling	<ul style="list-style-type: none">• Licensed Independent Clinical Social Workers• Licensed Marriage and Family Therapists• Licensed Mental Health Counselors• Psychiatrists• Psychologists
Speech-Language Therapy	<ul style="list-style-type: none">• Licensed Speech-Language Pathologists

Appendix C: 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 – the SBMP covers direct medical services provided in the school-setting including speech, occupational, and physical therapies; psychological counseling; skilled nursing services; audiology services; personal care services; and ABA therapy services when all Medicaid-claiming requirements are met. Services for which there is an SBMP-corresponding procedure code is a “covered service.” 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 – 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 D: Life Cycle of a Service

Massachusetts School-Based Medicaid Program: From Service Delivery to Disbursement

LEA

MassHealth

Qualified practitioner provides an authorized service that meets requirements for billing to a MassHealth-enrolled student.

1. Practitioner RMTS Direct Service Pool Participation
2. Practitioner Qualifications (including supervision requirements)
3. Medicaid Medical Necessity
4. Service Authorization
5. Service Documentation



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.



Interim Claim submitted to MMIS for processing.



MMIS processes claim (“paid,” “denied,” or “suspended”).



Claim monitoring:

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



Quarterly **claims report** pulled to inform federal claiming and federal revenue **claimed** from CMS.



MassHealth disburses **federal revenue** payments to LEAs.

Appendix E: SBMP Guides and Other Resources

Most written guidance is available on 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
- SBMP Billable Procedure Codes and Maximum Fees
- SBMP Schedule SFYXX
- School-Based Medicaid Program: Program Guide for Local Education Agencies