TOOL KIT FOR BILLING INDIANA MEDICAID FOR HEALTH-RELATED INDIVIDUALIZED EDUCATION PROGRAM SERVICES PROVIDED BY SCHOOL CORPORATIONS

MEDICAID BILLING TOOL KIT

A Tool Kit for Public School Corporations
Indiana Department of Education

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CHAPTER 1: INTRODUCTION TO TOOL KIT

1. 1. GENERAL INFORMATION

1.1.1. Introduction

This section introduces the Tool Kit's format. The Tool Kit explains how school corporations may bill Indiana Medicaid for Medicaid-covered Health-Related Individualized Education Program ("IEP") or Individualized Family Service Plan ("IFSP") Services provided by school corporations (hereinafter such services are referred to as "Medicaid-covered IEP or IFSP services").

1.1.2. Background

The Tool Kit describes Medicaid-covered services in a student's Individualized Education Program ("IEP") or Individualized Family Service Plan ("IFSP"), Medicaid coverage limitations and Medicaid-qualified provider requirements for each type of service. The Tool Kit is to be used in conjunction with the *Guide to Billing Indiana Medicaid for IEP Health-Related Services Provided by School Corporations* (the "Guide"), which provides general information about the Medicaid program and billing for services authorized in a student's IEP. The Guide is intended to assist school corporations with assessing whether to seek Medicaid reimbursement for IEP services and helping school corporation staff understand and comply with Medicaid program requirements.

1.1.3. Legal, Statutory and Regulatory Authority, and other reference resources regarding Special Education services and Medicaid-covered IEP or IFSP services.

1. Title XIX of the Social Security Act, "Medicaid" (42 USC § 1396 et. seq.; note especially § 1396b(c) regarding payments for services provided under the IDEA).

2. The Code of Federal Regulations, Title 42, Chapter IV, Parts 430 through 498.

3. Indiana Medicaid State Plan available at www.indianamedicaid.com/ihcp/StatePlan/state_plan.asp.

4. Title 12, Article 15 of the Indiana Code.

5. Title 405 of the Indiana Administrative Code, Articles 1 and 5.

6. The Individuals with Disabilities Education Act, IDEA, as reauthorized December 3, 2004 (Part B, 20 USC § 1411 et seq., and Part C, 20 USC § 1431, et seq.).

7. The Code of Federal Regulations, Title 34, Chapter III, Part 300

8. Title 511 of the Indiana Administrative Code, Article 7.

9. Indiana Health Coverage Programs Provider ("IHCP") Manual, as amended by Provider Bulletins. The IHCP Manual is available at www.indianamedicaid.com/ihcp/Publications/manuals.htm.

   Provider Bulletins are available at www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp.

10. Office of Management and Budget ("OMB") Circular A-87, Cost Principles for State, Local and Indian Tribal Governments.

11. Current Procedural Terminology ® (CPT) codes and descriptions of the American Medical Association (AMA) and any changes as published by the AMA.

12. Healthcare Common Procedure Coding ® (HCPCS) codes and descriptions of the American Medical Association and any changes as published by the AMA.

NOTE: This Tool Kit describes specific Medicaid services and requirements for school corporations to bill for Medicaid-covered IEP or IFSP services, as well as interpretations and guidance regarding such requirements. School corporations must continually monitor authoritative resources that take precedence over this Tool Kit, specifically:

a. Applicable state rules and federal regulations governing the Medicaid program
b. The IHCP Manual, Monthly Newsletter, bulletins and banner pages. Additional resources are identified in Appendix I of this Tool Kit.

1.2. TOOL KIT USE AND FORMAT

1.2.1. Purpose

The purpose of the Tool Kit is to educate Medicaid-enrolled school corporations about the policies and procedures governing Medicaid coverage, billing and reimbursement for IEP or IFSP health-related services provided to Medicaid-eligible students by Medicaid-qualified service providers. The Tool Kit provides descriptions and instructions on how and when to complete forms and other documentation necessary for Medicaid billing and audit purposes.

1.2.2. Format

The format used in this handbook is a consistent way of displaying complex, technical material and is intended to simplify the process for updating such information.

1.2.3. Chapter Information

Each "Tool Kit Chapter" addresses a specific type of service. A provider who renders more than one type of service should refer to the appropriate chapter for specific information concerning each type of service.

1.2.4. Section Information

Sections within each Tool Kit Chapter are dedicated to a specific topic, such as definitions, provider qualifications, service requirements, reimbursement, audit requirements, etc. For each Medicaid-covered IEP service, the provider should familiarize himself/herself with each topic (Section) within each Tool Kit Chapter to ensure that all requirements for documenting and billing the service have been met.

1.2.5. Section Numbering System

The Section number is included in the page header along with the Chapter number.

1.2.6. Pagination

Tool Kit pagination contains the Chapter, Section and Page number separated by hyphens. Each section within a chapter begins on page 1, for example, Chapter 2, Section 6 begins with page number 2-6-1, followed by page number 2-6-2.

1.2.7. Tool Kit Publication Date

A date appears on the bottom left corner of each page to indicate the publication date of the Chapter and Section. Replacement pages will bear new publication dates.

1.3. TOOL KIT UPDATES

1.3.1. Updating Changes

The Medicaid Tool Kit will be updated by Chapter and/or Section as needed, but at least annually, to reflect changes throughout the year. The entity responsible for updating the Tool Kit will be determined by the Indiana Department of Education. Updates will be coordinated with the Office of Medicaid Policy and Planning. Updates will be communicated when there is a change in the applicable:

1. Federal law, including statute, regulation or policy

2. State law, including statute, promulgated rule or policy

3. Provisions of the Indiana Medicaid State Plan

4. Indiana Department of Education (DOE) policies and Medicaid program policies (communicated to Medicaid-enrolled school corporations through Medicaid publications such as provider bulletins, newsletters, remittance advice banner messages, etc.) as well as the IDOE School-based Medicaid Web page and Medicaid in Schools Community on the Learning Connection.

Chapter and/or Section changes will be sent as replacement pages. The effective date of a change will be noted in the Update Log.

1.3.2. Update Log

The Tool Kit Update Log will accompany Tool Kit updates and serve as a reference for the school corporation to track updates and accurately incorporate changes into locally maintained hard copies of the Tool Kit. The log lists updates by "Update Number," describes the "Topic" of the updated information, and gives the "Section Number" of the affected portion of the Tool Kit. The log also lists, by page number, the updated page or pages to be incorporated into the Tool Kit ("Page Number(s) Added") as well as the outdated page or pages to be removed from the Tool Kit ("Page Number(s) Deleted"). Additionally, the Tool Kit Update Log shows the "Effective Date" on which any new or changed policies/procedures take effect.

1.3.3. Publication Date

The publication date of the Tool Kit replacement pages will appear in the bottom left corner of each page. The provider should check this date periodically to ensure that the material is current.

1.4. HOW TO USE THE UPDATE LOG

1.4.1. Introduction

To help ensure that their Medicaid-qualified providers of medical services comply with Medicaid program requirements, Medicaid-participating school corporations should share Tool Kit updates with all who furnish Medicaid-covered IEP/IFSP services.

1.4.2. Explanation of the Update Log

Update Number: these are sequential and include the publication date of the update.
Topic: briefly describes the topic of the information updated.
Section Number: the section of the Tool Kit affected by the update.
Page Number(s) Added: updated pages to be incorporated into the Tool Kit.
Page Number(s) Deleted: outdated pages to be removed from the Tool Kit.
Effective Date: the date on which changes or additions take effect.

Use the Update Log, DOE newsletters and Tool Kit updates to stay current on policy:

- DOE newsletters may precede your receipt of Tool Kit updates. Upon receipt of a DOE newsletter, make pen and ink changes to the appropriate section(s) of the Tool Kit and file the DOE newsletter for reference.

- Upon receipt of a Tool Kit update, file the Update Log, remove superseded Tool Kit pages and add newly updated pages as directed in the accompanying Update Log (see sample Update Log on page 1-4-2). Discard or file page(s) that have been replaced.

- Verify receipt of all updates by periodically checking the School-based Medicaid page at the DOE website: http://doe.state.in.us/exceptional/speced/medicaid.html.

Medicaid Billing "Tool Kit"

Medicaid School-Based Services

TOOL KIT UPDATE LOG

UPDATE NUMBER	TOPIC	SECTION NUMBER	PAGE NUMBER(S) ADDED	PAGE NUMBER(S) REMOVED	EFFECTIVE DATE
2007-12-01.1	Title Page	N/A	Title Page (No page #)	Remove former Title Page	12-01-07
2007-12-01.2	Table of Contents		i, ii	i, ii	12-01-07
2007-12-01.3	(1) Clarify existing policies; and (2) Add new chapter reference	Chapter 2, all sections	2-1-1 through 2-8-2	2-1-1 through 2-8-2	(1) 06-17-05* (2) 12-01-07
2007-12-01.4	Clarify existing group speech therapy coverage	5.5.4 5.5.5	5-5-1	5-5-1	06-17-05*
2007-12-01.5	Medicaid Program Compliance Monitoring *new addition*	Chapter 9, all sections	9-1-1 through 9-3-4	None *new addition*	12-01-07
2007-12-01.6	Clarify existing provider qualification criteria	Appendix B	B1	B1	06-17-05*
2007-12-01.7	Revised Parental Consent Form	Appendix F	F1	F1	12-01-07

* Technical amendment only; in effect when Tool Kit was issued but not included in original Tool Kit

SAMPLE

December 1, 2007

CHAPTER 2: PURPOSE, BACKGROUND, AND PROGRAM INFORMATION

2.1. PURPOSE AND BACKGROUND

2.1.1. Purpose

This Tool Kit is intended for use by school corporations enrolled in the Indiana Medicaid program. It outlines specific Indiana Medicaid program requirements for billing Medicaid-covered IEP or IFSP services. It also educates school corporations about policies and procedures governing Medicaid payment for Medicaid-covered IEP and IFSP services, coverage parameters and limitations, as well as provider qualifications and Medicaid billing requirements for such services. In addition, this Tool Kit provides descriptions and instructions on how and when to complete forms and other documentation necessary for Medicaid billing and audit purposes.

This Tool Kit must be used in conjunction with billing instructions and other pertinent information in the Indiana Health Coverage Programs ("IHCP") Provider Manual. The IHCP Provider Manual, which includes sample claim forms and further instructions, is available online at www.indianamedicaid.com. Each school corporation receives a copy of the IHCP Provider Manual upon enrolling as a Medicaid provider and will also receive periodic Provider Manual updates from the Medicaid agency or its contractor.

2.1.2. Background

Indiana Code § 12-15-1-16 requires school corporations to enroll in the Medicaid program. The purpose of this statutory requirement is to encourage school corporations to claim available Medicaid reimbursement for Medicaid-covered IEP and IFSP services.

School corporations must ensure students with disabilities receive all appropriate services regardless of whether Medicaid reimbursement is available for the services.

2.1.3 Medicaid Billing and Reimbursement for Covered IEP Services

The Medicaid program is a state and federally funded medical assistance program. Medicaid-enrolled school corporations may use their Medicaid provider numbers only to bill for Medicaid-covered special education services in an **IEP** or **IFSP** (***not*** including services in a Non-Public School Service Plan or 504 Plan) and not for primary or preventive care furnished by a school-based health center or clinic. Primarily, Medicaid-covered IEP or IFSP services include: Evaluations and Re-evaluations; Occupational, Speech, and Physical Therapy Services; Audiology Services and Behavioral Health Services.

Medicaid recognizes the IEP or IFSP as the Medicaid prior authorization for IEP/IFSP services provided by a school corporation's Medicaid-qualified provider. Managed care pre-certification by the student's primary medical provider is not required. A school corporation cannot use its Medicaid provider number to bill Medicaid for covered services that are not in or necessary to develop the student's IEP or IFSP. *Non-IEP/IFSP services are subject to all Medicaid Prior Authorization and Managed Care approval/referral requirements.*

2.2. DEFINITIONS

The following definitions apply for purposes of this Tool Kit:

1. Individuals with Disabilities Education Act ("IDEA") refers to the federal law enacted in 1990 (Public Law 101-476), which amends and renames the Education of the Handicapped Act (Public Law 94-142). IDEA was enacted to: assure that all children with disabilities have available to them a free and appropriate education, with an emphasis on special education and related services designed to meet their unique needs; assure that the rights of children with disabilities and their parents or guardians are protected; assist states and localities to provide for the education of all children with disabilities; and assess and assure the effectiveness of efforts to educate children with disabilities.

2. Individualized Education Program ("IEP") means a written document developed by a case conference committee to describe how a student will access the general education curriculum and the special education and related services needed to participate in the educational environment. The required components of an IEP are specified in 511 IAC 7-42-6.

3. Individualized Family Support Plan ("IFSP") refers to a written plan for providing early intervention services to an eligible child under the age of three (3) years, developed pursuant to Title 34 of the Code of Federal Regulations, Sections 303.342 and 303.343.

4. "Mid-level practitioner" refers to practitioners who may only provide direct service to the student, within their scope of practice, under the direct supervision of a licensed or registered practitioner as required by applicable state licensure or registration laws and regulations. In some cases, direct *on-site* supervision is required.

5. "On-site supervision" for Medicaid-covered IEP/IFSP billing purposes means the supervising practitioner must be *in the same building* as the "mid-level" practitioner directly providing service to the student. Furthermore, practice standards established by the applicable licensing, registering or certifying entity may prescribe additional supervision requirements with which the supervising practitioner must comply.

6. "Provider" is used to describe any entity, facility, person, or group who meets state and federal Medicaid provider qualifications and provides specific Medicaid-covered IEP services to Medicaid-eligible students for which a Medicaid-enrolled school corporation may submit a Medicaid claim. If a school corporation bills Medicaid for Medicaid-covered IEP services, the individual furnishing the direct service is not required to be enrolled as a Medicaid provider, but (s)he <u>must</u> meet the qualifications for Medicaid providers of the specific services (s)he is furnishing.

7. Special Education-Related Services, not all of which are covered by Medicaid, are defined by Indiana's *Rules for Special Education*, Title 511, Article 7 (511 IAC 7-43-1) and include but are not limited to:

a. Audiological services.
b. Counseling services.
c. Early identification and assessment of disabilities in children.
d. Interpreting services
e. Medical services for the purpose of diagnosis and evaluation.
f. Occupational therapy.
g. Orientation and mobility services.
h. Parental counseling and training.
i. Physical therapy.
j. Psychological services.
k. Recreation.
l. Rehabilitation counseling.
m. School health services.
n. School nurse services.
o. School social work services.
p. Transportation.
q. Other supportive services.

Not all "related services" in a student's IEP or IFSP are Medicaid-covered. This Tool Kit refers to related services that are "Medicaid-covered IEP/IFSP services."

2.3. MEDICAID SERVICE PROVIDER QUALIFICATIONS

2.3.1. Qualified School Corporation Providers of Medicaid Services

State law requires Indiana public school corporations to enroll as Indiana Medicaid providers (IC 12-15-1-16). *Only a school corporation, charter or state-operated school* (not a special education cooperative) may enroll as a Medicaid provider under the School Corporation provider type and specialty. Please note that a Medicaid-enrolled school corporation or charter may designate a special education cooperative as the payee to receive its Medicaid reimbursement checks by inserting the designated entity's name and address in the "Pay To" field of the relevant Medicaid Provider enrollment form.

2.3.2. Enrollment Process

To bill Medicaid for IEP services, a school corporation must enroll as an Indiana Medicaid provider. For the necessary forms and enrollment assistance, contact HP (formerly EDS) Medicaid Provider Enrollment toll free at 877-707-5750 or online at http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp. To obtain a National Provider Identifier (NPI), school corporations may apply online at the National Plan and Provider Enumerator System (NPPES) Web site:

https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

or complete and submit to NPPES a paper form (available from the above NPPES Web site). Once obtained, the school corporation's National Provider Identifier and taxonomy code (see next two paragraphs) may be reported to Indiana Medicaid's fiscal agent, HP. For NPI reporting instructions, please visit the Provider site at www.indianamedicaid.com and click on the Provider Enrollment quick link at the right. Then click on "National Provider Identifier" and choose "Getting/Reporting an NPI."

As part of the NPI enumeration process Medicaid-participating schools corporations are asked to enter the corporation's federal tax ID number and mailing (street) address, indicate that they function as a group/organization rather than an individual health care provider, and choose a "taxonomy code" that describes their health care provider type and specialty. When applying for an NPI, the school corporation or state-operated school should select the following taxonomy code for Local Education Agency:

"Local Education Agency (LEA) 251300000X - *The term local education agency means a public board of education or other public authority legally constituted within a State to either provide administrative control or direction of, or perform a service function for public schools serving individuals ages 0 – 21 in a state, city, county, township, school district, or other political subdivision including a combination of school districts or counties recognized in a State as an administrative agency for its public schools. An LEA may provide, or employ professional who provide, services to children included in the Individuals with Disabilities Education Act (IDEA), such services may include, but are not limited to, such medical services as physical, occupational, and speech therapy."*

School corporations that are not yet enrolled in the Indiana Medicaid program should contact the Medicaid fiscal agent either through the Indiana Health Coverage Programs (IHCP) Web site at www.indianamedicaid.com and click on "*Provider Enrollment*", or by telephone or mail at:

HP Provider Enrollment
P.O. Box 7263
Indianapolis, Indiana 46207-7263
1-877-707-5750

Each school corporation must sign a Medicaid provider agreement (see Appendix A) to enroll in Medicaid. Please note that the Medicaid provider agreement changes periodically. Recent changes included the addition of a standard ethical statement and a requirement for all newly enrolling Medicaid providers to establish an Electronic Funds Transfer ("EFT") account for bill payment.

As of this Tool Kit's publication date, an EFT account is currently not mandated for providers already enrolled in the Medicaid program. However, it is recommended that Medicaid-enrolled school corporations establish an EFT account. A school corporation can simultaneously complete an EFT account enrollment form and update its provider agreement. Please refer to Chapter 12, Section 6 of the IHCP Provider Manual, available at www.indianamedicaid.com, for additional information and instructions.

Note also: See the *Guide to Billing Indiana Medicaid for IEP Health-Related Services Provided by School Corporations* (the "Guide"), Chapter VI., Section 1.

2.3.3. Medicaid Provider Enrollment File Update Requirements

Once enrolled as an Indiana Medicaid-participating provider, the school corporation must be careful to keep its provider enrollment file up to date. Examples of updates that must be communicated timely to the Indiana Health Coverage Programs (IHCP) Provider Enrollment Unit include any changes in: the name of the school corporation; the name of the person authorized to represent the school corporation; the name of the entity filing the corporation's electronic claims; the tax ID number(s) that are required to be on file; and the school corporation's address(es).

