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



Executive Office of Health and Human Services

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This training was distributed in April 2021 and was accurate at the time of distribution. As always, Local Education Agencies are responsible for reviewing information on the School-Based Medicaid Program website([www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)) to determine whether subsequent guidance has superseded the content shared here. MassHealth plans to update these trainings periodically as needed.

## Introduction to Medicaid 101 Training Series

The Medicaid 101 training series is designed to provide the essentials to understanding the School-Based Medicaid Program (SBMP). Some modules are designed for a broad, general audience. Other modules are targeted to the learning needs of a specific audience within each Local Education Agency (LEA).

| **Training Module** | **Intended Audience** |
| --- | --- |
| Module 1: Introduction | Everyone |
| Module 2: SBMP for LEA Administrators | LEA Administrators, such as superintendents, business managers, health services and special education directors |
| Module 3: SBMP for LEA Random Moment Time Study (RMTS) Coordinators | Designated LEA RMTS Coordinators, including those who support an RMTS coordinator with required information |
| Module 4: SBMP for Clinical Leadership | LEA clinical leadership staff, such as health directors and nursing directors |
| Module 5: SBMP for Financial Leadership | LEA financial leadership, such as business managers, accounting managers |

## Introduction to Medicaid 101 Training Series

The Medicaid 101 Training Series, continued:

| **Training Module** | **Intended Audience** |
| --- | --- |
| Module 6: SBMP for Legal/Regulatory Leadership | LEA Administrators, such as superintendents, compliance staff, finance directors, legal and contracts staff |
| Module 7: SBMP for Technology Leadership | LEA technology directors/managers |
| Module 8: SBMP for Direct Service Practitioners\* (*this module*) | LEA staff who participate in the Direct Medical Services reimbursement portion of the SBMP |
| Module 9: SBMP for LEA RMTS Participants performing Medicaid Administrative Activities | LEA staff who participate in the RMTS |

## Training Agenda

* Training Objectives
* What is Direct Service Claiming (DSC)?
* Reimbursable Services Requirements
* Interim Claims & Billing Forms
* ICD Diagnosis and/or Signs and Symptoms Codes
* Random Moment Time Study Tips for Direct Service Practitioners

## Training Objectives

By the conclusion of this training, you will:

* Develop an understanding of what direct service claiming (DSC) is and what types of services are reimbursable.
* Understand your role, from Medicaid’s perspective, as a clinically trained health care professional working in a school setting.
* Understand Medicaid’s requirements that must be met to be considered a Reimbursable Service.
* Gain a better understanding of how your direct service work activities should be documented when responding to the Random Moment Time Study.

**NOTE**: This training is an introductory “101” level. The intention is to provide an overall description of concepts and processes, but not all the necessary details that school-based practitioners need to know. This is a great place to start to build foundational knowledge. Resources and training opportunities for additional information will be provided.

## What is Direct Service Claiming (DSC)?

* The Direct Service Claiming (DSC) program is the mechanism through which LEAs seek federal reimbursement for the provision of direct services.
* 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 Applied Behavior Analysis (ABA) therapy services when all Medicaid claiming requirements are met.
* The SBMP program provides reimbursement for the provision of Medicaid Covered Services that meet Medicaid’s definition of medical necessity and all other program requirements, whether services are pursuant to an IEP, or not.
* LEAs submit interim claims for Covered 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 Direct Services Cost Report (Cost Report).

