Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
School-Based Medicaid Bulletin 17
April 2009

TO: School-Based Medicaid Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director

RE: **The School-Based Medicaid Program**

Background

This bulletin updates the School-Based Medicaid program for direct services provided and for administrative activities performed after July 1, 2009. There are new requirements for both the Direct Service Claiming (DSC) and Administrative Activity Claiming (AAC) components of the School-Based Medicaid program. This bulletin also describes a new payment methodology for the DSC component and contains details on a new AAC cost report. Finally, this bulletin contains information about covered direct services and required practitioner qualifications.

New Provider Agreement Required

Beginning July 1, 2009, local education authorities must execute a new provider agreement with MassHealth in order to participate in either the DSC or the AAC components of this program. Provider agreements will be distributed by the University of Massachusetts Medical School (UMMS) in the spring of 2009. For more information on obtaining a copy of the provider agreement, contact UMMS by telephone at 1-508-856-7640 or by e-mail at schoolbasedclaiming@umassmed.edu.

Direct Service Claiming Reimbursement

Under the new provider agreement, final reimbursement for the DSC component of the School-Based Medicaid program will be based on actual Medicaid-allowable incurred costs related to service delivery. Expenditures will be captured for each state fiscal year in the Massachusetts School-Based Cost Report. This report will include both DSC-related and AAC-related costs associated with individuals who provide direct services under the program. A draft copy of this report and related instructions will be available in the spring of 2009.

Massachusetts School-Based Cost Reports must be submitted to UMMS within six months after the close of the state fiscal year. Each School-Based Medicaid provider must certify annually, through its completed cost report, its total actual, incurred allowable costs and expenditures. Submitted cost reports are subject to desk review.

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Administrative Activity Claiming Reimbursement

Final reimbursement for the AAC component of the School-Based Medicaid program will continue to be based on actual Medicaid-allowable incurred costs related to administrative activities. Costs must be captured for each billing quarter in a new Massachusetts School-Based AAC Cost Report. Costs included in this report are related to AAC claims. The new School-Based AAC Cost Report will be available in the spring of 2009.

Massachusetts School-Based Medicaid AAC Cost Reports must be submitted to UMMS by October 15 following the end of the state fiscal year in which the activity occurred. For example, claims for the following four quarters must be submitted by October 15, 2010:

- July 1-September 30, 2009;
- October 1- December 31, 2009;
- January 1-March 30, 2010; and
- April 1- June 30, 2010.

Each School-Based Medicaid provider must certify annually, through its completed reports, its total actual, incurred allowable costs and expenditures. Submitted cost reports are subject to desk review.

Random Moment Time Study (RMTS)

To participate in either the DSC or AAC components of this program, School-Based Medicaid providers must participate in the statewide random moment time study (RMTS). Results from the statewide RMTS will be used in both the Massachusetts School-Based Cost Report and the Massachusetts School-Based Medicaid AAC Cost Reports.

Details about the RMTS will be available in a statewide RMTS User Guide. A draft copy of the guide is available upon request from UMMS at 1-508-856-7640, or by e-mail at schoolbasedclaiming@umassmed.edu. A final copy of the RMTS User Guide will be available on www.mass.gov/masshealth/schools later this year.

Each School-Based Medicaid provider must designate a single RMTS contact. School-Based Medicaid providers must supply the name, phone number, fax number, and e-mail address for this RMTS contact by using the UMMS phone number or e-mail address above.

As further described in the RMTS User Guide, if the statewide response rate on the RMTS does not reach 85% for a given quarter, all moments for which there is no response will be treated as non-Medicaid activities. Every School-Based Medicaid provider whose response rate was lower than 85% in a given quarter will be sent a notification letter. If the statewide response rate on the RMTS does not reach 85% for a given quarter, any School-Based Medicaid provider who received a notification letter within the last two years and whose response rate is lower than 85% in that quarter will be unable to claim reimbursement for that quarter.

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Direct Service Claiming Interim Payments

While final reimbursement for the DSC component of the School-Based Medicaid program will be based on actual, incurred Medicaid-allowable expenditures that have been certified using the new Massachusetts School-Based Cost Report, the School-Based Medicaid program will pay interim DSC payments according to the following process.

Interim payments will be based on per-unit-service claims filed by School-Based Medicaid providers to the Medicaid Management Information System (MMIS). School-Based Medicaid providers may submit only interim claims for services that are included in a MassHealth member's Individualized Education Plan (IEP), delivered by qualified practitioners, as described in this bulletin, and documented as described in Municipally Based Health Services Bulletin 9. Claims for interim payments must be submitted within 90 days of the date of service. After the close of each state fiscal year, interim payments will be reconciled with actual costs following the process described in the next section of this bulletin.