Important Note: Medicaid stresses the importance of updating address information because outdated address(es) can impact receipt of payments, tax documents and program-related correspondence, including advance notice of an audit. Address updates can be accomplished through a written *IHCP Provider Name Address Maintenance Form* or via Web interChange. Please visit www.indianamedicaid.com for further information, including security restrictions applicable to updating provider file information. [Note: up to four different address types can be recorded in the Medicaid provider file, depending on the school corporation's preferences. See details in the blue text box below.]

Service Location – this address is where services are performed and claim documentation is kept
Pay To – this address is where checks are sent; note remittance advice statements explaining payments are now available only in electronic format via Web interChange
Mail To – this address was previously used for mailing hard copy manual updates, bulletins and newsletters; however these are now only available online via the provider site option at www.indianamedicaid.com
Home Office – this is your legal address, which is where all 1099 and other legal or tax forms and documentation will be mailed; this address ***must match*** the address on the W-9 form on file with Medicaid Provider Enrollment

2.3.3.a. Medicaid Paperless Communications with All Providers

Effective September 1, 2009, Indiana Medicaid ceased generating paper copies of Medicaid Provider Remittance Advice (RA) statements (explanations of Medicaid claims activity and reimbursements). RA statements are now available in electronic format only and can be accessed at the Indiana Health Coverage Program (IHCP) secure Web site via "Web interChange." **Please note that electronic Remittance Advice statements are maintained on Web interChange for a period of *four weeks* only.** Indiana Health Coverage Programs recommends saving copies of RA statements in Adobe PDF format to personal storage devices for future reference. View bulletin BR200912 for more information by clicking on the "News, Bulletins and Banners" tab at www.indianamedicaid.com; select "Bulletins" then "View Bulletins," and enter BR200912 in the Keyword or Bulletin # Search.

To obtain a Web interChange user ID and password go to the Web interChange logon screen at https://interchange.indianamedicaid.com and click on **How To Obtain An ID**. Read and follow the applicable instructions. *Note: To determine whether your school corporation already has a Web interChange administrator, use the Administrator Listing function located at* https://interchange.indianamedicaid.com. Contact the IHCP Electronic Data Interchange (EDI) Solutions Help Desk, (317) 488-5160 or toll free (877) 877-5182, for assistance as necessary.

In addition to paperless Remittance Advice statements, Indiana Medicaid provider bulletins, banner pages, newsletters and Claim Correction Forms are all paperless. View these paperless provider communications and forms via the IHCP Web site. To stay informed of current procedures, policy updates and provider workshop offerings, enroll in the IHCP E-mail Notifications service. Follow the enrollment instructions provided at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp. It is a good idea to verify your e-mail address(es) periodically to keep your enrollment up to date.

2.3.4. School Corporation Staff Qualifications

To bill Medicaid, a school corporation must be enrolled as an Indiana Medicaid service provider. In accordance with its signed Medicaid provider agreement, the school corporation must employ or contract with health care practitioners who meet applicable Medicaid provider qualifications to provide specific services for which the school

corporation will bill Medicaid. However, it is not necessary for the persons performing the services to be individually enrolled as Indiana Medicaid providers.

It is the school corporation's responsibility to ensure its staff and contractors who provide Medicaid services meet applicable Indiana Medicaid provider qualifications, Indiana Medicaid State Plan provisions, state licensure and practice standards, as well as applicable provisions of federal laws and regulations. All Medicaid providers, including school corporations, must ensure that service rendering practitioners do not appear on the U.S. Department of Health and Human Services Office of Inspector General's "List of Excluded Individuals," accessible online at http://www.oig.hhs.gov/fraud/exclusions.asp. **See Appendix C for a copy of Medicaid's latest (2009) Provider Bulletin on this topic.**

Medicaid provider qualifications for each type of covered IEP/IFSP health-related services are discussed in each service-specific Tool Kit chapter. A summary of Medicaid provider qualifications is included in Appendix B and pertinent excerpts from Indiana Medicaid's covered-services rule are provided in Appendix C. School corporations must periodically review applicable laws and rules to ensure that school practitioners are complying with the most current versions. [Note: Instructions on how to check for updates are provided in Appendix I.] Additionally, a Medicaid-participating school corporation is responsible for ensuring that its employees or contractors who provide Medicaid services:

(1) are performing within the scope of practice of their state licensure and certification; and
(2) have not been banned from Medicaid participation (please refer to information on the "List of Excluded Individuals" in the blue text box at the bottom of Page 2-3-2).

2.4. STUDENTS ELIGIBLE FOR MEDICAID-COVERED IEP/IFSP SERVICES

2.4.1. Students Eligible for Medicaid-Covered IEP/IFSP Services

In order for school corporations to bill Medicaid for Medicaid-covered IEP or IFSP services provided to a student in Special Education, the student must:

1. Be Medicaid-eligible on the date of service.

2. Be at least three but less than 22 years of age. Under federal regulations 34 CFR § 300.534, the age of eligibility for a free and appropriate public education under IDEA is to be determined by the state. Indiana's rule governing Special Education, 511 IAC 7-33-2(a)(1) establishes the age of eligibility as <u>at least three (3) years of age but less than twenty-two (22) years of age</u>.

   The school corporation <u>cannot</u> bill Medicaid for Medicaid-covered IEP or IFSP services rendered to the student on or after the day the student turns 22 years of age.

3. Be entitled to services under IDEA. [IDEA also requires school corporations to provide services to students with disabilities regardless of whether the student is Medicaid-eligible and regardless of whether the school corporation will be reimbursed for such services.]

4. Have an IEP or IFSP that specifically lists the Medicaid-covered IEP/IFSP service and have a demonstrated medical need for the Medicaid-covered IEP/IFSP service that is provided. (Please note: initial evaluations necessary for the development of, but not necessarily listed in a student's IEP/IFSP, are covered if the student is eligible to receive services under Part B or Part C of the IDEA.)

5. Receive Medicaid-covered IEP/IFSP services provided by the school corporation's employee or contractor who meets Medicaid's provider qualifications to provide the service. Medicaid provider qualifications are outlined in each service-specific Chapter of the Tool Kit under the "Provider Qualifications" section.

2.4.2. Additional Information on Medicaid Eligibility, Liens and Estate Recovery

Occasionally the Department of Education receives inquiries indicating parents' concerns about potential consequences of accepting Medicaid assistance for their special needs child. The next paragraph contains information from the Indiana Office of Medicaid Policy and Planning (OMPP) and is included here for your information. We recommend parents call the OMPP about Medicaid Lien or Estate Recovery questions.

Medicaid cannot place a lien on the parent's home. The only circumstance under which Medicaid can file a lien on property is where an individual is permanently institutionalized, does not have a spouse, minor child, or disabled child living in the home. Even then the lien can only be placed on the Medicaid *recipient's* real property and only to the extent of his or her ownership interest. If a child is the beneficiary of a special needs trust there is a provision that requires the state be repaid from the remainder of the trust upon the beneficiary's death.

2.5. GENERAL SERVICE REQUIREMENTS

2.5.1. Introduction

Medicaid reimbursement is only available to school corporations for services that are identified in an eligible student's IEP/IFSP, furnished by a Medicaid-qualified provider and for which there is an order or referral from a physician/other licensed practitioner of the healing arts acting within the scope of his or her state licensure. Each service-specific section of this Tool Kit addresses Medicaid requirements including but not limited to: provider qualifications; procedure codes; reimbursement limitations; documentation requirements; and plan of care requirements.

While other school-based Medicaid services may be billed by school-based clinics separately enrolled in Medicaid, only health-related IEP or IFSP services can be billed by the school corporation on the school corporation's Medicaid provider (NPI) number. Medicaid-covered IEP evaluation and treatment services are face-to-face, health-related services provided to a student or group of students who is/are *eligible to receive services under IDEA*. Covered services must be medically necessary, included in the Indiana Medicaid State Plan, and required to develop or listed in a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Examples include:

1. Speech/language pathology and audiology services
2. Nursing services provided by an R.N.
3. Health-related, including mental health, assessments/evaluations
4. Physical and occupational therapy
5. Psychological testing, evaluation and therapy services
6. IEP-required special transportation services

See Appendix E for typical examples of covered services billed by school corporations.

Medicaid recognizes the student's IEP/IFSP as the Medicaid prior authorization (PA); no further PA or Primary Medical Provider (PMP) certification is required for IEP services provided to an eligible student by a school corporation's Medicaid-qualified provider in accordance with Medicaid requirements.

2.5.2. The Federal Free Care Prohibition

Historically, the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that oversees states' administration of the Medicaid program, has interpreted federal law as prohibiting Medicaid payment for services provided free of charge. **Federal policy *exempts* IEP/IFSP services from this prohibition on paying for "free care."**

Medicaid reimbursement IS available for covered IEP/IFSP services regardless of the fact that such services are provided free of charge.

2.5.3. Medicaid Reimbursable Services

Only services medically necessary for the development of an IEP/IFSP or that are listed in an IEP/IFSP may be billed to Medicaid. For example: An initial evaluation that is *medically necessary to develop an IEP/IFSP* may be billed to Medicaid. Similarly, other *medically necessary diagnostic and treatment services included in the student's IEP/IFSP* are billable. Do not bill Medicaid for the student's initial evaluation if the student is determined ineligible to receive services under IDEA.

The Medicaid-required referral for an evaluation should clearly indicate the medical need for the evaluation, such as acting out behaviors, fine/gross motor or speech issues, suspected mental disability, etc., if the school corporation bills Medicaid for the evaluation. See Tool Kit section 2.8.1. regarding referrals.

2.5.4. Service Limitations

Service specific limitations are addressed in each Tool Kit Chapter, where applicable.

2.5.5. Claim Filing Limitations

With few exceptions, Medicaid will not make a payment on a claim filed more than one year from the date the service is rendered ("date of service" or "DOS"). School corporations are advised to contact the Medicaid fiscal agent promptly to research and resolve claim issues, or submit a written correspondence inquiry to the fiscal agent's Written Correspondence Unit. The contact information is listed in Appendix D.

School corporations may request a waiver of the one-year filing limit when submitting a claim with dates of service more than one year prior to the date the claim is submitted. Medicaid's fiscal agent may waive the filing limit in certain circumstances after reviewing supporting documentation from the school corporation.

Note also: IHCP Provider Manual, Chapter 10, Section 5: Claim Filing Limitations.

2.5.6. Medical Necessity

Indiana Medicaid's rule at 405 IAC 5-2-17 defines "medically reasonable and necessary service" to mean a covered service that is required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. Medicaid reimburses school corporations for Medicaid-covered IEP/IFSP services if such services:

1. Are determined to be medically necessary.

2. Do not duplicate another provider's services.

3. Are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Medicaid-eligible student's needs.

4. Are not experimental or investigational.

5. Are reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

6. Are furnished in a manner not primarily intended for the convenience of the Medicaid-eligible student, the Medicaid-eligible student's caretaker, or the provider.

2.5.7. Treatment Plans

Treatment Plans
A treatment plan, or plan of care, is required for all Medicaid-covered IEP/IFSP services and must be reviewed every sixty (60) days. The IEP or IFSP may qualify as the treatment plan if it meets the criteria in the Plan of Care sections in each service-specific Chapter of this Tool Kit. Such plans should *include the amount, frequency, duration and goals of the services to be provided*.

Please note: bill Medicaid only in accordance with the service frequency described in the student's IEP (whether or not a separate care plan exists in addition to the IEP). For example, if the IEP describes the frequency of speech therapy as three times per week, do not claim Medicaid reimbursement for a fourth session delivered within one week.

2.5.8. Diagnosis Code

Medicaid requires that the applicable diagnosis code, based on the International Classification of Diseases, 9th Revision Clinical Modification (ICD-9-CM), published by the American Medical Association (AMA), 2005, and any subsequent revisions thereto, be entered on the CMS-1500 claim form. For behavioral health services, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV), published by the American Psychiatric Association, 1994, and any updates thereto, must be entered on the claim form. A student's diagnosis and corresponding code must be contained in the student's record.

2.5.9. Place of Service Code

On the CMS-1500 (medical) claim form, school corporations must enter the Place of Service (POS) code that most appropriately describes the location where the student received the service. Appropriate POS codes for school corporation services include:

Place of Service Code	Description	Usage
03	School	Use when the service is provided to the student anywhere on school grounds (e.g., in the school building or school clinic)
12	Home	Use when the service is provided to the student at his or her home or at the residential facility where the student is placed
99	Other location	Use when none of the above apply (e.g., if the service is provided during a school trip, or on the school bus).

For audit purposes, school corporations must ensure that there is appropriate documentation to support the use of the POS code.

Examples of supporting documentation:

1. For POS Code 03, attendance records must show that the child was at school when the service was provided.
2. For POS Code 99, attendance and other school activity records (e.g., permission slips for field trips) must show that the child was on a school field trip when the service was provided.
3. For POS Code 12, attendance records must reflect that the child was not on campus but receiving services at his or her home/residential facility.

School corporations generally provide IEP or IFSP health-related services on the school grounds (i.e., in the school building or clinic). In some circumstances, the services may be provided in the child's home. In rare occasions, it may be necessary to provide a service during a field trip or while the student is being transported. Appropriate use of the POS code can be helpful in an audit situation.

2.5.10. Procedure Codes and Fees

Appendix E of this Tool Kit contains a list of CPT Codes most commonly billed or that may be billed by school corporations when the services are authorized in a student's IEP or IFSP. The dollar amount of Medicaid reimbursement for each of the CPT Codes can be obtained at www.indianamedicaid.com, by clicking on "Fee Schedule".

Please note that the Office of Medicaid Policy and Planning (OMPP) limits certain Medicaid provider types to billing only a specific set of procedure codes. As of this Tool Kit Update's release date, a school corporation provider-specific procedure code set has not been established. If OMPP restricts billing by school corporation Medicaid providers in this manner, the school billing code set will be available at www.indianamedicaid.com/ihcp/Bulletins or by clicking on "Code Sets" at www.indianamedicaid.com.

2.5.11. Modifiers and Explanation of Tables in Appendix E

In conjunction with CPT procedure codes, school corporations must use appropriate modifiers to provide other details about delivery of the service billed. Appendix E provides information about modifiers and procedure codes for common IEP services as well as the impact each modifier has on payment for the service.

Table 1. This table lists behavioral health service codes for use by school corporations. CPT Codes 90801 – 90853 can only be used for services provided by a physician, HSPP or Medicaid-qualified mid-level practitioners under HSPP or physician supervision, subject to all other applicable Medicaid requirements. When billing the codes in the upper portion of Table 1, provider type modifiers AH, AJ, HE and HO must be used in conjunction with TM (IEP service), per the list on the right side of Table 1. The codes in the lower portion of Table 1 may be billed only when the services are provided by a physician or HSPP.

Table 2. This table includes billing codes for physical and occupational therapy services provided by licensed physical therapists, certified PT assistants, registered occupational therapists or certified OT assistants, subject to all applicable order/referral and supervision requirements. In addition to TM (IEP service), use modifier GP for services provided by a licensed PT or certified PTA and modifier GO for services provided by a registered OT or COTA. Note circumstances under which modifier 59 is applicable.

Table 3. This table addresses services for individuals with speech, language or hearing disorders. CPT Codes 92506-92593 can only be provided by licensed speech-language pathologists or licensed SLP Support Personnel subject to applicable order/referral and supervision requirements. In addition to TM (IEP service), modifier GN must be used with the codes listed. Use modifier HM to bill services provided under the supervision of a Medicaid-qualified Speech-language Pathologist (e.g., service performed by an SLP Aide or an SLP that does not have the ASHA Certificate of Clinical Competence or has not completed the equivalent academic program and supervised work experience to qualify for the certificate). Note circumstances under which modifier 59 is applicable.

Table 4: General Modifiers. In addition to the modifiers specified above, school corporations are required to use the following modifiers: TL for IFSP/early intervention services, TM for IEP services, and TR for any IEP/IFSP health-related services provided outside the school district in which the student is enrolled. These modifiers are informational only (i.e., they do not affect payment). However, they must be used for purposes of tracking IEP and IFSP services billed by school corporations.

Table 5. This table addresses nursing services provided by an R.N. Code 99600 TD TM is used for all IEP nursing services except Diabetes Self-Management Training. Codes for IEP DSMT services provided by an R.N. are included in the lower half of Table 5. ***Please note: the order of the modifiers is critical for appropriate reimbursement.***

Table 6. This table lists codes and modifiers for common ambulatory and non-ambulatory Special Education Transportation services.

2.6. PARENTAL/GUARDIAN AUTHORIZATION

2.6.1. Informing the Parent per IDEA Requirements

School corporations must inform a student's parent/guardian of the "Free and Appropriate Public Education" (FAPE) provisions of IDEA, 34 CFR § 300.142. Federal regulations at 34 CFR § 300.154[d][2][iv][A]) also require LEAs to obtain parental consent to bill Medicaid each time that access to public benefits or insurance is sought. (See 34 CFR § 300.9 for the federal definition of "consent.") As clarified by the Office of Special Education Programs, U.S. Department of Education, this regulation requires LEAs to obtain parents' consent to bill Medicaid one time for all the specific services and duration of services identified in a student's Individualized Education Program (IEP). Therefore, consent to bill Medicaid must be obtained annually, and at any time the IEP is revised to include additional services or increased frequency of services for which Medicaid is to be billed. (Note that federal law requires all Medicaid providers to bill available third party insurance prior to billing Medicaid; therefore, if the student has third party insurance coverage, the school corporation cannot bill Medicaid for covered IEP or IFSP services unless it bills the available third party insurance first.)

When obtaining parental consent to bill Medicaid for health-related IEP services, the school corporation must inform parents that refusal to consent does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent. (See example consent forms at Appendix F.)

Indiana also requires school corporations to comply with state rules governing the use of public and private insurance proceeds, as set out in Title 511 of the Indiana Administrative Code, Article 7, Rule 33, Section 4, which provides as follows:

511 IAC 7-33-4: Use of Public and Private Insurance Proceeds

Sec.4.(a) A public agency may use Medicaid or other public benefits or insurance programs in which a student participates to provide or pay for services required under this article, as permitted under the public benefits or insurance program. With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency:

(1) may not:
  (1) require a parent to:
    (i) sign up for or enroll in public benefits or insurance programs in order for the student to receive a free appropriate education; or
    (ii) incur an out-of-pocket expense, such as the payment of a deductible or copay amount incurred in filing a claim for services provided, but may pay the cost that the parent otherwise would be required to pay; or
  (2) use a student's benefits under a public benefits or insurance program if that use would:
    (i) decrease available lifetime coverage or any other insured benefit;

(ii) result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;
(iii) increase premiums or lead to the discontinuation of benefits or insurance; or
(iv) risk loss of eligibility for home and community-based waivers, based on aggregated health related expenditures; and

(2) must do the following:
(A) Obtain informed parental consent as defined by 511 IAC 7-32-17 each time that access to public benefits or insurance is sought, for the specific services, and duration of services identified in a student's IEP. If the:
(i) IEP is revised or extended to require additional services; or
(ii) Public agency charges different amounts for such services;
the public agency must again obtain informed parental consent as defined in 511 IAC 7-32-17.
(B) Notify the parent that refusal to allow access to the public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.