## Medicaid-Covered Direct Services

The services listed below are MassHealth “Covered Services” when provided by a qualified school-based practitioner:

|  |
| --- |
| **SBMP Covered Services** |
| * Applied Behavior Analysis (ABA) Services
* Audiology
* Dental Assessments / Screenings
* Medical Nutritional Services
* Mandated Health / Behavioral Health Screenings
* Occupational Therapy
* Personal Care Services
* Physical Therapy
* Psychological Counseling
* Skilled Nursing Services
* Speech-Language Therapy
* Vision Services
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Refer to the “LEA Covered Services & Qualified Practitioners” document published on the SBMP Resource Center: <https://www.mass.gov/info-details/sbmp-resource-center>

## Reimbursable Services Requirements

* If a **“Covered Service”** is delivered, the following requirements must be met to be considered a **“Reimbursable Service:”**
1. Practitioner RMTS Direct Service Pool Participation (in-district only)
2. Practitioner Licensure Qualifications
3. Medicaid’s Definition of Medical Necessity
4. Service Authorization
5. Service Documentation
* LEAs must ensure that each of the five requirements is met before an interim claim is submitted to MMIS for adjudication.
* The LEA must maintain, and produce upon request, documentation of compliance with these requirements for each reimbursable service.

## Reimbursable Services Requirements

**What does this look like in school-based practice?**

* A large portion of the Medicaid-covered services provided in the school setting are provided pursuant to a student’s IEP.
	+ IEP related services such as PT, OT, Speech therapy, ABA therapy and behavioral health counseling are common examples of services that can be reimbursable when the Medicaid program requirements are met.
* Additionally, some students receive Medicaid-covered services that are not part of an IEP and are unrelated to special education needs. For example,
	+ Health care services, such as nursing care, behavioral health counseling and others, often are provided due to a student’s medical or behavioral health needs unrelated to special education.
	+ Many students receive health screenings in school, such as vision, hearing and others.

## Process for Medicaid Qualified Service Delivery

* We’re going to look at the service delivery process/cycle for IEP services first, since it’s the largest portion of services being delivered and reimbursed through the School-Based Medicaid Program (SBMP).
* We’re going to be using the **framework** of the IEP process and the work performed by an IEP team to draw a **parallel** to the Medicaid-Qualified Service Process performed by a qualified practitioner, typically as part of the IEP team in the case of IEP services.
* The IEP process is **not the same thing** as the Medicaid-Qualified Service Process and **does not substitute** for the Medicaid-Qualified Service Process.

## Health Care Services provided in a School Setting

* As a “related services” provider, you’re a clinically licensed health care professional working in a school setting, and you bring your clinical expertise to the rest of your school’s educational team, working together to support the needs of your students.
* Your school district hired you to perform your job because you have clinical skills and training that allow you to provide health care services that cannot be safely or effectively provided by other types of school staff.
* Educational needs and health care needs can and sometimes do overlap!
	+ Medically necessary health care services have a clinical basis and may also help students achieve educational goals and access the curriculum.
* From MassHealth’s perspective, it’s your role in the IEP process, as the **qualified practitioner,** that we’re focused on.

## Special Education Process versus Medicaid-Qualified Services Process



These processes are NOT the same, but they do **work in parallel**

## Medicaid Qualified Practitioners

* To qualify for Medicaid reimbursement, services must be provided by qualified practitioners who have a clinical license (when required under state law) and are providing services within their scope of practice as a licensed clinician.
* The list of qualified practitioners can be found in the “**Local Education Agencies Covered Services and Qualified Practitioners**” document, published on the SBMP Resource Center: <https://www.mass.gov/info-details/sbmp-resource-center>
* Please note that although SBMP practitioners may also hold DESE licenses, for the purposes of the SBMP, licensure status is based on the Massachusetts clinical licensing boards (except for DESE-licensed psychologists, who are explicitly listed as qualified practitioners)
* LEAs must monitor the license status of staff and ensure that only appropriately and actively licensed staff are:
	+ submitting interim claims for services/having claims submitted on their behalf
	+ included in a RMTS direct service pool