School-Based Medicaid providers must use the following codes when filing claims for services provided through DSC. The value of the interim rate for each code below will be distributed in a bulletin later this spring.

Service Code and Modifier	Service Description	Eligible Practitioner(s)
97001-TM	Physical therapy evaluation (related to an IEP) (per hour with a maximum of two hours)	• Physical Therapist
97003-TM	Occupational therapy evaluation (related to an IEP) (per hour with a maximum of two hours)	• Occupational Therapist
97110-TM	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility (provided pursuant to an IEP)(may bill multiple units)	• Physical Therapist • Occupational Therapist • Physical Therapy Assistant • Occupational Therapy Assistant
97150-TM	Therapeutic procedure(s), group (2 or more individuals)(provided pursuant to an IEP) (per 15 minutes; may bill multiple units)	• Physical Therapist • Occupational Therapist • Physical Therapy Assistant • Occupational Therapy Assistant
92506-TM	Evaluation of speech, language, voice, communication, and/or auditory processing (pursuant to an IEP)(per hour with a maximum of four hours)	• Speech-Language Therapist
92507-TM	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual (pursuant to an IEP) (per 15 minutes; may bill multiple units)	• Speech-Language Therapist • Speech-Language Pathology or Audiology Assistant
92508-TM	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals (pursuant to an IEP) (per 15 minutes; may bill multiple units)	• Speech-Language Therapist • Speech-Language Pathology or Audiology Assistant

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Service Code and Modifier	Service Description	Eligible Practitioner(s)
T1002-TM	RN services, up to 15 minutes (pursuant to an IEP) (may bill multiple units)	• Nurse (RN)
T1003-TM	LPN/LVN services, up to 15 minutes (pursuant to an IEP)(may bill multiple units)	• Nurse (LPN)
T1019-TM	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)(may bill multiple units)(pursuant to an IEP)	• Personal Care Services Provider
90801-TM	Psychiatric diagnostic interview examination (pursuant to an IEP)(per 30 minutes; may bill multiple units)	• Psychiatrist • Psychologist • Social Worker • Counselor
96101-TM	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report (pursuant to an IEP) (may bill multiple units)	• Psychiatrist • Psychologist
90804-TM	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient (pursuant to an IEP) (may bill multiple units)	• Psychologist • Social Worker • Counselor
90847-TM	Family psychotherapy (conjoint psychotherapy) (with patient present) (pursuant to an IEP)(per 30 minutes; may bill multiple units)	• Psychologist • Social Worker • Counselor
90853-TM	Group psychotherapy (other than of a multiple-family group) (pursuant to an IEP) (per 30 minutes; may bill multiple units)	• Psychologist • Social Worker • Counselor

Reconciliation of Interim DSC Payments

After the close of each state fiscal year, MassHealth will reconcile interim payments made to the School-Based Medicaid provider with the actual incurred Medicaid-allowable costs that the provider has certified using the Massachusetts School-Based Medicaid Cost Report. To do this, certified costs included in the Cost Report are compared to the School-Based Medicaid provider's interim rate claims for services delivered during the reporting period, as documented in MMIS. Each School-Based Medicaid provider's interim rate claims will be adjusted to reflect, in the aggregate, the total Medicaid-allowable costs based on the certified Cost Report.

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Reconciliation of Interim Payments (cont.)

If the Commonwealth determines that an underpayment has been made, the difference between the value of the interim payment and the value of the certified costs on the Cost Report will be paid to the School-Based Medicaid provider. If the Commonwealth determines that an overpayment has been made, MassHealth will recoup the amount of the overpayment from the School-Based Medicaid provider.

Discontinuing "Per Diem" Billing Codes

For services provided on or after July 1, 2009, Massachusetts will not use the "per diem" rates for reimbursement through the School-Based Medicaid program. School-Based Medicaid providers should therefore not bill the per-diem codes, which are described in Municipally Based Health Services Bulletin 9, for services provided on or after July 1, 2009. School-Based Medicaid providers should only use these "per diem" codes to bill services provided before July 1, 2009.

Practitioner Qualifications

MassHealth will pay for direct services provided through the program only when they are:

- included in a student's Individual Education Program (IEP);
- medically necessary; and
- furnished by practitioners possessing the qualifications listed below who are acting within the scope of their license. *Note: Personal care service providers are not required to be licensed. Covered personal care services are described in more detail elsewhere in this bulletin.*

Practitioners may be School-Based Medicaid provider employees or staff or contractors who provide direct services to students. Practitioners for whom there are supervision requirements, as specified below, must be so supervised in order for the service to be reimbursable. In addition, services must also meet all other applicable MassHealth program requirements and limitations and any other standards set by applicable licensing and certification authorities, certain of which are specified below.