(b) With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency may access a parent's private insurance proceeds only if the parent provides informed consent as defined by 511 IAC 7-32-17. Each time the public agency proposes to access the parent's private insurance proceeds, it must do the following:
(1) Obtain informed parental consent as defined by 511 IAC 7-32-17.
(2) Inform the parent that refusal to permit the public agency to access the private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.

(c) If a public agency is unable to obtain informed parental consent to access the parent's private insurance, or public benefits or insurance when the parent would incur a cost for a specified service required under this article, the public agency may use its Part B federal funds to pay for the service in order to ensure a free appropriate public education is provided to the student. These funds may also be used to avoid financial cost to a parent who otherwise would consent to the use of private insurance or public benefits or insurance. If the parent would incur a cost, such as a deductible or copay amounts, the public agency may use its Part B funds to pay the cost.

(d) Proceeds from public benefits or insurance or private insurance shall not be considered program income for purposes of 34 CFR 80-25 with respect to the administration of federal grants and cooperative agreements.

(e) If a public agency spends reimbursements from federal funds, such as Medicaid, for services under this article, those funds shall not be considered state or local funds for purposes of maintenance of effort provisions.

(f) Nothing in this article shall be construed to alter the requirements imposed on the state Medicaid agency, or any other agency administering a public benefits or insurance

program by federal statute, regulations, or policy under Title XIX or Title XXI of the Social Security Act, or any other public benefits or insurance program.

Note also: Discussion of HIPAA and FERPA in Tool Kit Chapter 10 and Third Party Liability requirements in Chapter IV, Section 8 of the *Guide*.

2.6.2. Methods for Obtaining Parental Consent to Bill Medicaid for Services

Each year, school corporations must obtain signed authorizations from parents/guardians prior to verifying a student's Medicaid eligibility or seeking Medicaid reimbursement for Medicaid-covered IEP/IFSP services.

Consent, as used in Article 7, is defined at 511 IAC 7-32-17 (see Tool Kit Appendix C). Appendix F provides a sample parental consent form that may be used or modified for use by school corporations. As an alternative, school corporations may include the consent statement on their IEPs or IFSPs. Note: Appendix G provides copies of two letters from the U.S. Department of Education, Office of Special Education and Rehabilitation Services, which provide guidance on parental consent requirements.

2.6.3. Release of Progress Notes to Physician

School corporations are strongly encouraged to provide the student's Primary Medical Provider (PMP) with progress notes. Such release must be in compliance with the privacy requirements of the Family Educational Rights and Privacy Act (FERPA), 34 Code of Federal Regulations, Part 99 (34 CFR Part 99). In other words, school corporations must obtain a signed authorization from parents/guardians prior to releasing progress notes to the student's PMP.

2.7. AUDIT REQUIREMENTS

2.7.1. Provider Records

A school corporation must have copies on file of each of its employed and contracted providers' medical licenses, certifications, criminal background check results, and other documentation that verifies that each provider meets the Medicaid provider qualifications for the services he or she renders and for which the school corporation bills Medicaid. Such records must be retained for 7 years and made available upon request to federal or state auditors or their representatives.

2.7.2. Documentation

Each school corporation must retain sufficient documentation to support each of its claims for reimbursement for Medicaid-covered IEP/IFSP services. Please note that a copy of a completed claim form is not considered sufficient supporting documentation. Such documentation must be retained for 7 years and available to federal and state auditors or their representatives. Refer to Chapter 10, Monitoring Medicaid Program Compliance, for service-specific documentation checklists for self-auditing purposes.

The school corporation must maintain the following records:

1. A copy of the student's IEP or IFSP and any addenda that are incorporated by reference into the IEP or IFSP, such as the student's health plan, behavior plan, nutrition plan, etc. To be eligible for Medicaid reimbursement under the school corporation's Medicaid provider number the service must be part of the IEP or IFSP. Services in a health or service plan that are not incorporated into the student's IEP or IFSP process are not eligible for Medicaid reimbursement under the school corporation's Medicaid provider number.

2. Medical or other records, including x-rays or laboratory results that are necessary to fully disclose and document the extent of services provided. Such records must be legible and include, at a minimum, all of the following, including the signature(s) of the service provider and the supervising practitioner if required:
   a. Identity of the student who received the service.
   b. Identity, title and employment records of the provider or the employee who rendered the service.
   c. The date that the service was rendered.
   d. A narrative description of the service rendered.
   e. The diagnosis of the medical condition of the student to whom the service was rendered.
   f. Evidence of physician involvement and personal patient evaluation for purposes of documenting acute medical needs, if applicable.
   g. Progress notes about the necessity and effectiveness of treatment.

3. When the student is receiving therapy, progress notes on the medical necessity and effectiveness of therapy as well as on-going evaluations to assess progress and

redefine goals must be a part of the therapy program. All of the following information and documentation is to be included in the medical record:

a. Location at which the Medicaid-covered IEP/IFSP services were rendered.
b. Documentation of referrals and consultations.
c. Documentation of tests ordered.
d. Documentation of all Medicaid-covered IEP/IFSP services performed and billed.
e. Documentation of medical necessity.

Documentation must be qualitative as well as quantitative. Remember that an auditor has not met or seen the student. The more information a school corporation can provide related to the student's health condition, services provided and who provided the services, the easier it is for an auditor to determine whether the Medicaid-covered IEP services for which a school corporation billed and received payment were medically necessary and in compliance with all applicable Medicaid requirements.

Note: Refer to Section 2.7.4. for Medicaid Records Retention Requirements as well as the Audit Requirements section in each service-specific Tool Kit Chapter. See also: (1) Tool Kit Chapter 10, Monitoring Medicaid Program Compliance, for additional information regarding state and federal audits, service-specific documentation checklists and school corporation self-audit guidelines; (2) IHCP Provider Manual [July 1, 2010 version], Page 4-8 "Provider Records," Page 13-13 "Medical and Financial Record Retention," and Pages 13-14 through 13-18 "Provider Utilization Review" http://provider.indianamedicaid.com/general-provider-services/manuals.aspx.

2.7.3. Documentation Timeliness and Security

Documentation of services by the service provider must be made at the time service is provided. If documentation of service occurs at any other time, then the provider must indicate that late entry on the record.

Service records are subject to the applicable privacy safeguards under the Health Insurance Portability and Accountability Act (HIPAA) and "FERPA," the Family Educational Rights and Privacy Act (refer to Tool Kit Section 9.2. for a discussion of HIPAA and FERPA applicability). The following paragraphs contain general information on securing electronic service documentation.

2.7.3.a. Electronic Service Documentation

For service records that are maintained electronically, Indiana Medicaid's Surveillance and Utilization Review (SUR) reviewers look for the following to ensure validity of electronic medical records for audit purposes:

1. the electronic medical records database must be password protected,
2. all medical record entries are date and time stamped, and
3. all revisions to medical records entries are maintained via an audit trail.

Password protection should restrict medical records access to authorized personnel only. Each authorized provider should have a unique, confidential password that must be changed at least every 60 days. Authentication is recommended to ensure data integrity. For example, when a provider makes an entry in a medical record, an electronic signature linked to the password is appended onto the medical record with the date and time. This signature creates an electronic fingerprint that is unique to the provider and verifies when the data was entered or modified.

The database should also provide an audit trail. Each time a medical record is entered into the database, a permanent record should be created. This original document should be retrievable without edits or alterations and allow a side-by-side comparison between the original record and the modification. An electronic signature with a date and time stamp must be on the original record and any modified records. The author of any changes should be linked and easily identifiable to the original record.

2.7.4. Records Retention Requirement

Records retention requirements ***differ*** for Special Education and Medicaid records. In addition to requirements for retaining Special Education records, Medicaid-participating school corporations must maintain, **for a period of seven (7) years from the date Medicaid services are provided**, such medical and other records, including but not limited to progress notes, practitioner service documentation, clinician/therapist attendance records, licensure/certification and student attendance, as are necessary to fully disclose and document the extent of the services provided to Medicaid-enrolled students. A copy of a claim form is insufficient documentation to comply with this requirement.

2.7.5. Recoupment

Failure to appropriately document services and maintain records may result in recoupment of Medicaid reimbursement.

<u>Note Also</u>: See Chapter IX of the *Guide* for Records Maintenance requirements.

2.8. GUIDELINES FOR BILLING IEP/IFSP SERVICES

2.8.1. General Billing Guidance for Medical Services Authorized in a Student's IEP

1. Medicaid recognizes the IEP/IFSP as the prior authorization for Medicaid-covered IEP/IFSP services provided to a Medicaid-eligible student. When billing IEP services to Medicaid, *the IEP/IFSP must identify the service(s), including the length, frequency, location, and duration of the service(s). The school corporation may bill only for the service(s) identified, at the length, frequency, location and duration specified in the student's IEP/IFSP.* No other Medicaid prior authorization or Primary Medical Provider (PMP) certification is required for the school corporation to bill Medicaid for the IEP/IFSP services using its Medicaid provider number.

   Note: (1) In accordance with federal regulations at 42 CFR 440.110, to be covered by Medicaid certain services must be ordered by a physician (M.D. or D.O.) or other licensed practitioner of the healing arts within the scope of his/her state licensure (other licensed practitioners are identified in the sample referral forms in Appendix F). Referrals should be obtained at least annually and as necessary to support significant changes in the type of services listed in the IEP (e.g., "consultation once per semester" is changed to "speech therapy three times per week"). (2) The frequency of Medicaid billing for a particular service cannot exceed the frequency described in the student's IEP.

   Referral or order from a licensed practitioner of the healing arts per scope of state licensure: Effective July 1, 2006, Senate Enrolled Act 333 amended the School Psychology practice act at IC 20-28-1-11 (copy in Tool Kit Appendix C) to add the following clarification regarding the scope of practice of a school psychologist: "*referring* a student to (A) a speech-language pathologist (…)* licensed under IC 25-35.6 for services for speech, hearing and language disorders; or (B) an occupational therapist certified under IC 25-23.5 for occupational therapy services; by a school psychologist who is employed by a school corporation and who is defined as a practitioner of the healing arts for the purpose of referrals under 42 CFR 440.110." ****(Please note: Medicaid requires a physician (MD or DO) referral for audiology services.)***

2. *Each time an IEP is developed or modified, the school corporation must obtain a signed release/consent from the parent(s) or guardian* in order to bill Medicaid for covered IEP/IFSP health-related services that are provided to the student in accordance with 34 CFR 300.154(d)(2)(iv)(A).

3. When billing Medicaid, school corporations *must use the Current Procedural Terminology (CPT) code that best describes the Medicaid-covered IEP/IFSP services provided* as well as any applicable CPT code modifiers (see code and modifier tables in Appendix E).

4. School corporations must pay particular attention to *duration limits for each unit of service as defined in the CPT code description*. There is no default 15-minute unit for CPT codes.

5. CPT codes are specific to the types and specialties of the practitioners furnishing services within the scope of their licensure. *School corporations must ensure they or their*

billing agents are billing for services for which the rendering provider (practitioner furnishing the service): a) has proper licensure/certification and b) meets the criteria to be a Medicaid-qualified provider. (See also #6 below and service-specific Medicaid provider qualifications in Tool Kit Chapters 3 through 9.)

School corporations are enrolled in Indiana's Medicaid program as "billing providers." Rendering providers (e.g., therapists, psychologists, etc. who are furnishing medically necessary services pursuant to a student's IEP/IFSP) are not required to enroll in the Medicaid program (or obtain an individual Medicaid provider number) in order for the school corporation to bill Medicaid for the services these practitioners provide. However, the rendering practitioner must meet the qualifications for the *Medicaid* provider type and specialty, and she or he must maintain service records that identify who provided the service. The school corporation enters its Medicaid provider number in the billing provider field on the CMS-1500 claim or 837P format and, if opting to enter a rendering provider number, should use the school corporation provider number in that field as well.

6. Services must be provided pursuant to an order or referral from a physician or other licensed medical practitioner with specific practice act authority to prescribe, order or refer. The school corporation must maintain documentation of such order or referral in the student's records.

2.8.2. Things to Consider When Contracting with a Billing Agent

Most Medicaid-participating school corporations contract with a billing agent vendor to assist with preparation and submission of their Medicaid claims for health-related IEP services. When contemplating this type of contractual arrangement it may be helpful to consult other school corporations with experience in this area. Listed below are a few general questions to consider when entering into a billing arrangement. See also: Appendix E of the companion "Billing Guide."

1. What are the specific responsibilities of the school corporation and the billing agent?
2. Is there a clause in the proposed contract for mutual or unilateral discontinuance?
3. Does the school corporation establish a schedule for the billing agent to submit claims or required reports? Is there a penalty for non-compliance?
4. To what extent will the agent refund money to the district if any claims are disallowed or result in a refund to the Medicaid program?
5. If the agent is to be paid on a contingency fee basis, is the fee based on a percentage of the federal share (not total) of the school corporation's Medicaid reimbursements?

CHAPTER 3: AUDIOLOGICAL SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-7; 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: 880 IAC 1-1 and 880 IAC 1-2.1; Division of Professional Standards rules promulgated pursuant to IC 20-28-2-6 (formerly 20-1-1.4-7); see also 515 IAC 1-1-72

3.1. SERVICE DESCRIPTION

3.1.1. Service Definition

Audiological services include, but are not limited to: determination of suitability of amplification and recommendation regarding the need for a hearing aid; assessment of hearing; determination of functional benefit to be gained by the use of a hearing aid; and fitting with a hearing amplification device by either an audiologist (please see provider qualifications, Section 3.2) or a registered hearing aid specialist.

3.1.2. Service Limitations

1. The following requirements must be met to claim Medicaid payment for audiological services:
   a. The service must be provided pursuant to a physician's written order.
   b. The student's history must be completed by a provider who meets Medicaid qualifications to render audiological services, as specified in Section 3.2. of this Tool Kit.
   c. The referring physician must complete and sign Part II of the *Medical Clearance and Audiometric Test Form*, see Appendix H, no earlier than six (6) months prior to the provision of a hearing aid.
   d. The form must be maintained as documentation for audit purposes.

2. Children fourteen (14) years of age and under must be examined by an otolaryngologist. Older students may be examined by a licensed physician if an otolaryngologist is not available.

3. Initial audiological assessments are limited to one (1) assessment every three (3) years per student, per provider, except where there is documented otological disease. Medical necessity must be documented.

4. All testing must be conducted in a sound-free enclosure. If a student's physical or medical condition precludes testing in a sound-free enclosure (or if the student is confined; e.g., hospitalized or homebound), the ordering physician must verify medical confinement in the initial order for audiological testing.

5. If the audiological evaluation reveals one (1) or more of the following conditions, the student must be referred to an otolaryngologist for further evaluation:
   a. Speech discrimination testing indicating a score of less than sixty percent (60%) in either ear.
   b. Pure tone testing indicating an air bone gap of fifteen (15) decibels or more for two (2) adjacent frequencies in the same ear.

6. The hearing aid contract portion of the audiometric test form must be signed by an audiologist or registered hearing aid specialist.

3.2. PROVIDER QUALIFICATIONS

3.2.1. Qualifications

To be reimbursed by Medicaid, audiological services must be performed by the following qualified providers:

1. *Audiological assessment and evaluations*: A physician must certify in writing the need for audiological assessment or evaluation. Audiological services must be rendered by a licensed, Medicaid-qualified audiologist (see below) or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by Medicaid.

2. *Hearing aid evaluation*: A hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist. The results must be documented and indicate that significant benefit can be derived from amplification.

In addition to meeting all applicable state licensure and practice standards (in 405 IAC 1 and 405 IAC 5, 880 IAC 1-1 and 880 IAC 1-2.1, and applicable rules promulgated by the Division of Professional Standards established under Indiana Code 20-1-1.5), Medicaid-qualified audiologists must also meet all applicable Medicaid provider qualifications, including the criteria copied directly below from federal regulations at 42 CFR 440.110.

Federal regulations at 42 CFR 440.110(c)(3), as amended May 28, 2004, define a Medicaid-qualified audiologist as:

"(3) A "qualified audiologist" means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted form State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.

(B) Have successfully completed a minimum of 350 clock hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary."
(Note: "Secretary" refers to the Secretary of the U.S. Department of Health and Human Services.)

Please see Appendix F for a sample form to document the physician referral for audiological assessment or evaluation.

3.3. REIMBURSEMENT LIMITATIONS

3.3.1. Limitations

The following billing and reimbursement limitations apply to audiological services:

1. In general, audiology procedures cannot be fragmented and billed separately.

2. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otorhinolaryngoly services and must not be billed separately. These descriptions refer to testing of both ears.

3. Basic comprehensive audiometry includes pure tone, air and bone threshold and discrimination. These descriptions refer to testing of both ears.

4. All other audiometric testing procedures will be reimbursed on an individual basis, based on only the medical necessity of such test procedures.

5. A screening test performed separately and independently of other testing is not reimbursed under Medicaid.

6. A screening test indicating the need for additional medical examination is not separately reimbursed under the Medicaid program.

3.4. PLAN OF CARE

School corporations should send progress notes and the plan of care to each Medicaid-eligible student's primary medical provider in order to facilitate continuity of care. School corporations must obtain a signed authorization from parents/guardians prior to release of the progress notes and plan of care to the student's physician.

3.5. AUDIT REQUIREMENTS

A school corporation must maintain sufficient records to support a claim for Medicaid-covered IEP services. Please note that a copy of a completed claim form is not considered sufficient supporting documentation. The school corporation must maintain the following records at a minimum:

1. General Audit Requirements for Medicaid-covered IEP/IFSP services specified in Chapter 2, Section 7 of this Tool Kit.

2. Documentation must be qualitative as well as quantitative. Remember that an auditor has not met or seen the student. The more information the school corporation can provide related to the student's health condition, services provided and who provided the services, the easier it is for an auditor to determine whether the services for which the school corporation billed and received payment were medically necessary and in compliance with all applicable Medicaid requirements.

3. Children who are being fitted for a hearing aid must have a signed and completed Medical Clearance and Audiometric Test Form. Please note that the form must be fully completed, and Part II must be completed and signed by the physician. The form must be maintained as part of the student's medical records for audit purposes.