## Medicaid Qualified Practitioners

The complete list of Medicaid qualified practitioners can be found on the SBMP Resource Center in the **“Local Education Agencies Covered Services and Qualified Practitioners”** document. Below is summarized from that document:

|  |  |
| --- | --- |
| **Practitioner** | **Licensing Body** |
| Applied Behavior Analysts & Assistants | MA Board of Registration of Allied Mental Health and Human Services Professions |
| Audiologists | MA Board of Registration in Speech-Language Pathology and Audiology  |
| Licensed Mental Health Counselors / Marriage & Family Therapists | MA Board of Allied Mental Health and Human Services Professions  |
| Nurses (APRN, RN & LPN) | MA Board of Registration in Nursing |
| Occupational Therapists & Assistants | MA Board of Registration of Allied Health Professionals |
| Physical Therapists & Assistants | MA Board of Registration of Allied Health Professionals |
| Psychologists | MA Board of Registration of Psychologists or the Dept. of Elementary and Secondary Education |
| Social Workers | MA Board of Registration of Social Workers |
| Speech/Language Therapists & Assistants | MA Board of Registration in Speech-Language Pathology and Audiology  |

## Practitioner Qualifications – Clinical Supervision

* Medicaid qualified providers must follow their individual licensing regulations regarding supervision requirements.
	+ Supervision may be provided indirectly (i.e., telephonically), if allowed under the individual licensing regulations;
	+ The supervisor must document supervision accordingly.
* Licensed practitioners whose licensing regulations require that they be supervised are NOT considered Medicaid Qualified unless such clinical supervision is in place and is documented.
	+ For example, an adjustment counselor who is licensed as a Licensed Certified Social Worker (LCSW) requires clinical supervision per the regulations of the Massachusetts Board of Registration of Social Workers. Services provided by an LCSW who did NOT receive clinical supervision would therefore not meet qualifications to be billable under Medicaid.

## Practitioner Qualifications – Clinical Supervision

**Direct supervision is not a substitute for licensure.**

* For all service types, except Personal Care Services and ABA therapy provided by autism specialists, if the LEA staff do not hold a current active license for the practice specialty area for the services being performed, then the staff does not meet Medicaid requirements for reimbursement, even if supervised by a licensed practitioner.
* For example, a paraprofessional carrying out activities recommended by a Licensed Occupational Therapist would not be reimbursable. The only reimbursable providers for occupational therapy services would be a Licensed Occupational Therapist or a Licensed Occupational Therapy Assistant.

## Evaluations

Regardless of referral source or method of identifying that the student needs to be evaluated, both the IEP Process and the Medicaid-Qualified Services Process begin with an evaluation by a qualified practitioner.



* In the IEP Process, there may be several IEP team members who have a role in evaluating the student’s needs for various types of educational, social and health-related services and supports.



* For Medicaid’s purposes, the evaluation for health care services is performed by a Medicaid Qualified practitioner whose licensed scope of practice allows them to determine a student’s need for specific health-care services. The extent and type of evaluation needed should be consistent with clinical standards of practice.

## Determination of Need for Health Care Services

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



In the IEP Process, the IEP team comes together and determines whether the student qualifies for special education and an IEP.



For Medicaid’s purposes, the qualified practitioner, through their evaluation, determines whether it is **Medically Necessary** to provide health care services. The signed evaluation report substantiates the medical need, not the IEP.

## Medicaid Medical Necessity

* All covered services must meet medical necessity standards under 130 CMR 450.204 to be reimbursable.
* MassHealth does not pay for services that are not medically necessary.
* The service must be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.
	+ If the service does not meet this standard, it is **not** reimbursable.
* Services that are required under a student’s IEP or health plan, or provided at the request of a third party, are **not automatically** considered medically necessary.

## Medicaid Medical Necessity

**Skilled Services:**

* To be a Medicaid reimbursable service, the service must be a “skilled” service that requires the clinical expertise of the practitioner.
	+ If the student or an untrained lay person could provide the care in another setting, then the service does not meet the Medicaid medical necessity requirement because it is not a skilled service.
	+ The only exception to this requirement is personal care services, which are routinely provided by paraprofessionals and, by definition, do not require clinical skills to provide.