Practitioner	Qualifications	Supervision Requirements
Audiologists	Meets the qualifications in 130 CMR 426.404	
Counselors	Meets the qualifications in 130 CMR 429.424(E)(2)	Must be supervised according to 130 CMR 429.424(E)(1)
Hearing Instrument Specialists	Meets the qualifications in 130 CMR 416.404	
Nurses (LPN and RN)	Meets the qualifications in 130 CMR 414.404(A)	
Occupational Therapists	Meets the qualifications in 130 CMR 432.404(B) or 432.405	

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Practitioner	Qualifications	Supervision Requirements
Occupational Therapy Assistants	Currently licensed by the Massachusetts Board of Registration of Allied Health Professionals	Supervision required by Occupational Therapist in accordance with 259 CMR 3.02(1) through (3)
Personal Care Services Providers	Must be able to perform personal care services and cannot be a family member of the individual receiving services	
Physical Therapists	Meets the qualifications in 130 CMR 432.404(A) or 432.405	
Physical Therapy Assistants	Currently licensed by the Massachusetts Board of Registration of Allied Health Professionals	Supervision required by a Physical Therapist in accordance with 259 CMR 5.02(1) through (3)
Psychiatrists	Meets the qualifications in 130 CMR 429.424(A)(1) or 429.424(A)(2)	Individuals who are qualified according to 130 CMR 429.424(A)(2) must be under the direct supervision of a fully qualified psychiatrist.
Psychologists	Meets the qualifications in 130 CMR 429.424(B)(1) or 429.424(B)(2)	Individuals who are qualified according to 130 CMR 429.424(B)(2) must be under the direct and continuous supervision of a psychologist meeting the requirements set forth in 130 CMR 429.424(B)(1)
Social Workers	Meets the qualifications in 130 CMR 429.424(C)(1) or 429.424(C)(2)	Individuals who are qualified under 130 CMR 429.424(C)(2) must be under the direct and continuous supervision of an independent clinical social worker
Speech/Language Therapists	Meets the qualifications in 130 CMR 432.404(C) or 432.405	
Speech-Language Pathology Assistants or Audiology Assistants	Currently licensed by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology	Supervision required by a Supervising Speech-Language Pathologist or Supervising Audiologist in accordance with 260 CMR 10.02

Personal Care Services

Personal care services consist of ***physical assistance*** with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), as defined below. Please note that personal care services must be authorized by a physician as described in the "Written Request for Service Requirements" section of this bulletin, in order to be reimbursable under the School-Based Medicaid program.

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Personal Care Services
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Activities of Daily Living (ADLs) include the following:

- mobility: physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
- assistance with medications or other health-related needs: physically assisting a member to take medications prescribed by a physician that otherwise would be self-administered;
- bathing/grooming: physically assisting a member with basic care such as bathing, personal hygiene, and grooming skills;
- dressing or undressing: physically assisting a member to dress or undress;
- passive range-of-motion exercises: physically assisting a member to perform range-of-motion exercises;
- eating: physically assisting a member to eat, including assistance with tube-feeding and special nutritional and dietary needs; and
- toileting: physically assisting a member with bowel and bladder needs.

Instrumental Activities of Daily Living (IADLs) include the following:

- household services: physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;
- meal preparation and clean-up: physically assisting a member to prepare meals;
- transportation: accompanying the member to medical providers; and
- special needs: assisting the member with
  - the care and maintenance of wheelchairs and adaptive devices;
  - completing the paperwork required for receiving personal care services; and
  - other special needs approved by MassHealth as being instrumental to the health care of the member.

Written Recommendations Or Authorizations for Services

The following services must be prescribed by, referred by, recommended by, ordered by, provided under the direction of, or otherwise authorized in writing by a prescribing practitioner as described below.

- Services provided by a physical therapist, a physical therapy assistant, an occupational therapist, an occupational therapy assistant, a speech and language therapist, a speech-language therapy assistant, an audiology assistant, or a behavioral health provider must be recommended by a physician or by a licensed practitioner of the healing arts within the scope of his or her license.
- Personal care services must be authorized by a physician.

School-Based Medicaid providers must retain documentation related to such written requests for four years.

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Questions

If you have any questions about the information in this bulletin, please contact UMMS at 1-508-856-7640 or e-mail your inquiry to schoolbasedclaiming@umassmed.edu