CHAPTER 4: PHYSICAL THERAPY SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-8; 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: 844 IAC 6

4.1. SERVICE DESCRIPTION

4.1.1. Service Definition

1. Physical therapy

   Physical therapy is a specific program to develop, improve, or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. Physical therapy services include *evaluation* and *treatment* of range-of-motion, muscle strength, functional abilities, and the use of adaptive/therapeutic equipment. Activities can include rehabilitation through exercise, massage, and the use of equipment through therapeutic activities. The student's IEP or IFSP must specify that the therapy services are health-related.

   Note Also: See Indiana Administrative Code: 405 IAC 1-11.5-2(c)(4).

2. Therapy-related services

   Therapy-related services are included in the therapy scope of practice. *These are not separately reimbursable through the Medicaid program as IEP/IFSP health-related services. School corporations cannot bill separately for therapy-related services.* Therapy-related services include, but are not limited to:
   a. Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment.
   b. Assembling and disassembling equipment.
   c. Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.
   d. Following established procedures pertaining to the care of equipment and supplies.
   e. Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.
   f. Transporting patients, records, equipment, and supplies in accordance with established policies and procedures.
   g. Performing clerical procedures in accordance with professional licensure standards.

Note: See Provider Qualifications 4.2.2.

4.1.2. Physician Orders

An order/referral signed by a physician is required upon initiation of treatment and annually thereafter. The physician's order/referral is needed only once, unless there is a significant change in the student's medical condition. Please see Appendix F for a sample form to document the physician referral for Physical Therapy services.

4.2. PROVIDER QUALIFICATIONS

4.2.1. Provider Qualifications for Therapy Services

To be eligible for Medicaid reimbursement, a physical therapy service must be performed by a licensed physical therapist or certified therapist assistant under the *direct supervision* of a licensed physical therapist.

Providers must meet all applicable state and federal laws governing Medicaid provider qualifications, licensure and practice standards set out in 42 CFR 440.110, 405 IAC 1 and 405 IAC 4, 844 IAC 6.

4.2.2. Provider Qualifications for Therapy-Related Services

Therapy-related activities may be performed by someone other than a licensed therapist or certified therapist assistant who must be under the direct supervision of a licensed physical therapist.

Therapy-related services cannot be billed separately to Medicaid.

4.3. REIMBURSEMENT LIMITATIONS

The following activities are included in reimbursement rates for physical therapy services performed by a licensed physical therapist:

1. Assisting patients in preparation for and, as necessary, during and at the conclusion of physical therapy treatment.

2. Assembling and disassembling equipment.

3. Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.

4. Following established procedures pertaining to the care of equipment and supplies.

5. Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.

6. Transporting patients, records, equipment, and supplies in accordance with established policies and procedures.

7. Performing established clerical procedures.

The therapy-related services listed above cannot be billed separately as they are included in the reimbursement for the service modality provided by the licensed physical therapist or certified physical therapy assistant under the licensed physical therapist's supervision.

4.4. PHYSICAL THERAPY EVALUATIONS

4.4.1. Service Definition

Physical therapy evaluations determine a Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. Additionally, physical therapy evaluations are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits, and limitations.

4.4.2. Service Limitations

To be reimbursed by Medicaid, a physical therapy evaluation must be conducted by a licensed physical therapist. It must be based on the physical therapist's professional judgment and the specific needs of the student. A physical therapist assistant may <u>not</u> perform an evaluation.

4.4.3. Required Components

To be reimbursed by Medicaid, an evaluation must include the following components:

1. Student's name;

2. Diagnostic testing and assessment; and

3. A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have to be a "stand alone" document. It may be a part of the plan of care, IEP or IFSP.

<u>Note:</u> See Provider Qualification 4.2.1.

4.4.4. Reimbursement

Medicaid will only reimburse for a maximum of one (1) physical therapy evaluation and one (1) re-evaluation per eligible student, per provider, per year. Evaluations and re-evaluations are limited to three (3) hours per student evaluation or re-evaluation.

4.5. PLAN OF CARE

4.5.1. Plan of Care Requirements/Recommendation for Services

If an evaluation indicates that physical therapy is warranted, the physical therapist must develop and maintain a plan of care.

The student's IEP or IFSP may suffice as a plan of care as long as the IEP or IFSP contains the required components as described in Section 4.5.3. below.

4.5.2. Provider Qualifications

Only a licensed physical therapist can initiate, develop, submit, or change a plan of care. A physical therapy assistant cannot initiate, develop, submit, or change a plan of care.

4.5.3. Plan of Care Components

A student's plan of care must include the following information:

1. The student's name.

2. A description of the student's medical condition.

3. Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of physical therapy activities the student will need.

4. Frequency and estimated length of treatments (may be total minutes per week) and the duration of treatment.
   Examples:
   a. "Treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)."
   b. "Treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)."

4.5.4. Plan of Care Approval

A student's plan of care must be signed, titled and dated by a licensed physical therapist. Initials alone are not acceptable.

An IEP/IFSP may serve as a plan of care if it meets all the components in this Section. If an IEP/IFSP is used as a plan of care, the date of the IEP/IFSP meeting, as entered on the IEP/IFSP, will suffice as a physical therapist's date for the document.

A student's plan of care along with the physician's order must be retained in the student's record.

4.5.5. Plan of Care Review

A plan of care must be updated annually. The plan of care must be updated more frequently if the student's condition changes or alternative treatments are recommended. A physician's order is needed only once, before initiation of service. However, if the student's medical condition requiring the student's therapy significantly changes then a physician's order must also be provided more frequently. School corporations should send progress notes and the annual plan of care to each Medicaid-eligible student's primary medical provider in order to facilitate continuity of care. School corporations must obtain a signed authorization from parents/guardians prior to release of progress notes and the plan of care to the student's physician.

A student's plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care.

In the event that services are discontinued, the physical therapist must indicate the reason for discontinuing treatment in the student's record.

4.5.6. Reimbursement

Medicaid does not reimburse separately for developing or reviewing the plan of care.

4.6. PHYSICAL THERAPY SESSIONS

4.6.1. Individual Therapy Sessions

1. Service limitations

   Based on the individual session codes definitions in the Current Procedural Terminology (CPT) codes, 2005, published by the American Medical Association (AMA), individual physical therapy session codes involve fifteen (15) minutes of direct contact with the student. Direct contact must be between the student and the physical therapist or physical therapy assistant under the direct, but not necessarily on-site, supervision of the licensed physical therapist.

2. Provider qualifications

   Medicaid reimburses for individual physical therapy sessions performed by a licensed physical therapist or a physical therapist assistant under the direct supervision of a licensed physical therapist.

4.6.2. Group Therapy Sessions

1. Service limitations

   Based on the individual session codes definitions in the CPT 2005, published by the AMA, group physical therapy session codes involve fifteen (15) minutes of direct contact with the student, with two (2) or more students in a session. There is no requirement that all the members of the group be eligible for Medicaid.

2. Provider qualifications

   Medicaid reimburses for group physical therapy sessions performed by a licensed physical therapist or a physical therapy assistant under the direct supervision of a licensed physical therapist.

4.6.3. Reimbursement Limitations

Reimbursement does not include telephone responses to questions, conferences with the student's parent/guardian or teacher, informing the physician of concerns, mileage, or travel time off school campus. "Therapy-related" services, listed in Section 4.3 above, <u>cannot</u> be billed to Medicaid.

4.6.4. Supervision of Physical Therapy Assistants

Medicaid reimburses for sessions performed by a physical therapy assistant at 75% of the Physical Therapist's rate for the same service if the services are rendered under the direct, but not necessarily <u>on-site,</u> supervision of a licensed physical therapist.

A licensed physical therapist must examine and evaluate the student, and complete a plan of care before a physical therapy assistant can render services.

Note: See Appendix E of this Tool Kit for physical therapy sessions CPT Codes and modifiers.

4.7. AUDIT REQUIREMENTS

4.7.1. Student Records

School corporations are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable services. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or IFSP.

Each Medicaid-eligible student's records must meet the general documentation requirements specified in Chapter 2, Section 7.2 of this Tool Kit, which would include, but is not limited to:

1. A current and valid plan of care.

2. Test results and evaluation reports.

3. Documentation describing each session as listed in the following section.

4.7.2. Documentation Components

Documentation of each individual or group session must include the following information:

1. Student's name.

2. Date of service.

3. Type of service.

4. If a group session, the number of students in the group.

5. Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with student).

6. Description of therapy activity or method used.

7. Student's progress toward established goals.

8. Signature of licensed physical therapist or therapy assistant, title and date.

All documentation must be signed, titled and dated by the provider of the services at the time services are rendered. Late entries must be noted accordingly.

Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation requirements above.

CHAPTER 5: SPEECH-LANGUAGE PATHOLOGY SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-9 and 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: 880 IAC 1-2, 880 IAC 1-2.1 (SLP Aides), 880 IAC 1-2.1-7 (SLP Aide allowable activities); 880 IAC 1-2.1-8 and 880 IAC 1-2.1-9 (delegation and supervisory responsibilities of the licensed SLP); Division of Professional Standards rules promulgated pursuant to 20-28-2-6 (formerly IC 20-1-1.4-7); see also 515 IAC 1-1-79 and 515 IAC 4-2-17

5.1. SERVICE DESCRIPTION

5.1.1. Service Definition

Speech-language pathology services involve the evaluation and treatment of speech and language disorders. Services include evaluating and treating disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, communication/ cognition (including the pragmatics of verbal communication), auditory and/or visual processing, memory/comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the student's communication needs, when appropriate. Speech-language pathology services also include the evaluation and treatment of oral pharyngeal and laryngeal sensory-motor competencies.

Services include diagnostic testing, intervention and treatment of speech and/or language disabilities.

"Speech-language pathology service" is also commonly referred to as "speech-language therapy" by school corporations and therapists.

5.1.2. Service Limitations

Evaluations and re-evaluations are limited to three (3) hours of service per evaluation or re-evaluation. Medicaid will only reimburse for one (1) evaluation and one (1) re-evaluation per student, per provider, per year.

5.1.3. Physician/Other Medical Professional Orders or Referrals

To be covered by Medicaid, speech-language pathology services must be provided pursuant to an order or referral from a physician or other licensed medical practitioner with specific practice act authority to prescribe, order or refer. The school corporation must maintain documentation of such order or referral in the student's records. Physician/other Medical Professional order or referral must be obtained upon initiation of service and annually thereafter.

Please see the sample referral forms for Speech-Language and Occupational Therapy Services in Appendix F for more information concerning which practitioners of the healing arts have practice act authority to make referrals for speech-language pathology services.

5.2. PROVIDER QUALIFICATIONS

5.2.1. Qualifications

A school corporation can bill Medicaid for IEP speech-language pathology services provided to a Medicaid-eligible student by a speech-language pathologist who is licensed by the Indiana Professional Licensing Agency (formerly the Health Professions Bureau) or the Division of Professional Standards, is providing services within his/her scope of licensure, and:

1. has a certificate of clinical competence (C's) from the American Speech and Hearing Association; or,
2. has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or,
3. has completed the equivalent educational requirements and work experience necessary for the certificate. *(Note number 3 would include those individuals who previously had the certificate but opted not to maintain it, as well as those who were qualified to obtain the certificate, but chose not to obtain it.)*

Medicaid-Qualified Speech-Language Pathologist

In addition to meeting state licensure and practice standards (in 405 IAC 1 and 405 IAC 5, 880 IAC 1-1 and 880 IAC 1.2.1, and rules promulgated by the Division of Professional Standards established under Indiana Code 20-1-1.5), all providers of *Medicaid-covered* speech-language pathology services must meet all applicable Medicaid provider qualifications, including the provisions of federal regulations at 42 CFR 440.110, which are set out in items 1. through 3. in Section 5.2.1. directly above. *Note: Medicaid's ASHA certification requirement for speech pathologists was in effect prior to 1990 when Indiana school corporations began billing Medicaid. In 2004 Medicaid added similar requirements for audiologists (see Tool Kit section 3.2.1).*

The ASHA Web site at http://www.asha.org/public/cert/ has the current academic, clinical and exam standards for the American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence in Speech-Language Pathology as well as the maintenance of certification requirements and fees. As of January 1, 2005, individuals applying for certification in speech-language pathology must: (1) have completed academic courses in areas specified by ASHA; (2) have been assessed to ensure achievement of the knowledge and skills set out in the 2005 Standards for Certification in Speech-Language Pathology in a graduate program holding accreditation by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA); and upon completion of academic course work and clinical practicum requirements, must complete a clinical fellowship under the supervision of an individual holding ASHA certification. Additionally, applicants for certification must successfully complete the Praxis exam administered by the Educational Testing Service (ETS), and exam results must be submitted directly to ASHA from ETS at least 5 years prior to application for certification and no less than two years following completion of the knowledge and skills required for certification.

Speech Pathology Support Personnel

Registered speech-language pathology support personnel may also provide services subject to 880 IAC 1-2.1 under the supervision of a certified licensed speech-language pathologist.

5.2.2. Supervision Requirements

The supervisor of an SLP Aide must provide ***direct supervision*** a minimum of 20% weekly for the first 90 days of work and a minimum of 10% thereafter; the supervisor must also review all data and documentation on clients seen for treatment every five (5) working days. The supervisor of an SLP Aide must be physically present within the same building as the SLP aide at all times when direct client care is provided, and the supervisor must directly provide 33% (1/3) of treatment weekly to each client as required by the practice standards.

The supervisor of an SLP Associate or an SLP Assistant must provide ***direct supervision*** a minimum of 20% weekly for the first 90 days of work and a minimum of 10% thereafter. Supervisors of SLP Associates and SLP Assistants must alternate supervision days and times to ensure all individuals receive direct treatment from the supervisor as required; and the supervisor must review all data and documentation on clients seen for treatment every five (5) working days. Supervision of SLP Associates and SLP Assistants means the supervisor must provide direct treatment a minimum of one time per 2 weeks to each client, as required by the practice standards, and the supervisor must always remain accessible to the supervised support personnel (i.e., the supervisor must be reachable by personal contact, telephone, pager or other immediate means).

Important Note: "***Direct supervision***" means on-site, in-view observation and guidance by the supervising speech-language pathologist while an assigned therapeutic activity is being performed.

Appendix C includes copied excerpts from the SLP Support Personnel practice act at 880 IAC 1-2.1. A complete copy of the latest version of these rules is accessible on-line at http://www.in.gov/pla/2646.htm.

5.3. SPEECH-LANGUAGE PATHOLOGY EVALUATIONS

5.3.1. Service Description

Speech-language pathology evaluations determine a Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. Additionally, speech-language pathology evaluations are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits, and limitations.

5.3.2. Provider Qualifications

Please refer to Section 5.2. of this Tool Kit chapter.

5.3.3. Required Components

To be reimbursed by Medicaid, documentation must meet the general requirements specified in Chapter 2, Section 7 of this Tool Kit, which would include, but is not limited to:

1. Student's name;

2. Diagnostic testing and assessment done; and

3. A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in student's records. A speech-language pathology evaluation does not need to be a "stand alone" document. It may be a part of the plan of care, IEP or IFSP.

5.3.4. Reimbursement Limitations

Evaluations and re-evaluations are limited to three (3) hours of service per evaluation or re-evaluation. Medicaid will only reimburse for a maximum of one (1) speech-language pathology evaluation and one (1) re-evaluation per student, per provider, per year.

Note: See Appendix E of Tool Kit for speech-language pathology evaluation CPT Codes and fee schedule.

5.4. PLAN OF CARE

5.4.1 Requirement/Recommendation for Services

If an evaluation indicates that speech-language pathology treatment is warranted, the licensed speech-language pathologist must develop and maintain a plan of care. A student's IEP or IFSP may suffice as the plan of care as long as the IEP or IFSP contains the required components described in this section (see 5.4.3. Plan of Care Components).

5.4.2. Provider Qualifications

Please refer to section 5.2.1. of this Tool Kit chapter.

5.4.3. Plan of Care Components

A student's plan of care must include the following information:

1. Student's name;

2. Description of student's medical condition;

3. Achievable, measurable, time-related goals and objectives that are related to the functioning of student and include the type of speech-language pathology activities the student will need; and

4. Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment necessary.
   Examples:
   a. "Treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)."
   b. "Treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)."

5.4.4. Plan of Care Approval

A student's plan of care must be signed, titled and dated by a licensed speech-language pathologist prior to billing Medicaid for services. An IEP/IFSP may be used as a plan of care if it meets all the above components.

A student's plan of care must be retained in the student's record and maintained for audit purposes.

5.4.5. Plan of Care Review

A student's plan of care must be updated annually or more frequently if the student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this Chapter.

A student's plan of care must be reviewed and updated according to the student's level of progress. If a determination is made during treatment that additional services are required, such services must be added to the student's plan of care. School corporations are encouraged to share progress notes and plans of care with the Medicaid-eligible student's primary medical provider to facilitate continuity of care. Please note: School corporations must obtain a signed authorization from parents/guardians prior to releasing the progress notes or plan of care to the student's physician.

In the event that services are discontinued, the licensed speech-language pathologist must indicate the reason for discontinuing treatment in the student's record.

5.4.6. Reimbursement Limitations

Medicaid does not reimburse separately for developing or reviewing a student's plan of care.

5.5. SPEECH-LANGUAGE PATHOLOGY SESSIONS

5.5.1. Service Description

In order to receive Medicaid reimbursement, speech-language pathology sessions should include procedures to maximize a student's oral functions (for example, diction, language, swallowing, and communication).

5.5.2. Provider Qualifications

Please refer to Section 5.2. of this Tool Kit chapter.

5.5.3. Individual Sessions

1. Service limitations

   Services are reimbursable per service per day unless otherwise defined in the Current Procedural Terminology (CPT) code description.

2. Provider qualifications

   Please refer to Section 5.2. of this Tool Kit chapter.

5.5.4. Group Sessions

1. Service limitations

   Group size is two (2) or more students. Services are reimbursable per service per day for each student in the group unless otherwise defined in the CPT code definition. There is no requirement that all the members of the group be eligible for Medicaid. Group speech therapy is covered in conjunction with, not in addition to, regular individual treatment. Medicaid will not pay for group therapy as the only or primary means of treatment.

   A speech-language pathology evaluation (even if the evaluation was not reimbursed by Medicaid) and plan of care must be completed for a student by a licensed speech-language pathologist prior to billing Medicaid for sessions with a student.

2. Provider qualifications

   Please refer to Section 5.2. of this Tool Kit chapter.