## Medicaid Medical Necessity

Professionally Recognized Standards Requirement

* The medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. (See 130 CMR 450.204(1)(B).)
* This means that the amount, frequency, and duration of services must be considered reasonable by professionally recognized standards of practice for the clinical service specialty and require the skill level of the qualified practitioner.
* Practitioners are responsible for understanding their own standards of care and scope of license, including whether the clinical standards of practice differ from educational standards of practice.
* For services to be within the scope of a practitioner’s license, the student’s condition must require treatment of a level of complexity and sophistication that can be safely and effectively performed only by such a licensed practitioner.

## ICD Diagnosis and/or Signs and Symptoms Codes

* The clinical evaluation performed by a qualified practitioner is often the first source of identifying the reason(s) that health care services are medically necessary.
* The reason(s) must be translated for claiming purposes into clinically appropriate ICD code(s).
* Per HIPAA requirements, all claims must include a clinically appropriate ICD code that is supported by clinical documentation and identifies WHY the service was needed.
* The LEA may utilize an ICD code related to the presenting signs and symptoms instead of, or in addition to, a code with a formal diagnosis.
* Every interim claim includes at least one ICD code. LEAs are responsible for ensuring that at least one clinically appropriate ICD code that explains the reason for the service is submitted on each interim claim.
* When appropriate, an ICD code provided by a qualified practitioner not employed by or contracted with the LEA, such as a physician or nurse practitioner, may be reported on an interim claim, as long as the LEA maintains written and signed documentation of such diagnosis.

## Plan of Care – Medicaid Service Authorization

All Medicaid-qualified services must be authorized by a qualified practitioner through a written plan of care, treatment plan or order.



* The IEP team documents a student’s disability and identifies the comprehensive program of services and supports that the school will provide to address the student’s needs so that they can succeed in school.



* For Medicaid’s purposes, the qualified practitioner, following an evaluation or assessment of the student’s health care needs, writes a Plan of Care to define the course of skilled treatments/interventions needed to achieve specific clinical treatment goals. The clinician-signed plan of care authorizes services provided pursuant to that plan.

## Plan of Care – Medicaid Service Authorization

* Service authorization must be written documentation signed by an appropriately licensed and qualified practitioner that documents the medical necessity of the service, and the clinically appropriate **Plan of Care**.
	+ The signature on a Plan of Care can never be back-dated.
	+ Services provided prior to signature date on the Plan of Care are not considered to be authorized by the POC and are not billable.
* Determination of medical necessity and the development of a clinically appropriate plan of care typically occur following an evaluation or clinical assessment. The extent and type of assessment needed to support medical necessity and develop or revise a plan of care should be consistent with clinical standards of practice.
* SBMP service authorization requirements are consistent with clinical standards and requirements of practitioners’ licensing bodies.
* The licensing bodies and standards of practice for most SBMP-covered services require “plans of care.”
* The plan of care should be developed consistent with licensing bodies’ standards of practice, including licensure requirements for the person developing the plan of care, and the frequency of plan of care development and revision.

## Plan of Care – Medicaid Service Authorization

As with all documentation, the Plan of Care, which authorizes services, must directly include all of the following information or incorporate supplemental information by reference:

* the name of the student to whom the services will be provided;
* the student diagnosis or presenting signs and symptoms and/or relevant ICD 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);
* the time period for which services are being authorized;
* the printed name, legible signature, and signature date of a practitioner who is licensed, registered, and/or certified as the relevant licensed professional acting within his or her scope of license, including his or her type of license and license number (note: signatures may not be back-dated); and
* the authorizing practitioner’s contact information, including school address and phone number.

## Plan of Care – Medicaid Service Authorization

The Plan of Care, which authorizes services, must directly include all of the following information or ***incorporate supplemental information by reference***.

Information that must be directly in the POC:

* Information identifying the student
* Description of services being authorized, including frequency and duration
* Time period for which services are authorized
* Authorizing practitioner’s information (printed name, license information, date of license, and contact information)
* Practitioner signature and signature date

Information that ***may*** be contained in a supplemental source and incorporated by reference:

* Clinical rationale/basis for medical necessity
* Student diagnosis or presenting signs and symptoms and/or relevant ICD code
	+ This information might be contained in an evaluation report, which could be referenced in the plan of care (including name of the evaluator, and date of the evaluation)
	+ This information might be contained in documentation from a community provider, which could be referenced in the POC (including the provider’s name and date of the order or other document)

## Services not pursuant to an IEP

* As was mentioned at the beginning of this presentation, the SBMP also provides reimbursement for health care services that are unrelated to special education and not pursuant to an IEP.
* The requirements for Medicaid reimbursement are identical for IEP and non-IEP based services.
* There are, however, a few situations that occur with non-IEP based services that will need to meet the Service Authorization requirement in a different way than what would occur with IEP-based services.

## Medicaid Service Authorization for Non-IEP Services

Unplanned services, screenings, and evaluations must meet the service authorization requirement in the following ways.

* When unplanned nursing services are provided pursuant to a physician’s standing order, rather than a plan of care, the standing order may serve as the authorization.
* Unplanned behavioral health interventions cannot be pursuant to a plan of care by nature of being unplanned. Medical necessity should be supported through service documentation; and the service is considered authorized when such documentation is signed by a qualified practitioner.
* EPSDT screenings that are listed in the SBMP Billable Procedure Codes and Maximum Fees document (as published and updated in the SBMP Resource Center) are automatically considered to be authorized.
* Since evaluations are performed to determine whether services are necessary, the evaluations do not require service authorization. The documentation of the evaluation must support medical necessity and include a description of the clinical reasons that the evaluation was appropriate and necessary.

## Service Delivery & Documentation

All Medicaid-qualified services must be documented.



* IEP services are provided to students to address the educational goals in the student’s IEP.



* For Medicaid’s purposes, the qualified practitioner documents the specific skilled treatments or interventions provided to the student during each service session. These signed clinical treatment notes document that the treatment provided is consistent with the POC and working toward achieving specific clinical treatment goals.

## Service Documentation

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

**Note**: Service documentation is not the interim claim record or a billing form.

## Service Documentation

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

* Student name
* Student date of birth
* Student’s MassHealth ID, if known, and State Assigned Student Identifier (SASID)
* School district name and school name (if different)
* Date(s) service(s) were provided
* Time of service and duration of service in minutes
* Individual or group indicator
* IEP or non-IEP indicator
* Diagnosis and/or presenting signs and symptoms and/or relevant ICD code
* Telehealth information
* Activity/Procedure note
* Printed name, legible signature, and signature date of the practitioner and legible, printed name, signature, and signature date of supervising provider, where applicable. The practitioner’s type of license and license number must be listed.

**Note:** For a more detailed listing, please refer to page 16 of the School-Based Medicaid Program Direct-Service Claiming (DSC) Program Guide.

## Re-Assessment

In the IEP process, there’s an annual review of the various components of the IEP and an opportunity to make changes to the IEP as needed. For the SBMP, re-assessment for the purpose of determining whether changes are needed to the Plan of Care occur at clinically appropriate intervals.



* In the IEP Process, there may be several IEP team members who have a role in reviewing the student’s progress towards achieving their IEP goals and continuing needs for various types of educational, social and health-related services and supports.



* For Medicaid’s purposes, the interval between assessments and potential revisions of the Plan of Care are determined by the needs of the individual student and clinical standards. The extent and type of assessment needed to support medical necessity and revise a plan of care should be consistent with clinical standards of practice.

## Interim Claiming is Required

* Whenever an LEA provides a Reimbursable Service (for which an LEA seeks reimbursement) to an eligible MassHealth enrolled student…

… submit an interim claim!

EVERY time a qualified practitioner who participates in a Direct Service RMTS pool provides a MassHealth Covered Service with the required authorization and service documentation that meets Medicaid’s definition of Medical Necessity (i.e. is a Reimbursable Service) to a MassHealth-enrolled student, an interim claim should be submitted.