Medicaid reimbursement for speech-language pathology sessions does not include telephone responses to questions, conferences with a student's parent/guardian or teacher, informing a physician of concerns, mileage, or travel time off school campus. Such services cannot be billed to Medicaid.

Note: See Appendix E of Tool Kit for the speech-language pathology session CPT Codes.

5.6. AUDIT REQUIREMENTS

5.6.1. Student Records

School corporations are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable services. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or IFSP.

Each Medicaid-eligible student's records must include the general documentation requirements specified in Chapter 2, Section 7 of this Tool Kit. This would include, but is not limited to, following:

1. A current and valid plan of care;

2. Test results and evaluation reports; and

3. Documentation describing each session as listed in the following section.

5.6.2. Documentation Components

Documentation of each individual or group session must include the following information:

1. Student's name.
2. Date of service.
3. Type of service.
4. If a group session, the number of students in the group.
5. Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with student).
6. Description of therapy activity or method used.
7. Student's progress toward established goals.
8. Signature of service provider, title and date.

All documentation must be signed, titled and dated by the provider of the services at the time services are rendered. Late entries must be noted accordingly.

Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation requirements above.

All documentation must be signed, titled and dated by the provider of the services and by the supervising certified licensed pathologist if supervision is required.

CHAPTER 6: OCCUPATIONAL THERAPY SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-11 and 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: IC 25-23.5-1-6 (OT Assistant); 844 IAC 10-5 (roles & responsibilities of practitioners)

6.1 SERVICE DEFINITION

6.1.1. Service Description

"*Occupational therapy*" means the functional assessment of learning and performance skills and the analysis, selection, and adaptation of exercises or equipment for a student whose abilities to perform the requirements of daily living are threatened or impaired by physical injury or disease, mental illness, a developmental deficit, or a learning disability. The term consists primarily of the following functions:

1. Planning and directing exercises and programs to improve sensory-integration and motor functioning at a level of performance neurologically appropriate for a student's stage of development.

2. Analyzing, selecting, and adapting functional exercises to achieve and maintain a student's optimal functioning in daily living tasks and to prevent further disability.

6.1.2. Service Limitation

General strengthening exercise program for recuperative purposes are not covered by Medicaid. Also passive range of motion services are not covered by Medicaid as the only or primary modality for therapy.

6.1.3. Physician/Other Medical Professional Orders or Referrals

To be covered by Medicaid, occupational therapy services must be provided pursuant to an order or referral from a physician or other licensed medical practitioner with specific practice act authority to prescribe, order or refer. The school corporation must maintain documentation of such order or referral in the student's records. Physician/other Medical Professional orders or referrals must be obtained upon initiation of service and annually thereafter.

Please see the sample referral forms for Speech-Language and Occupational Therapy Services in Appendix F for more information concerning which practitioners of the healing arts have practice act authority to make referrals for OT services.

6.2. PROVIDER QUALIFICATIONS

6.2.1. Provider Qualifications

Occupational therapy must be provided by:

1. A Registered Occupational Therapist.

2. A Certified Occupational Therapy Assistant acting within his/her scope of practice, under the direct, on-site supervision of the Registered Occupational Therapist as prescribed by OT practice standards.

Providers must meet all applicable state and federal laws governing Medicaid provider qualifications, licensure and practice standards set out in 42 CFR 440.110, 405 IAC 1 and 405 IAC 5, and 844 IAC 10.

6.3. REIMBURSEMENT LIMITATIONS

General strengthening exercise program(s) for recuperative purposes are not covered by Medicaid. Also passive range of motion services are not covered by Medicaid as the only or primary modality for therapy.

Specific reimbursement limitations applicable to occupational therapy evaluations, sessions, and plan of care development, are addressed in the following sections.

6.4. OCCUPATIONAL THERAPY EVALUATIONS

6.4.1. Occupational Therapy Evaluation

Occupational therapy evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. Additionally, occupational therapy evaluations are used to develop baseline data to identify the need for early intervention and to address a student's functional abilities capabilities, activities performance, deficits, and limitations.

6.4.2. Service Requirements

To be reimbursed by Medicaid, the evaluation must be conducted by a registered occupational therapist. An occupational therapy assistant may not perform an evaluation.

6.4.3. Required Components

To be reimbursed by Medicaid, documentation must meet the general requirements specified in Chapter 2, Section 7 of this Tool Kit, which would include, but is not limited to:

1. Student's name.

2. Diagnostic testing and assessment.

3. A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in student's records. An evaluation does not have to be a "stand alone" document. It may be a part of a student's plan of care or IEP or IFSP.

6.4.4. Reimbursement Limitations

Medicaid will only reimburse for one (1) evaluation and one (1) re-evaluation per student, per provider, per year. In addition, reimbursement for evaluations and re-evaluations is limited to three (3) hours of service per evaluation or re-evaluation.

Note: See Appendix E of this Tool Kit for the evaluation procedure codes.
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6.5. PLAN OF CARE

6.5.1. Plan of Care Requirement

If an occupational therapy evaluation indicates that occupational therapy is warranted, the registered occupational therapist must develop and maintain a plan of care.

A student's IEP or IFSP may suffice as a plan of care if the IEP or IFSP contains the required components as described below.

6.5.2. Provider Requirements

Only a registered occupational therapist may initiate, develop, submit, or change a student's plan of care. An occupational therapy assistant may not initiate, develop, submit, or change a student's plan of care.

6.5.3. Plan of Care Components

A student's plan of care must include the following information:

1. Student's name.

2. Description of student's medical condition.

3. Achievable, measurable, time-related goals, and objectives that are related to the functioning of student and include the type of occupational therapy activities the student will need.

4. Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment.
   Examples:
   a. "Treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)."
   b. "Treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)."

6.5.4. Plan of Care Approval

A student's plan of care must be signed, titled and dated by a registered occupational therapist prior to billing Medicaid for services.

A student's IEP/IFSP may suffice as a plan of care if it meets all the requirements in this section.

A student's plan of care must be retained in the student's record and maintained for audit purposes.

6.5.5. Plan of Care Review

A plan of care is required annually, or more frequently if student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this chapter.

A student's plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to student's plan of care.

School corporations should send progress notes and the plans of care to each Medicaid-eligible student's physician in order to facilitate continuity of care. School corporations must obtain a signed authorization from parents/guardians prior to release the progress notes and plan of care to the student's physician.

In the event that services are discontinued, the registered occupational therapist must indicate the reason for discontinuing treatment in student's record.

6.5.6. Reimbursement Limitations

Medicaid does not reimburse separately for developing or reviewing a student's plan of care.

6.6. OCCUPATIONAL THERAPY SESSIONS

6.6.1. Service Description

In order to receive Medicaid reimbursement, occupational therapy sessions can include perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment, and other techniques related to improving motor development.

6.6.2. Provider Requirements

Medicaid reimburses for occupational therapy sessions provided by a registered occupational therapist or a certified occupational therapy assistant under the direct, on-site supervision of a registered occupational therapist.

6.6.3. Occupational Therapy Sessions

Medicaid reimburses for individual or group occupational therapy sessions provided by a registered occupational therapist or a certified occupational therapy assistant under the direct, on-site supervision of a registered occupational therapist.

6.6.4. Service Limitations

Services are reimbursable per service per day unless otherwise specified in the CPT code description.

Group size is two (2) or more students. There is no requirement that all the members of the group be eligible for Medicaid.

An evaluation (even if it was not reimbursed by Medicaid) and plan of care must be completed for a student by a registered occupational therapist prior to billing Medicaid for sessions with a student.

6.7. AUDIT REQUIREMENTS

6.7.1. Student Records

School corporations must maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable services.

Each Medicaid-eligible student's records must include the general documentation requirements specified in Chapter 2, Section 7 of this Tool Kit. This documentation would include, but is not limited to, following:

1. Current and valid plan of care.

2. Test results and evaluation reports.

3. Documentation describing each session as listed in the following section.

6.7.2. Documentation Components

Documentation of each individual or group session, at the time service is rendered, must include the following information:

1. Student name.

2. Date of service.

3. Type of service.

4. If a group session, the number of students in the group.

5. Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student).

6. Description of therapy activity or method used.

7. Student's progress toward established goals.

8. Signature of service provider, title and date.

All documentation must be signed, titled and dated by the provider of the services at the time service is provided. Late entries must be noted accordingly. Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation requirements above.

CHAPTER 7: BEHAVIORAL HEALTH SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-20-8; 42 CFR 440.50-440.60
LICENSURE AND PRACTICE STANDARDS: IC 25-33-1-5.1 (health service provider in psychology); IC 20-28-12 and 515 IAC 2-1 (independent practice school psychologists); 839 IAC 1 (social workers, mental health counselors, and licensed marriage and family therapists); rules promulgated by the Division of Professional Standards established under IC 20-1-1.5. See Appendix C and www.in.gov/legislative.

7.1. SERVICE DEFINITION

7.1.1. Service Description

1. Psychological/psychiatric Services

   Behavioral health services include, but are not limited to:
   a. Testing, assessment and evaluation that appraise cognitive, developmental, emotional, social, and adaptive functioning.
   b. Interviews, behavioral evaluations and functional assessments, including interpretations of information about the student's behavior and conditions relating to functioning.
   c. Therapy and counseling.
   d. Behavioral analysis/assessment and treatment/interventions.
   e. Unscheduled activities for the purpose of resolving an immediate crisis situation.

2. Behavioral Health Services

   The term "behavioral" health service is used in this Chapter as a generic term to cover the many psychological/psychiatric services (the above list consists of examples) school corporations offer to students. School corporation providers, including staff members, should be aware of the specific services their licenses or certifications allow them to provide and must work within practice parameters allowed.

   Services include psychological testing, psychiatric diagnostic interviews, examinations, and individual, group, and family psychotherapy services.

   Note: See Appendix E of this Tool Kit for behavioral health services procedure codes and definitions.

7.2. PROVIDER QUALIFICATIONS

7.2.1. Provider Qualifications

Services must be provided by or under the direction of a licensed physician, including a psychiatrist, or a psychologist endorsed as a health service provider in psychology (HSPP). "Health service provider in psychology" is a title conferred by endorsement upon Indiana psychologists who have training and experience sufficient to establish competence in an applied health service area of psychology (such as clinical, counseling, or school psychology) and who meet the experience requirements of IC 25-33-1-5.1(c).

Testing

In a July 2010 rule revision, the Indiana Office of Medicaid Policy and Planning clarified its provider qualifications for administration of psychological testing. The public notice required for state rulemaking describes the revised rule as "a technical correction to bring the rule into conformity with current practices pursuant to 405 IAC 5-20-8," … "for purposes of adding practitioners who may be reimbursed for neuropsychological and psychological testing and includes practitioner obligations."

Recopied below are subdivisions (6) through (9) of Medicaid's July 2010 rule revision that lists Medicaid-qualified providers of neuropsychological and psychological testing. [See highlighting. The entire rule is recopied in Tool Kit Appendix C, Pages *C25-C27*.]

"*(6) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:*
(A) A physician.
(B) An HSPP.
(C) A practitioner listed in subdivision (7).
(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a master's degree in a mental health field and one (1) of the following:
(i) A certified specialist in psychometry (CSP).
(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.
(8) The physician and HSPP are responsible for the interpretation and reporting of the testing performed.
(9) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed in subdivision (7)."

See the following page (7-2-2) for a list of Medicaid-qualified providers of outpatient psychotherapy services.

Psychotherapy

Outpatient group, family and individual psychotherapy can be provided by the following practitioners (referred to as "mid-level practitioners" throughout this Chapter) *under the direction of a physician or HSPP.*

1. A licensed psychologist.

2. A licensed independent practice school psychologist. (See Pages C19-25.)

3. A licensed clinical social worker.

4. A licensed marital and family therapist.

5. A licensed mental health counselor.

6. A person holding a masters degree in social work, marital and family therapy or mental health counseling.

Providers must meet all applicable state and federal laws governing Medicaid provider qualifications, licensure and practice standards set out in 405 IAC 1 and 405 IAC 5, 515 IAC 2, IC 20-28-1-11, IC 20-28-12, IC 25-33-1, 839 IAC 1, 868 IAC 1.1, and applicable rules promulgated by the Division of Professional Standards established under Indiana Code 20-1-1.5. Click on "legislative" branch at www.in.gov for current versions of state laws and rules. See also: Appendix C of this Tool Kit.

7.2.2. Supervision

The responsibilities of the physician or HSPP in supervising and directing mid-level practitioners include certifying the diagnosis and supervising the plan of treatment as follows:

1. The physician or HSPP must see the student for an initial visit/intake process or review the medical information obtained by the mid-level practitioner within seven (7) days of the intake process. If the physician or HSPP does not see the student but instead reviews the medical documentation, the review must be documented in writing.

2. At least every ninety (90) days after the intake process, the physician or HSPP must see the student or review the student's medical information and certify medical necessity on the basis of medical information provided by the mid-level practitioner. The review must be documented in writing.

7.3. REIMBURSEMENT LIMITATIONS

7.3.1. Diagnostic Interview Examinations

For psychiatric diagnostic interview examinations (see Table 1, Appendix Page E-3, procedure code 90801), Medicaid reimbursement is available for one (1) diagnostic exam per student, per provider, per rolling twelve (12) month period of time, except as follows:

1. A maximum of two (2) diagnostic exams per rolling twelve (12) month period of time per student, per provider, may be reimbursed when student is separately evaluated by both a physician or HSPP and a midlevel practitioner.

2. Of the two (2) diagnostic exams allowed, one (1) unit must be provided by the physician or HSPP and one (1) unit must be provided by the midlevel practitioner. Each "unit" of service is based on the CPT code definition and varies depending on the type of examination conducted.

Please note: Although similar procedures may be billed when performed by a midlevel practitioner, Medicaid reimburses only physicians and HSPPs for CPT© procedure codes 96101 (psychological testing) and 96116 (neurobehavioral status exam). Table 1 in Appendix E gives specific examples of billing codes and modifiers for psych services performed by practitioners other than a physician or HSPP.

To be billed to Medicaid, testing pursuant to a student's IEP must evaluate the student's health-related educational needs. Testing that evaluates strictly educational needs, for example psycho educational testing for Learning Disability, is not a medical service that can be billed to Medicaid.

7.3.2. Group therapy

Reimbursement is subject to the limitations set out in 405 IAC 5-20-8. See Appendix C, page *C21*.

7.3.3. Hypnosis and Biofeedback

Hypnosis and biofeedback are not reimbursable by the Indiana Medicaid program.

7.4 SERVICE REQUIREMENTS

7.4.1. General Service Requirements

If a Medicaid-eligible student receives counseling, therapy or behavioral treatments from a school corporation and a community mental health provider during the same time period, the services should be coordinated by both providers in order to ensure that there is no service duplication.

7.4.2. Physician/HSPP Orders for Services

As noted above, the Physician or HSPP must perform the initial visit/intake or review and sign off on the documentation of the initial visit/intake (if intake is done by a mid-level practitioner) prior to initiation of the service, within seven (7) days of the initial visit/intake.

In addition, the physician or HSPP must see the student or review the medical information and certify the medical necessity on the basis of the medical information provided by the mid-level practitioner at least every ninety (90) days.

The physician or HSPP must sign and date the documentation within the required time frames before claims for behavioral services rendered by qualified mid-level practitioners can be billed to Medicaid.

7.5. INDIVIDUAL BEHAVIORAL HEALTH SERVICES

7.5.1. Individual Behavioral Health Sessions

Individual behavioral health sessions as defined in this Chapter may be billed to Medicaid when a school corporation is rendering services to a specific Medicaid-eligible student.

7.5.2. Service Limitations

If services are provided to an individual Medicaid-eligible student, regardless of which service or combinations of services are being rendered, the school corporation must bill for an individual behavioral health session.

When a consultation is performed for an individual Medicaid-eligible student, the service is considered to be an individual session, regardless of the number of family members, school staff or providers present.

7.5.3. Service Reimbursement Limitations

Medicaid reimbursement is based on a daily reimbursement rate per service or the amount of time spent by school corporation providers with the individual Medicaid-eligible student. The CPT specifies per service per day codes as well as time-based codes.

Note: See Appendix E for individual behavioral health service procedure codes.

7.6. GROUP BEHAVIORAL HEALTH SERVICES

7.6.1. Group Behavioral Health Sessions

Group behavioral health services as defined in this Chapter may be billed to Medicaid when school corporation providers are rendering services to a group of students. Note: Services are billed only for those students in the group who are Medicaid-enrolled and only when the health-related service is required per the student's IEP.

7.6.2. Service Requirements

If services are rendered to a group of students, regardless of which service or combination of services are being rendered, a school corporation must bill the session with the proper procedure code to indicate group behavioral health services.

The group size is defined as a minimum of two (2) students. It is not required that all students in a group be eligible for Medicaid.

7.6.3. Service Reimbursement Limitations

Medicaid reimbursement is based on the amount of time spent by school corporation providers with a group of students as provided in the CPT code descriptions.

Note: See Appendix E for group behavioral health service procedure codes.

7.7 AUDIT REQUIREMENTS

7.7.1. Student Records

School corporations are required to maintain a record for each Medicaid-eligible student that includes documentation of Medicaid reimbursable behavioral services. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or IFSP.

Each Medicaid-eligible student's records must include the general documentation requirements specified in Chapter 2, Section 7 of this Tool Kit. This would include, but is not limited to, following:

1. Test and assessment results.

2. Documentation describing each behavioral service, as listed in the following sections.

7.7.2. Diagnosis Code

A statement of a DSM-IV diagnosis and code must be contained in each Medicaid-eligible student's record.

7.7.3. Documentation Components

Documentation of each behavioral service billed to Medicaid must include the following information:

1. Student's name.

2. Date of service.

3. Description of therapy or counseling session.

4. Description of student's progress toward any established goals, if appropriate (can be weekly).

5. Length of time the service was performed (time may be recorded based on start and stop times or length of time spent with the student).

6. Signature of service provider, title and date.

All documentation must be signed, titled and dated by the provider of the services at the time service is provided. Late entries must be noted accordingly. Attendance forms alone do not constitute documentation unless they meet all of the service documentation requirements above.

CHAPTER 8: NURSING SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-2; 42 CFR 440.60(a); 42 CFR 440.80
LICENSURE AND PRACTICE STANDARDS: IC 25-23-1-1.1; IC 25-23-1-11; 848 IAC 2-1-2; 848 IAC 2-2-1 through 848 IAC 2-2-3.

8.1. SERVICE DEFINITION

8.1.1. Service Description

Nursing services carry out a treatment plan developed by a physician and can include health maintenance, treatment services, health systems support, including ventilator monitoring and care, or patient health education, such as diabetes self care management training services.

To be covered by Medicaid, IEP nursing services must be performed by a licensed Registered Nurse (R.N.).