## 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 **typically** **separate** from “service documentation” as described earlier in this training module.
* How this is implemented in each LEA will vary. Your LEA may utilize a system or software that fully integrates clinical documentation with the Medicaid billing process, or these types of information may stand alone. Your LEA’s process may be paper-based, computer-based, or a combination of the two.
* As a participating direct service practitioner it is your responsibility to seek guidance from your clinical leadership and/or Medicaid coordinator regarding your LEA’s internal procedures for meeting all Medicaid program requirements.

## Billing Forms – Out-of-District Programs

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

## Procedure Codes and Service Units

* Depending on the billing forms and processes in place for your LEA, practitioners may need to indicate which procedure code should be billed for services performed.
* The SBMP uses a limited set of procedure codes for interim billing purposes. The complete list of codes can be found in the “**SBMP Billable Procedure Codes and Maximum Fees**” document published on the SBMP Resource Center: <https://www.mass.gov/info-details/sbmp-resource-center>.
* For Medicaid billing purposes, each service must also be billed in units, which in most cases translates into service duration, but in other cases may simply be billed per “encounter.” For example,
	+ Individual speech therapy treatment is billed using procedure code 92507 and the service duration is billed in 15-minute units.
	+ A vision screening is billed using procedure code 99173 and is billed per screening, so it is always 1 unit.
* Please refer to your LEA’s specific instructions for how to complete the billing forms in use in your LEA.

## What Exactly is on the Interim Claim Submitted to MMIS?

Some of the key information on an SBMP interim claim record includes:

1. **Who** **received** **the service?** Identification of the Medicaid-enrolled student (name, DOB, Medicaid ID)
2. **Who provided** **the service?** Identification of the LEA submitting the claim
3. **When** **was the service provided?** Date of service
4. **What** **service was provided?** Identified by the procedure code and modifier(s)
5. **How many services were provided?** Identified by the billed units of service (some services are billed per encounter, others are billed in time units)
6. **Why** **was the service provided?** Identified by the ICD code(s)
7. **Where** **was the service provided?** Identified by a ‘place of service’ code – either in-school or telehealth
8. **Payment requested**: LEAs submit the claim and bill up to the maximum allowed rate per service

**Note**: Most of the documentation discussed in this presentation is retained by the LEA to support the claim in case of an audit.

## Random Moment Time Study Tips for Practitioners

When responding to the Random Moment Time Study, direct service practitioners need to apply your understanding of the reimbursable service requirements to your moment responses.

If you were providing a direct health care service (or preparing to provide a service, or documenting service delivery) at the time of a random moment, you’ll need to respond to questions which ask:

* Was the service medically necessary?
* Was the service authorized by a qualified practitioner?
* Was the service within your scope of clinical practice?
* And with all services, you’ll need to specify whether it was pursuant to an IEP or not.

**Note**: You’ll never need to identify any student specifically, and you’ll never need to consider whether the student you were working with is enrolled in MassHealth when responding to an assigned moment.

## Random Moment Time Study Tips for Practitioners

* LEAs also receive reimbursement for Medicaid Administrative work activities performed by Direct Service practitioners.
* We recommend viewing Medicaid 101 Series, Module 9: Administrative Activities in RMTS for information about those work activities.

## Next Training Steps

There may be other modules in the Medicaid 101 training series that apply to your specific training needs.

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## Contact Information & Resources

*MassHealth School-Based Medicaid Program information:*

[www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)

Specific items published on the SBMP website related to the materials covered in this training module are:

* “SBMP Direct Service Claiming (DSC) Guide”
* “Local Education Agencies Covered Service and Qualified Practitioners”
* “SBMP Billable Procedure Codes and Maximum Fees”

*UMMS School-Based Help Desk:*

SchoolBasedClaiming@umassmed.edu

1-800-535-6741

M-F 7:30 a.m. – 7:30 p.m.