Note: See Provider Qualifications 8.2.1.

8.1.2. Service Limitations

Medicaid reimbursement for IEP nursing services is limited to services provided by a licensed Registered Nurse (R.N.) who is employed or contracted with a Medicaid-participating school corporation. Services must be medically necessary, provided pursuant to a Medicaid-enrolled student's IEP and provided in a school setting, including a field trip location and on a school bus or other school-owned vehicle as required by the IEP.

8.1.3. Physician Order

Medicaid-reimbursed IEP nursing services must be performed pursuant to a physician's order. Medicaid requires a physician's order/referral, signed by an M.D. or D.O., at least annually for all IEP nursing services, including assessment(s) and treatment. A new referral or order is required if the student's changing needs warrant revision of the IEP to include services not described in the existing physician's order/referral.

8.2. PROVIDER QUALIFICATIONS

8.2.1. Qualifications

IEP Nursing Services must be provided by a licensed Registered Nurse (R.N.) who is employed by the Local Educational Agency or working under a contract between the Local Educational Agency and (1) the nurse/individual service provider, or (2) a company that employs the nurse (for example, a nurse registry or home health agency).

Registered Nurses providing IEP Nursing Services must meet all applicable state and federal laws governing Medicaid provider qualifications, licensure and practice standards as set out in 405 IAC 5-22-2, IC 25-23-1-1.1, IC 25-23-1-11, 848 IAC 2-1-2, and 848 IAC 2-2-1 through 848 IAC 2-2-3.

8.3. REIMBURSEMENT LIMITATIONS

8.3.1. Limitations

The following billing and reimbursement limitations apply to IEP Nursing services provided by an R.N.:

1. The student's IEP must authorize the nursing service, for which there is a demonstrated medical need.

2. School corporations must bill for the appropriate start and stop times of services. The place of service must be indicated for services provided off-site (refer to Tool Kit Section 2.5.9. for Place of Service Codes).

3. When billing all nursing care services except for diabetes self-care management training (DSMT), school corporations must use the Current Procedural Terminology (CPT) ® code 99600 TD TM, which is an all inclusive code for services performed in accordance with the individual's scope of practice, including but not limited to oral or rectal medication administration and nebulizer treatment administration. See Tool Kit Page *F11* for examples of nursing services that may be billed to Medicaid.

   Aggregate total time providing IEP nursing services should be billed per day, using the appropriate CPT code and modifier to describe the service, in conjunction with the IEP-related modifier TM and the appropriate number of units of service (one unit = 15 minutes). Partial units of service must be rounded to the nearest whole unit. *A minimum of eight minutes of service must be provided to bill for one unit.*

4. If an R.N. provides diabetes self-care management training (DSMT) pursuant to a a student's IEP, then the school corporation should bill the most appropriate code along with the IEP-related modifier TM (see Appendix E, Table 5 for billing code examples). As with all IEP nursing services, DSMT must be medically necessary, ordered by a physician and included in the IEP of a Medicaid-enrolled student.

8.4. PLAN OF CARE

8.4.1. Plan of Care Requirement

For services ordered by a physician and authorized in the student's IEP, a Registered Nurse must provide Medicaid services in accordance with a plan of care developed and maintained specifically for the student. The student's Individualized Education Program (IEP) or Individualized Healthcare Plan (IHP) may suffice as this plan of care so long as it contains the required components described below.

8.4.2. Plan of Care Components

A student's plan of care must include the following information:

1. The student's name.

2. A description of student's medical condition(s).

3. A description of the nurse's assessment of the student.

4. A description of anticipated nursing treatment(s), procedures(s), interventions(s), and medication(s).

8.4.3. Plan of Care Review

A plan of care is required at least annually and must be reviewed and updated at least annually or more frequently if the student's condition changes or alternative treatments or nursing services are ordered. School corporations are encouraged to coordinate plans of care with the student's physician to facilitate continuity of care. To share copies of the plan of care or progress notes, school corporations must obtain a signed authorization from parents/guardians prior to release.

8.5. AUDIT REQUIREMENTS

8.5.1. Student Records

The school corporation must maintain sufficient records to support claims for Medicaid-covered IEP services. Please note that a copy of a completed claim form is not considered sufficient supporting documentation. The school corporation must maintain the following records at a minimum:

Each Medicaid-eligible student's records must meet the general documentation requirements specified in Chapter 2, Section 7.2 of this Tool Kit, which include but are not limited to:

1. A current and valid plan of care.

2. Test results and evaluation reports.

3. Documentation describing each session as listed in the following section.

8.5.2. Documentation Components

Documentation of each nursing service must include the following information:

1. Student's name, date of birth and medical condition/diagnosis.

2. Date, time, duration and location of the nursing service encounter.

3. Description and duration of procedures performed.

4. Progress notes.

5. Signature and credentials of the nurse who performed the service(s).

All documentation must be signed (including service provider's credentials, e.g., R.N.), and dated by the provider at the time services are rendered. Late entries must be noted accordingly. Please see Tool Kit Section 2.7.3.a. for additional information on electronic service log documentation requirements.

Note: Appendix F includes a 2-sided sample form that can be adapted for local use to document provision of IEP nursing services. See pages *F10* and *F11*.

CHAPTER 9: SPECIAL EDUCATION TRANSPORTATION SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-30-11; 42 CFR 440.170(a)
PROVIDER QUALIFICATIONS RULES: 575 IAC 1-1-1(a) through (h); 575 IAC 5

9.1. SERVICE DEFINITION

9.1.1. Service Description

Indiana Medicaid-covered Special Education Transportation Services are IEP- required services provided by a school corporation which involve a trip (1) between home and school, or (2) between school or home and an off-site Medicaid service provider, on a day when the student receives another Medicaid-covered IEP/IFSP service. Medicaid-reimbursed Special Education Transportation must be furnished by the school corporation's employee or contractor. To qualify for reimbursement, special education transportation services must meet a health-related, including behavioral, need that is documented in the student's IEP.*

Additional payment is available for an attendant, subject to the limitations in 405 IAC 5-30-8(1) and (2), provided the student's IEP includes the need for an attendant and all other Medicaid requirements are met.

*__Note__: Appendix F, Page *F6* includes suggested criteria to determine the student's health-related need for Special Education Transportation as well as additional considerations for accommodating the student's specific need(s).

9.1.2. Service Limitations

Except as listed in the next paragraph, Special education transportation services between school and home shall be limited to services provided in a type of vehicle that meets the specifications established in 575 IAC Rule 5 "Vehicles for Transporting the Handicapped" and that is appropriate to accommodate the student's disability.

Special education transportation services may be provided in any school bus that meets the definitions set out in 575 IAC 1-1-1 (a) through (h), if:

A. The child resides in an area that does not have school bus transportation but has a medical need for transportation that is noted in the IEP; or
B. The transportation is from the school to a community-based Medicaid provider such as a mental health center for purposes of receiving a Medicaid-covered service listed in the child's IEP.

Special education transportation is not covered when provided by a member of the child's family if that person is not an employee of the school corporation.

Note: Medicaid defines a trip as transporting a student from the initial point of pick-up to the drop off point at the final destination. The transportation must be the least expensive type to meet the medical needs of the student (who must be present in the vehicle), and drivers are expected to take the shortest, most efficient route to and from the destination.

9.2. PROVIDER QUALIFICATIONS

9.2.1. Qualifications

To be reimbursed by Medicaid, special education transportation services must be rendered by the school corporation's employee or contractor who meets the standards for driver personnel.

In accordance with Indiana Medicaid rules in the Indiana Administrative Code (see draft proposed rule 405 IAC 5-30-11 at Appendix C, page *C41*), school corporations are exempt from the enrollment requirements set out in 405 IAC 5-4-2, when transportation services provided are in conformance with 405 IAC 5-30-11.

Note: In addition to holding a commercial driver's license, school bus drivers must comply with State safety experience, education, and certification requirements, per IC 20-27-8. School corporations must comply with State statutory requirements at IC 9-25-4 with regard to public liability and property damage insurance covering the operation of school bus equipment.

Note also: Vehicles used for Medicaid transportation services must comply with the applicable school bus standards outlined in 575 IAC Rules 1 and 5, including Rule 5.5 applicable to vehicles ordered for purchase and initially placed in service on or after July 1, 1990.

Copies of relevant excerpts from the rules cited above are included in Appendix C.

9.3. REIMBURSEMENT LIMITATIONS

9.3.1. Limitations

Indiana Medicaid does not reimburse for special education transportation services provided by a member of the student's family if that person is not an employee of the school corporation. No reimbursement is available for tolls or parking fees. Reimbursement is not available for transfer of durable medical equipment (DME) between the student's residence and the place of DME storage.

Reimbursement for special education transportation services is subject to the requirements set forth in 405 IAC 5-30-11and when provided in accordance with Indiana Medicaid provider communications such as Indiana Health Coverage Programs (IHCP) banners, provider manuals, bulletins (*see applicable sections of BT200505*, http://provider.indianamedicaid.com/ihcp/Bulletins/BT200505.pdf) and the Medicaid provider agreement. Trips must be billed according to the level of service rendered and not according to the vehicle type. All IEP transportation services provided to the same individual on the same date of service must be billed on one claim.

Note: the student's IEP is the prior authorization for the service, and thus no additional prior authorization is necessary. IDEA/Special Education services must be provided at no cost to the student or student's family; therefore Medicaid-participating school corporations shall not collect (and their Medicaid reimbursement will be reduced by the amount of) Medicaid member copayments that may otherwise be due for IEP-required special education transportation services provided to individuals over 18 years of age.

When transporting a student to and from an off-site medical service as required by the student's IEP, waiting time in excess of 30 minutes is reimbursable only when transporting the student 50 miles or more one way and the vehicle is parked outside the medical service provider's facility awaiting the student's return to the vehicle. The first 30 minutes of wait time is not covered; however, the total waiting time must be included in the documentation/driver trip log to support the amount of waiting time billed. One unit of service is billed for every 30 minutes of wait time. When the provider has waited between 15 to 30 minutes, partial 30-minute increments should be rounded up to the next unit. Partial 30-minute increments less than 15 minutes must be rounded down.

Note: See Appendix E, Table 6 for examples of IEP Transportation billing codes. When billing for IEP-required transportation services provided to a student with a disability, school corporation claims **must add the informational modifier TM** (IEP related) to the end of the most appropriate code to describe the service provided.

9.4. AUDIT REQUIREMENTS

9.4.1. Documentation Components

Student-specific records to document special education transportation services must be maintained to provide the required audit trail for state and federal oversight agencies. At a minimum, documentation of each special education transportation service billed to Medicaid must include the following information:

1. Student's name.

2. The date of service, i.e., date of trip.

3. First and last name of special education student transported.

4. Student's Medicaid ID number *added to trip log after log turned in by driver*.

5. Street address, city and Zip code of pick up location (trip origination)

6. Street address, city and Zip code of drop off/service location (trip destination)

7. Street address, city and Zip code of return location of round trip

8. Either: (1) the vehicle odometer readings at the beginning and end of the trip; or (2) the mileage for the total trip based on mapping software; if mapping software is used it must indicate the shortest route between the specified trip origination and destination locations.

9. The driver's printed name and signature.

IMPORTANT NOTE: In addition to components listed in 1 through 8 of this section, if attendant transport is required by the student's IEP, additional documentation is required to support each claim for additional reimbursement to transport an attendant:

10. Printed name and signature of attendant accompanying the student.

NOTE: In addition to components listed in 1 through 8 (and 9 if applicable) of this section, documentation of Wait Time (only claimable when vehicle is parked outside an off-site medical service provider awaiting the student's return) must include:

11. Actual waiting time, including start and stop time, e.g., "wait time 1pm to 3pm"

12. The name and location of the off-site medical service provider, including street address, city, state and ZIP. *Note: If the service provider's name is abbreviated on the driver's log, the driver or school corporation must maintain a facility abbreviation listing to document the full name and street address of the off-site medical service provider. This will help to expedite any post payment review or audit process.*

9.4.2. Trip Log

School corporations must document provision of each special education transportation service for which Medicaid reimbursement is claimed. This documentation requirement is typically met by maintaining a daily trip log. Because drivers will not necessarily know which students are Medicaid members and on what days each special education student receives Medicaid-covered services, it may simplify the record keeping process to log all special education transportation trips to and from school as well as trips to and from another, off-site medical service provider (such as a day treatment program facility, physical therapy clinic, etc. other than on school grounds) where a student receives a health-related IEP service. ***IMPORTANT NOTE: the student's Medicaid ID number must be added to the driver's trip log AFTER the driver has turned in the log (this can be done by administrative staff in a school corporation or centralized transportation office.***

Appendix F includes sample trip log formats, one for transportation between school and home (see Page *F8)* and one for transportation to/from an off-site medical service provider to receive a Medicaid-covered IEP service (see Page *F9)*, to help organize and record the required documentation for Medicaid special education transportation services provided per a student's IEP. School corporations are encouraged to incorporate into the Transportation Department's daily work flow similar form of other means (including electronic records) for capturing the documentation components necessary to support Medicaid claims for special education transportation services. IDOE School Transportation experts suggest that Local Education Agencies may find it helpful to route Medicaid service documentation (driver trip log paperwork or electronic documentation) through the transportation office first, for accuracy/completion verification and to allow any questions or concerns to be addressed before the documentation goes forward to the Special Education Office then its final destination(s) for claiming and records retention purposes.

Note: See Tool Kit Appendix F, pages F8 and F9 for sample trip log forms to adapt for local use.

CHAPTER 10: MONITORING MEDICAID PROGRAM COMPLIANCE

10.1. AUDITS: EXTERNAL AND INTERNAL

To guard against fraud and verify proper use of public funds, various entities audit Medicaid program expenditures. These include federal agencies within the U.S. Department of Health and Human Services, such as the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) or their contractors (e.g., "MIC" Medicaid Integrity Contractors), as well as state agencies, including the State Board of Accounts, the State Inspector General, and the state Medicaid agency (Office of Medicaid Policy and Planning, "OMPP") or its contractors.

In the case of a Payment Error Rate Measurement ("PERM") audit, the federal government takes a sample of all claims paid by the state Medicaid agency to determine the accuracy of the state's payments to Medicaid providers. If a school corporation's claim(s) should be included in the sample, the school corporation will be required to provide supporting documentation for only th(os)e claim(s) sampled to assess the state's payment error rate. See also IHCP BT200735: http://provider.indianamedicaid.com/ihcp/Bulletins/BT200735.pdf.

Via desk reviews and on-site audits, Indiana Medicaid's Surveillance and Utilization Review (SUR) contractor monitors compliance with billing requirements, provides education to correct any improper coding or billing practices, and recovers any identified Medicaid overpayments. Outlined below are the basic elements that are reviewed when SUR conducts an audit. Indiana Medicaid and the Department of Education recommend using this basic information to develop or strengthen a self-audit process. Self-auditing is one way to reduce the risk of adverse findings and repayments/interest penalties in the event that your school corporation is selected for a state or federal audit. See also IHCP Provider Manual Pages 13-13 to 13-18 [July 1, 2010] http://provider.indianamedicaid.com/media/23692/chapter13.pdf.

10.1.1. Required Documentation

IMPORTANT REMINDER: Medicaid records retention requirements (7 years) DIFFER from Special Education records retention requirements (5 years). Medicaid SUR reviewers consider the following documents essential to support Medicaid claims for IEP services:

- assessments or evaluations
- appropriate orders or referrals for the services provided
- student IEPs and any health plans referenced in student IEPs
- documentation of any required oversight by a licensed therapist, HSPP, etc
- practitioner credentials, certifications, licenses
- service logs and therapist/nurse notes
- practitioner and student attendance records

See the service-specific self-audit tools on Pages 10-1-6 through 10-1-19.

In addition, SUR reviewers recommend maintaining and regularly updating the following types of internal records, which may be requested during an audit.

Document	Purpose	Recommended Update Intervals
Standard Abbreviations List	**Clarify entries in service logs**	**Update at least annually.**
Master List of Signatures and Credentials	**Verification of service provider signatures and credentials**	**Update at least monthly as staff is hired, terminated or changes positions, titles, credentials or licensure. Reconcile the master list annually to ensure accuracy of both current and historical information.**

10.1.2. Focusing the Self-Audit Process

SUR recommends using a combination of approaches to analyze billed services for program compliance. The most common internal audit programs focus on comparing billed services (from claims and remittance advices) to student records to ensure that supporting documentation is present; however, this method alone does not consistently reveal the types of utilization concerns that SUR can discover. Varying the approach can be helpful to improve internal audit effectiveness. Consider incorporating one or more of these additional review methods when developing a comprehensive self-audit process:

1. Oversight and Supervision – Evaluate whether individual therapists and Health Service Providers in Psychology (HSPPs) can adequately oversee the volume of cases they are assigned to supervise.

> *Note*: Medicaid rules require direct supervision of certain mid-level practitioners by a physician, HSPP or licensed therapist as specified in Medicaid rules.

> *Note regarding Mental Health/Behavioral services*: Medicaid rules require the supervising physician or HSPP to see the student at initial intake or review the student's medical information (obtained by a mid-level practitioner) within seven (7) days of intake. Additionally, every ninety (90) days the supervising physician/HSPP must see the student or review his/her medical information and certify the medical necessity of services. See more detailed information in Tool Kit Chapters 3 through 9.

2. Type of Service – Compare IEP/health plans and frequency of services for students with similar health-related special education needs. Alternatively, review all speech services billed, or all OT services billed, to look for patterns or inconsistencies.

3. Attendance – Compare service logs and attendance records to verify services were billed only for days the student and practitioner attended school; verify that service logs note the place of service for any care provided off-site and that claims for off-site services were billed with the correct place of service code.

4. Evaluation and Treatment – Compare the IEP and health care plan (if referenced in the IEP) with the initial and subsequent evaluation results to analyze whether services billed

adequately address the student's needs, whether progress is being made toward treatment goals, and if changes in the student's medical condition are identified and addressed.

5. Automated Billing System – Compare the service-related information in your/your billing agent's automated billing system with the actual descriptions published in the applicable annual procedure code book (e.g., *Current Procedural Terminology* © published by the American Medical Association, and *Healthcare Common Procedure Coding System* published by the Centers for Medicare and Medicaid Services or CMS). Verify that the code descriptions are consistent with published guidelines and that the system accurately reflects, for each procedure, the units of service or time increment billing basis designated in the applicable publication. Recognize that billing companies work in and systems are designed for use in more than one state. Because no two states' Medicaid programs are identical, automated systems designed for use in another state or in multiple states may need to be customized for use in Indiana. Be familiar with Indiana Medicaid billing and coding requirements for the types of services provided by your school corporation (see Tool Kit Chapters 3-9 and the Tool Kit Appendices) and ensure that the system you use accurately reflects *Indiana* Medicaid billing and coding requirements. Finally, verify that electronic billing transactions comply with HIPAA requirements (refer to the HIPAA and FERPA section later in this chapter).

See the service-specific self-audit tools on Pages 10-1-6 through 10-1-19.

Note that the school corporation, and not the billing agent, is ultimately responsible for appropriate and accurate billing. If the billing agent works in other states or other districts that have been audited, it may be helpful to review any adverse audit findings with the contractor. Additionally, check to be sure your billing agent:

- complies with the terms of its agreement/contract with the school corporation
- continually reviews Medicaid policies, rules, laws and publications, and maintains billing practices that comply with *Indiana* Medicaid requirements
- verifies the student's Medicaid eligibility on the date of Medicaid service(s) billed
- routinely provides the school corporation with records of services/amounts billed
- notifies the school corporation of any billing errors immediately upon discovery

10.1.3. Pulling an Internal Audit Sample

There are various methods for audit sampling, and it can be helpful to vary your approach. In general, a minimum sample of five percent (5%) is recommended when pulling records for review. Various approaches may include: a 5% overall sample; a 5% sample drawn from records of each type of service provided (e.g., 5% of OT, 5% of Speech); 5% sample per practitioner (e.g., 5% of records of services provided by PT Jane Doe, 5% of records of services provided by HSPP Jim Doe). Increasing the sample size improves the likelihood of catching errors or inconsistencies. The goal of sampling and internal auditing is to correct errors or inconsistencies and refund any identified overpayments.

10.1.4. What to Expect if Selected for Audit

In most cases, you will be notified that your school corporation has been selected for audit via a letter mailed to the address stored in your Medicaid provider enrollment file. However, on rare occasions, auditors can arrive unannounced.

Keep the Indiana Medicaid Provider Enrollment Unit updated regarding address changes.

The narrative at the top of page 10-1-5 shares some insights gained from the Medicaid audit experience of a large urban Indiana school corporation.

Lessons Learned from a Medicaid Audit

Larry Bass, Director, Evansville-Vanderburgh Special Education

Don't wait until the audit notification to consider location and storage of records. Devise a 'game plan' to coordinate and retrieve data. Realize that records needed may be in schools or in storage somewhere else, may be digitized, may require that a 'complete' profile may need to be pulled from several locations. School records are not kept in a single file such as in a doctor's office or medical records office, which is what the auditors are typically looking for and which is part of the reason they may struggle with the way you maintain and retrieve records. School records may be utilized by multiple individuals in multiple locations over time and are moved back and forth frequently. Itinerants may be involved who serve multiple locations and often like to keep their 'own' records separately for many reasons, including convenience of reference and retrieval. And finally, remember that the audit range can be 2 or more years in the past.*

It might be a good idea to spend some time orienting the auditors to the IEP process if they feel that would be helpful. It is not a familiar document to them. And since I was going to be held accountable for their contents relative to billing practices, I wanted to make sure the auditors knew where/what to look for. They were attentive and appeared to appreciate the effort.

I thought I would feel more comfortable going into the audit process if I knew where my problems were; so I went through all the documents beforehand. Although it was very time consuming to do that, I think it was time well spent because I wanted to know what they were going to find before they found it, and I wanted to be able to feel confident that at least we had done all we could do to prepare. It also helped to know so that when the auditors asked questions about why things were and were not done a certain way, I could give them a better answer.

Prior to the audit, our therapists were entering data directly into our billing agent's system. After the audit, because of discrepancies in the way some therapists documented and subsequently entered data, I made a conscious decision to require documentation in a certain way from everyone and that they sign off on their service records and submit them to the central office for data entry.*

Anything done to bring consistency in the way services are billed is a good thing.

Editor's notes: Keep an eye out for audit notifications in the mail (they have been mistaken for contractor solicitations and ignored). Generally, a written notice will announce when the auditors will arrive (typically within the next two to three weeks) and give the date span of the audit period. It can take a very long time (months/years) for audit findings to be finalized and reported.

10.1.5. Self-Audit Tools: Documentation Checklists and Internal Audit Guidelines

Pages 10-1-6 through 10-1-19 contain samples of service-specific documentation checklists and internal audit guidelines that can be adapted for use in self-auditing and internal program compliance monitoring by Medicaid-participating school corporations.

Medicaid Documentation Checklist for IEP Audiology Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate order for service: Audiology orders must be signed by a physician (M.D. or D.O.). The referring physician must complete Part 2 of Medicaid's Medical Clearance and Audiometric Test Form no earlier than six (6) months prior to provision of a hearing aid. Children fourteen (14) years of age and under must be examined by an otolaryngologist.

□ A copy of the signed parental consent for Medicaid billing.

□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.

□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider); *if applicable, maintain a key to explain abbreviations/codes used by individual practitioners to document attendance, services, progress, etc.*

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.

□ Report/copy of initial evaluation and outcome, including if applicable, reports of outside evaluations conducted prior to initial placement and considered for eligibility determination.

□ Attendance records for student and providers of school-based audiology services.

□ Copy of service providers' license(s)/certification(s) at time of service provision:
Medicaid-reimbursed audiology services must be provided by a licensed otolaryngologist or Medicaid-qualified audiologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed. A hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist. The results must be documented and indicate that significant benefit can be derived from amplification.*
**A Medicaid-qualified audiologist must have a master's or doctoral degree in audiology and either:*
(1) a Certificate of Clinical Competence in Audiology granted by ASHA, or
(2) successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or in the process of accumulating that clinical experience under the supervision of a qualified master or doctoral level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral level audiologist after obtaining a master's or doctoral degree in audiology or a related field; and successfully completed a national exam in audiology approved by the Secretary, U.S. Dept. of Health and Human Services.

□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.**

□ Copies of Medicaid Remittance Advice statements.**

□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

**These records may be kept by a billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed **Audiology** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or service provider notes) available to verify the time spent? *Educate staff on supporting documentation for time sensitive procedure codes.*

3) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with CPT coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or therapist/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the audiology component of the IEP developed logically based on all the assessments/evaluations of the student?
2) Is there documentation in the student's file of an appropriate order for audiology services (initial evaluation and treatment services)? *Note: An otolaryngologist must examine a child age 14 or under.*
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals, and are changes in the student's condition noted?
2) Does the initial evaluation support the medical necessity of the Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each practitioner's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and provider attendance on service dates. If siblings receive services in the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for
IEP Behavioral/Mental Health Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate referral/order for service: mental health/behavioral service referrals must be signed by a physician (M.D. or D.O.) or Health Service Provider in Psychology (HSPP).
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider & supervisor's* signature for service providers requiring direct supervision by a physician or HSPP); *if applicable, maintain a key to explain abbreviations/codes used by individual practitioners to document attendance, services, progress, etc.* *The supervising physician/HSPP must see the student at intake or review the student's medical records within 7 days of intake, and for ongoing services, see the student or review the medical records every 90 days thereafter.

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.
□ Report/copy of initial evaluation and outcome, including if applicable, reports of outside evaluations conducted prior to initial placement and considered for eligibility determination.
□ Attendance records for student and providers of school-based mental health services.
□ Copy of service providers' license(s)/certification(s) at the time of service provision: *Medicaid-reimbursed behavioral services must be provided by or under the direction of a licensed physician, including a psychiatrist, or a psychologist endorsed as a health service provider in psychology. Outpatient group, family and individual psychotherapy can be provided by the following mid-level practitioners under the direction of a physician or HSPP: (1) a licensed psychologist, (2) a licensed independent practice school psychologist, (3) a licensed clinical social worker, (4) a licensed marital and family therapist, (5) a licensed mental health counselor, (6) a person holding a masters degree in social work, marital and family therapy or mental health counseling.*
□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a claim preparation/billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed Behavioral/**Mental Health** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or practitioner notes) to verify the time spent? Were mid-level practitioner services billed with the correct modifier(s), and is required supervision documented in the service log? *Educate staff on supportive documentation for time sensitive procedure codes and mid-level practitioner services supervision requirements.*

3) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with CPT coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or service provider/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the mental health component of the IEP developed logically based on all the assessments or evaluations of the student?
2) Is there documentation in the student's file of an appropriate order for behavioral/mental health services (for initial evaluation and ongoing treatment services)?
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs (*is treatment plan reviewed every 90 days*)?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial eval and initiation of services, is there ongoing assessment, at least every 90 days, of progress toward goals? Are changes in the student's condition/behavior noted?
2) Does the initial eval support the medical necessity of Medicaid-billed services included or authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each provider's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and provider attendance on service dates. If siblings receive services at the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for
IEP Nursing (R.N.) Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate referral/order for service: Referrals for nursing (R.N.) services must be signed by a physician (M.D. or D.O.).
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a Registered Nurse (R.N.), progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider); *if applicable, maintain a key to explain abbreviations/codes used by individual practitioners to document attendance, services, progress, etc.*

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.
□ Report/copy of initial evaluation/assessment and outcome, including, if applicable, reports of outside evaluations conducted prior to initial placement/considered for eligibility determination.
□ Attendance records for student and provider(s) of school-based nursing (R.N.) services.
□ Copy of service providers' license(s)/certification(s) at time of service provision: *Medicaid-reimbursed nursing services must be provided by a licensed Registered Nurse.*
□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed **Nursing (R.N.)** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or nurse's notes) available to verify the time spent? *Educate staff on supportive documentation for time sensitive procedure codes.*

3) Does the service documentation content accurately match the billed procedure/revenue code description? *Ensure compliance with applicable coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or nurse/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the nursing component of the IEP developed logically based on all assessments/evaluations of the student?
2) Is there documentation in the student's file of an appropriate order for nursing services (initial assessment and treatment services)?
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals, and are changes in the student's condition noted?
2) Does the initial evaluation support the medical necessity of the Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each nurse's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and nurse attendance on service dates. If siblings receive services in the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for
IEP Occupational Therapy Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate referral/order for service: OT referrals must be signed by a physician (M.D. or D.O.), school psychologist or Health Service Provider in Psychology (HSPP).
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider & supervisor's signature for service providers requiring direct supervision by a registered occupational therapist); *if applicable, maintain a key to explain abbreviations/codes used by individual therapists to document attendance, services, progress, etc.*

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.
□ Report/copy of initial evaluation and outcome, including if applicable, reports of outside evaluations conducted prior to initial placement and considered for eligibility determination.
□ Attendance records for student and providers of school-based occupational therapy services.
□ Copy of service providers' license(s)/certification(s) at time of service provision:
To be eligible for Medicaid reimbursement, an occupational therapy service must be performed by a Registered Occupational Therapist or Certified Occupational Therapy Assistant acting within his/her scope of practice under the direct, on-site supervision of a Registered Occupational Therapist.
□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a claim preparation/billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed **Occupational Therapy** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or therapist notes) available to verify the time spent? If an assistant provided service, was it billed with the correct modifier(s), and is the required supervision documented in the service log? *Educate staff on supporting documentation for time sensitive procedure code and, assistants' service provision.*

3) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with CPT coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or therapist/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the OT component of the IEP developed logically based on all assessments/evaluations of the student?
2) Is there documentation in the student's file of an appropriate order for occupational therapy services (initial evaluation and treatment services)?
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals and are changes in the student's condition noted?
2) Does the initial evaluation support the medical necessity of the Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each therapist's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and therapist attendance on service dates. If siblings receive services at the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for
IEP Physical Therapy Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate referral/order for service: PT referrals must be signed by an M.D., D.O., podiatrist, chiropractor, Health Service Provider in Psychology (HSPP) or dentist.
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider & supervisor's signature for service providers requiring direct supervision by a licensed physical therapist); *if applicable, maintain a key to explain codes or abbreviations used by individual therapists to document attendance, services, progress, etc.*

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.
□ Report/copy of initial evaluation and outcome, including if applicable, reports of outside evaluations conducted prior to initial placement and considered for eligibility determination.
□ Attendance records for student and providers of school-based physical therapy services.
□ Copy of service providers' license(s)/certification(s) at time of service provision:
To be eligible for Medicaid reimbursement, a physical therapy service must be performed by a physical therapist licensed in Indiana or a certified physical therapist assistant under the direct supervision of a licensed physical therapist.
□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a claim preparation/billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed **Physical Therapy** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or therapist notes) available to verify the time spent? If an assistant provided service, was it billed with the correct modifier(s), and is the required supervision documented in the service log? *Educate staff on supportive documentation for time sensitive procedure codes an assistants' service provision.*

3) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with CPT coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or therapist/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the PT component of the IEP developed logically based on all assessments/evaluations of the student?
2) Is there documentation in the student's file of an appropriate order for physical therapy services (initial evaluation and treatment services)?
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals and are changes in the student's condition noted?
2) Does the initial evaluation support the medical necessity of the Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each therapist's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and therapist attendance on service dates. If siblings receive services at the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for IEP Speech Therapy Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for medical services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ Appropriate referral/order for service: Speech referrals must be signed by a physician (M.D. or D.O.), school psychologist, or Health Service Provider in Psychology (HSPP).
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider & supervisor's signature for service providers requiring direct supervision by a licensed pathologist); *if applicable, maintain a key to explain abbreviations/codes used by individual practitioners to document attendance, services, progress, etc.*

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.
□ Report/copy of initial evaluation and outcome, including if applicable, reports of outside evaluations conducted prior to initial placement and considered for eligibility determination.
□ Attendance records for student and providers of school-based speech therapy services.
□ Copy of service providers' license(s)/certification(s) at time of service provision:
Medicaid-Qualified speech-language pathologists must be licensed in Indiana and have:

1. *a certificate of clinical competence (CCC's) from the American Speech and Hearing Association; or,*
2. *completed the academic program and acquiring supervised work experience to qualify for the certificate; or,*
3. *completed the equivalent educational requirements and work experience necessary for the certificate (e.g., those who previously had or were qualified for but did not obtain/renew the certificate).*

Registered speech-language pathology aides may also provide services subject to 880 IAC 1-2 under direct, on-site supervision of a qualified and licensed speech-language pathologist.
□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a claim preparation/billing contractor or other fiscal agent.

Internal Audit Guidelines
Medicaid-reimbursed **Speech Therapy** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider? Are the provider's credentials indicated? If not, is documentation available to verify credentials? *Educate staff regarding inclusion of credentials with signature/initials.*

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or provider notes) available to verify the time spent? If service was provided by an aide, was it billed with the correct modifier(s), and is required supervision documented in log? *Educate staff on supportive documentation for time sensitive procedure codes and aides' service provision.*

3) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with CPT coding guidelines for procedure codes billed.*

4) Does the date of service billed match the date of service documented? *Is there any contradiction in the file, such as cancellation or provider/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

Treatment Plan/IEP Review (*evaluate each plan/IEP and compare to billing*):
1) Was the speech component of the IEP developed logically based on all assessments/evaluations of the student?
2) Is there documentation of an appropriate order for speech pathology services (initial evaluation and treatment)?
3) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
4) Is there evidence of monitoring to ensure that the services provided are appropriate (in amount, duration and frequency) to meet the student's needs (*is there individual in conjunction with group therapy*)?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals and are changes in the student's condition noted?
2) Does the initial evaluation support the medical necessity of the Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support medical necessity?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether each provider's case load is reasonable. *Can s/he adequately manage the volume of assigned cases? How does his/her performance compare with that of peers?*
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and provider attendance on service dates. If siblings receive services at the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

Medicaid Documentation Checklist for IEP-required Special Education Transportation Services

Medicaid-participating school corporations ***must safeguard and be able to produce all documentation*** *required to support claims for services billed to Medicaid.*
This documentation must be available for 7 years from the date of service.

Medical necessity and service authorization:

□ The student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) must describe the medical (including physical disability or behavioral health) need for the Special Education transportation service required to accommodate the individual student.
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: reevaluations, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence (i.e., clinician's service documentation) that the student received another Medicaid-covered IEP service on the date(s) when Special Education transportation services were provided; *if applicable, maintain a key to explain abbreviations/codes used by individual drivers and practitioners to document attendance, student rode bus that day, services, progress, etc.*

Special Education Transportation service provision to a Special Education student:

□ Student's name and date of birth.
□ *Student's Medicaid ID number was added to trip log after the log was turned in by driver.*
□ Copy of date-of-service-specific transportation documentation/trip log.
□ Attendance records for student and providers of school-based transportation and other Medicaid-covered IEP services.
□ Copy of service providers' license(s)/certification(s) at time of service provision:
Medicaid-reimbursed Special Education transportation services must be rendered by the school corporation's employee or contractor who meets the standards for driver personnel. In addition to holding a commercial driver's license, school bus drivers must comply with State safety experience, education, and certification requirements, per IC 20-27-8-10 and 20-27-8-15. School corporations must comply with State statutory requirements at IC 9-25 with regard to public liability and property damage insurance covering the operation of school bus equipment.

Vehicles used for Medicaid transportation services must comply with the applicable school bus standards outlined in 575 IAC Rules 1 and 5, including Rule 5.5 applicable to vehicles ordered for purchase and initially placed in service on or after July 1, 1990.
□ File copy of transportation service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.*
□ Copies of Medicaid Remittance Advice statements.*
□ Copies of DOESA54 reports showing Medicaid state share contribution from tuition support funding (these reports may be on file with the school financial officer).

*These records may be kept by a claim preparation/billing contractor or other fiscal agent.

Internal Audit Guidelines

Medicaid-reimbursed Special Education **Transportation** Services

Claim Specific Review (*evaluate documentation and compare to billing*):
1) Is service documentation legible, signed/dated by the service provider/driver? *Educate staff regarding signing and dating the service log(s) and ensuring legibility.*

2) Does the content of the service documentation accurately match the description of the procedure code billed? *Ensure compliance with guidelines for procedure codes billed.*

3) If additional reimbursement was claimed for wait time and/or an attendant, is there documentation to verify each? Were these billed with the correct modifier(s)? *Educate staff on maintaining service log/supportive documentation for wait time and transportation including an attendant.*

4) Does the date of service billed match the date of service documented? Does the school also have documentation that the student received another Medicaid-covered IEP service that day? *Is there any contradiction in the file, such as cancellation or provider/student absence noted?*

5) If a late service log entry is made (e.g., a subsequent change or addition to an existing record), is it appropriately documented and consistent with school policy?

IEP Review (*evaluate each IEP and compare to billing*):
1) Was the need for transportation service, including needed accommodations such as an attendant, seat belt, oxygen, etc., logically based on assessments/evaluations of the student?
2) Are the services billed to Medicaid listed/authorized in the student's IEP or in an IHP that is incorporated into the IEP by reference?
3) Is there evidence of monitoring to ensure that the services provided are appropriate to accommodate the student's needs?

Assessment Review (*evaluate assessment; compare assessments with IEP*):
1) Following the initial evaluation and initiation of services, is there ongoing assessment of progress toward goals and notes regarding changes in the student's condition which might impact the need for transportation services?
2) Does the initial evaluation support the medical, including behavioral, need for Medicaid-billed services included/authorized in the student's IEP? Do ongoing progress notes continue to support this need?

Vary the Focus of Internal Audit Reviews:
* Evaluate whether vehicles and drivers meet the applicable standards in the Indiana Department of Education's rules.
* Compare services billed to hours worked. Review notes and service logs for a specific day/week for overlapping times; verify student and provider attendance on service dates; verify that the student received another Medicaid-covered IEP service on the date of transportation. If siblings receive services at the same school, check that claims were billed correctly for each and not duplicated.

FINAL STEP: Revise procedures, educate staff, improve forms/protocols based on findings. *Work with billing agent and school financial officer to refund to Indiana Medicaid any identified overpayments, duplicate payments or incorrectly billed amounts.*

10.2. HIPAA AND FERPA

10.2.1. HIPAA Electronic Transmissions and Claims Transactions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines an electronic health care transaction as "the transmission of information between two parties to carry out financial or administrative activities related to health care." 42 CFR § 160.103. When engaging in electronic transactions, e.g.., to verify Medicaid eligibility or submit claims, Medicaid-participating school corporations and their billing agents must comply with HIPAA rules governing (1) electronic transactions and code sets (the "TCS Rule," 42 CFR 162, et seq.), and (2) security of information transmitted electronically ("the Security Rule," 42 CFR 164, et seq.). Just as the Security Rule requires protection of electronically transmitted health information, the HIPPA Privacy Rule requires safeguards for paper and other non-electronic health records.

However, individually identifiable health information in a student education record protected under the Family Educational Rights and Privacy Act (FERPA) is not subject to the HIPAA Privacy rule. *Please refer to Section 10.2.2. for a discussion of HIPAA and FERPA privacy protections.*

The TCS Rule requires the use of standardized national billing codes and modifiers in electronic health care transactions. The Security Rule sets out security standards for administrative, physical and technical safeguards of electronically transmitted individually identifiable health information. Required administrative safeguards include policies and procedures for identifying who may have access to electronic health records; physical safeguards concern placement of equipment; and technical safeguards focus on controlling access to computer systems or software and protected communications.

School corporations that employ a billing agent to submit electronic claims on their behalf must require the billing company to comply with HIPAA TCS and Security Rule provisions. If the school corporation itself operates an electronic billing system or otherwise engages in electronic health care transactions, it must use HIPAA compliant transactions and code sets as well as safeguard electronic information in accordance with HIPAA security requirements.

The Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services, provides overviews and guidance on its TCS and Security Rules at the following web sites:

http://www.cms.hhs.gov/TransactionCodeSetsStands/

http://www.cms.hhs.gov/SecurityStandard/

10.2.2. HIPAA versus FERPA Privacy Protections and Student Health Records

A public school corporation or charter school that receives federal education funds is required, by the Family Educational Rights and Privacy Act (FERPA), to ensure that personally identifiable information from a student's education record is not disclosed improperly. Similarly, the Health Insurance Portability and Accountability Act of 1996

(HIPAA) requires health care providers to safeguard individually identifiable "Protected Health Information." Both federal laws are clearly intended to protect individuals' private health records from improper disclosure. As indicated in Section 9.2.1. above, Medicaid-participating public schools must comply with the HIPAA security rule when engaging in *electronic* health care transactions (for example, electronic data transactions to submit claims or verify eligibility/coverage), however, FERPA, not HIPAA, privacy requirements apply to non-electronically transmitted student education records, including Special Education records, for purposes of disclosing individually identifiable information.

The following excerpts are taken from the preamble to Final Rules addressing HIPAA privacy standards for individually identifiable health information. *Federal Register* Volume 65, Number 250 (12-28-2000).

> "FERPA, as amended, 20 U.S.C. 1232g, provides parents of students and eligible students (students who are 18 or older) with privacy protections and rights for the records of students maintained by federally funded educational agencies or institutions or persons acting for these agencies or institutions. We have excluded education records covered by FERPA, including those education records designated as education records under Parts B, C, and D of the Individuals with Disabilities Education Act [IDEA] Amendments of 1997, from the definition of protected health information. For example, individually identifiable health information of students under the age of 18 created by a nurse in a primary or secondary school that receives federal funds and that is subject to FERPA is an education record, but not protected health information. Therefore, the privacy regulation does not apply. We followed this course because Congress specifically addressed how information in education records should be protected in FERPA.
>
> We have also excluded certain records, those described at 20 U.S.C. 1232g(a)(4)(B)(iv), from the definition of protected health information because FERPA also provided a specific structure for the maintenance of these records. These are records (1) of students who are 18 years or older or are attending post-secondary educational institutions, (2) maintained by a physician, psychiatrist, psychologist, or recognized professional or paraprofessional acting or assisting in that capacity, (3) that are made, maintained, or used only in connection with the provision of treatment to the student, and (4) that are not available to anyone, except a physician or appropriate professional reviewing that record as designated by the student. Because FERPA excludes these records from its protections only to the extent they are not available to anyone other than persons providing treatment to students, any use or disclosure of the record for other purposes, including providing access to the individual student who is the subject of that information, would turn the record into an education record. As education records, they would be subject to the protections of FERPA."
>
> "While we strongly believe every individual should have the same level of privacy protection for his/her individually identifiable health information, Congress did not provide us with authority to disturb the scheme it had devised for records maintained by educational institutions and agencies under FERPA. We do not believe Congress intended to amend or preempt FERPA when it enacted HIPAA.

> With regard to the records described at 20 U.S.C. 1232(g)(4)(B)(iv), we considered requiring health care providers engaged in HIPAA transactions to comply with the privacy regulation up to the point these records were used or disclosed for purposes other than treatment. At that point, the records would be converted from protected health information into education records. This conversion would occur any time a student sought to exercise his/her access rights. The provider, then, would need to treat the record in accordance with FERPA's requirements and be relieved from its obligations under the [HIPAA] privacy regulation. We chose not to adopt this approach because it would be unduly burdensome to require providers to comply with two different, yet similar, sets of regulations and inconsistent with the policy in FERPA that these records be exempt from regulation to the extent the records were used only to treat the student."

Information published by the National Association of School Nurses states, "school districts that bill Medicaid," or otherwise do business with an entity covered by HIPAA, 'are encouraged to employ HIPAA privacy standards, even if they are not required to do so by law. Such compliance demonstrates the district's respect for the sensitivity and confidentiality of student health information, augments their procedural compliance with FERPA, and enhances trust and communication among schools, parents, students, and health care providers." Included below are suggested practices (from Guidelines for Protecting Confidential Student Health Information, ASHA), which schools may adopt to safeguard protected health information from inadvertent/unauthorized disclosure.

- Distribute individualized 504, education and health care plans to staff only as necessary to communicate the health and safety need of the student named therein, instead of circulating a list of students with their medical conditions.
- Handle health information obtained from students and families in a private, confidential manner. For example, conversations with students and families should occur in private, and when talking with families on the telephone, make calls from a private office. Staff opening mail and handling faxes should be educated about the importance of securing private health information and not leaving it open on desks or fax machines. Typed information and information on computer screens should be covered or positioned to protect it from casual observers.
- Store student health information in locked file cabinets and secure computer files with restricted access. FERPA {Sec.99.32(a)(1)} requires that each record have an access log, stating the name and title of the person receiving the information, the date of access, and the 'legitimate interest' for requesting the information. Although this does not apply to the person who created the record, it does include other school staff, and for any record that is copied or released to individuals outside the school, there must be a written parental consent for and description of the nature of the disclosure.
- Individual school health records that are transferred to another school should be sealed in an envelope labeled "CONFIDENTIAL for School Nurse" and included with the education record.

See also: http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf .

10.3. FALSE CLAIMS ACT

Applicable Only if the School Corporation's Medicaid Payments Total $5 Million or More Annually

10.3.1. Employee Education about False Claims Recovery

Section 6032 of the Deficit Reduction Act (DRA) of 2005 established section 1902(a)(68) of the Social Security Act, which relates to "Employee Education About False Claims Recovery." Beginning January 1, 2007, a governmental component providing health care items and services for which Medicaid payments are made (e.g., a school corporation) qualifies as an "entity" and must comply with the requirements of section 1902(a)(68) **if its annual Medicaid payments total at least $5,000,000 in any given federal fiscal year** (October 1 through September 30). Please refer to the Indiana Health Coverage Programs (IHCP) provider bulletin on this topic, as well as item #44 in the IHCP Provider Agreement, both of which can be viewed on-line at www.indianamedicaid.com.

There is no training requirement to comply with DRA Section 6032. "Education" refers only to providing information to employees, contractors and agents involved in providing health care items and services, monitoring health care provision and billing or coding for health care items and services. Social Security Act Section 1902(a)(68) requires an entity whose annual Medicaid payments total at least $5,000,000 to "establish and disseminate" (in paper or electronic form) written policies concerning detecting and preventing waste, fraud and abuse. These written policies must be readily available to all employees (including management), contractors (including contracted therapists) or agents (including claim billing agents) involved in health care provision, monitoring, billing or coding, and these written policies must be adopted by the entity's contractors or agents. There is no requirement to create an employee handbook if none already exists. However, any existing employee handbook must include a specific discussion of the entity's written policies concerning detecting and preventing waste, fraud and abuse; the laws described in such written policies; and the rights of employees to be protected as whistleblowers.

10.3.2. Federal and State False Claims Acts

The federal False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, provides that "(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government,…a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;… or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,… is liable to the United State government for a

civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person." For purposes of this section of the Act, "the terms 'knowing' and 'knowingly' mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required."

Thus, federal law imposes liability on any person who submits (or causes a contractor to submit) a Medicaid claim that s/he knows, or should know, is false. An example would be a school corporation employee who bills or directs a contractor to bill for medical services he or she knows were never provided. The school employee is similarly liable if s/he falsifies service logs or student health records to support a fraudulent Medicaid claim or knowingly conceals or falsifies information in order to avoid having to refund a Medicaid overpayment.

The federal False Claims Act further provides that a private party may bring an action on behalf of the United States Government. 31 U.S.C. 3730(b). Such a private party, typically referred to as a whistleblower or "qui tam relator," can share in the proceeds from an FCA action or settlement. The FCA also provides protection against and remedies for retaliation (such as discharge, demotion, suspension, threats, harassment or discrimination in terms and conditions of employment) against a qui tam relator for having acted on behalf of the government. 31 U.S.C. 3730(h).

The similar Indiana False Claims and Whistleblower Protection Act (IC 5-11-5.5) is a civil statute that helps the state combat fraud and recover losses resulting from fraud against the Indiana government. Violations of the Indiana False Claims and Whistleblower Protection Act include: presenting a false claim to the state for payment or approval; making or using a false record or statement to obtain payment or approval of a false claim; making or using a false record or statement to avoid an obligation to pay or transmit property to the state; and conspiring with, causing or inducing another person to commit any of the aforementioned violations. The state law allows individuals (or qui tam plaintiffs) with information concerning fraud to file a lawsuit on behalf of the state, and protects qui tam plaintiffs who provide information to the state. A whistleblower may have to pay the defendant its fees and costs if an action is determined to be frivolous or brought primarily for purposes of harassment, or if the whistleblower is found to have planned, initiated or been a conspirator in the violation.

10.3.3. Typical False Claims Act-related Policies

As stated in Section 9.3.1. above, school corporations that receive $5,000,000 in total annual Medicaid reimbursements are obligated, under Section 6032 of the Deficit Reduction Act (DRA) of 2005, to establish and disseminate to all employees, contractors and agents (who are involved in providing, monitoring, coding or billing health care services) written policies concerning detecting and preventing waste, fraud and abuse. The $5,000,000 threshold is determined by the total state and federal share of Medicaid reimbursement amounts paid to your school corporation in a federal fiscal year (October 1 through September 30). These written policies may be in paper or electronic form, and they must be (1) readily available to all employees, contractors and agents to whom you are obligated to disseminate such policies, and (2) included in any existing employee handbook (you need not create an employee handbook if one does not exist).

There have been no templates or suggested best practices issued by federal Medicaid officials at CMS. However, a search of resources available on the World Wide Web identified the following information that may be helpful should your school corporation need to establish and disseminate false claims act-related policies before formal guidance is issued by federal and state Medicaid officials. Such policies typically include:

- a statement that the entity (school corporation) is committed to detecting and preventing fraud and abuse in compliance with federal, state and local laws;
- a statement that the entity will make diligent efforts to identify and refund improper Medicaid payments
- descriptions of federal and state false claims acts and laws granting rights and protections to whistleblower/qui tam relator acting in good faith;
- a description of the entity's routine compliance monitoring efforts, such as self-audit and/or audits conducted by independent outside entities, verification of practitioners' credentials, remaining updated on billing/coding requirements)
- a statement obligating all employees, contractors, and agents involved in Medicaid service delivery, monitoring and coding/billing to conduct themselves in an ethical and legal manner, including maintaining accurate records of their business activities;
- an advisory statement advising all who prepare, process and/or review claims to be alert for potential fraud, waste and abuse, including examples, such as an employee knowingly or intentionally: claiming reimbursement for services that have not been rendered; characterizing a service differently than the service actually rendered; falsely indicating that a particular health care professional attended a procedure; billing for services/items that were not provided or were provided in excess of what was medically necessary for purposes of claiming additional, improper reimbursement; forging or altering a prescription or order/referral for service;
- a statement obligating all employees, contractors and agents to report potential or suspected incidents of fraud and abuse. Generally, employees are offered a variety of internal reporting methods, such as reporting in person or by phone to

an immediate supervisor, manager, compliance officer or legal counsel. Some larger entities set up a confidential "hot line" for reporting to executive management. Typical internal reporting policies assure employees that reports will be held in strict confidence, investigated promptly, and, if confirmed, will result in immediate corrective action, such as employee disciplinary action, improvements in internal procedures and safeguards, and/or referral to federal and state agencies or law enforcement officials;

- an assurance that retaliation or retribution is prohibited against an employee who, in "good faith," reports suspected fraud or abuse
- instructions for reporting suspected fraud or abuse directly to Medicaid officials. In Indiana, the Medicaid Fraud and Abuse Hotline numbers are 317-347-4527 (Indianapolis calling area) or 1-800-457-4515 (toll free within Indiana). Reports of Medicaid fraud and abuse can also be made to the Indiana Attorney General's Medicaid Fraud Control Unit at 800-382-1039.

APPENDIX A—MEDICAID PROVIDER AGREEMENT

Indiana Health Coverage Programs

IHCP PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide Medicaid-covered and Children's Health Insurance Program (CHIP)-covered services and/or supplies to Indiana Medicaid and Indiana CHIP members. As a condition of enrollment, this agreement cannot be altered and the Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the state of Indiana Family and Social Services Administration ("IFSSA").

2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program or CHIP, as they may be amended from time to time.

3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the state of Indiana Medical Assistance law, state of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.

4. To notify IFSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the state of Indiana.

5. To provide Medicaid-covered and CHIP-covered services and/or supplies for which federal financial participation is available for Medicaid and CHIP members pursuant to all applicable federal and state statutes and regulations.

6. To safeguard information about Medicaid and CHIP members including at a minimum:
   a. *members' name, address, and social and economic circumstances;*
   b. *medical services provided to members;*
   c. *members' medical data, including diagnosis and past history of disease or disability;*
   d. *any information received for verifying members' income eligibility and amount of medical assistance payments;*
   e. *any information received in connection with the identification of legally liable third party resources.*

7. To release information about Medicaid and CHIP members only to the IFSSA or its agent and only when in connection with:
   a. *providing services for members; and*
   b. *conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered and CHIP-covered services.*

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.

9. Provider also agrees to notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30-days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.

10. To submit claims for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered and CHIP-covered services rendered pursuant to this Agreement.

11. To comply, if a hospital, nursing facility, provider of home healthcare and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436*.

12. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.

13. To submit timely billing on Medicaid and CHIP approved claim forms, as outlined in the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

14. To be responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and/or state law.

15. To submit claim(s) for Medicaid or CHIP reimbursement only after first exhausting all other sources of reimbursement as required by the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages.

16. To submit claim(s) for Medicaid or CHIP reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.

17. To submit claims that can be documented by Provider as being strictly for:
    a. *medically necessary medical assistance services;*
    b. *medical assistance services actually provided to the person in whose name the claim is being made; and*
    c. *compensation that Provider is legally entitled to receive.*

18. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.

19. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

20. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program and CHIP withheld, within sixty (60) days of receipt of notice from IFSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.

21. To pay interest on overpayments in accordance with *IC 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3*.

22. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program or CHIP.

23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid and CHIP payments made to Provider, to assure the proper administration of the Medicaid Program and CHIP, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the *Indiana Health Coverage Programs Provider Manual*, and shall include, without being limited to, the following:
    a. *medical records as specified by Section 1902(a)(27) of Title XIX of the Social Security Act, and any amendments thereto;*
    b. *records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;*
    c. *any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program or Indiana CHIP;*
    d. *documentation in each patient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;*
    e. *financial records maintained in the standard, specified form;*
    f. *all other records as may be found necessary by the IFSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.*

25. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid program or CHIP.

26. To promptly correct deficiencies in Provider's operations upon request by IFSSA or its fiscal agent.

27. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    a. *the petitioner is a person to whom the order is specifically directed;*
    b. *the petitioner is aggrieved and, or adversely affected by the order;*
    c. *the petitioner is entitled to review under the law.*

28. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a. *the specific findings, actions, or determinations of IFSSA from which Provider is appealing;*
    b. *with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.*

29. Time limits for filing an appeal and the statement of issues are as follows:
    a. *A provider must file an appeal of any of the following actions within sixty days of receipt of IFSSA's determination:*
       (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
       (2) A notice of overpayment.
       (3) The statement if issues must be filed with the request for appeal.
    b. *All appeals of actions not described in (a) must be filed within 15 days of receipt of IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.*

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30. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

31. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a Medicaid-covered or CHIP-covered service.

32. The Provider and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *Indiana Code § 4-2-6 et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004. If the Provider is not familiar with these ethical requirements, the Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission Web site at <<http://www.in.gov/ethics/>>. If the Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to the Provider. In addition, the Provider may be subject to penalties under *Indiana Code § 4-2-6-12*. 33.

33. To disclose information on ownership and control, information related to business transactions, information on change of ownership, and information on persons convicted of crimes in accordance with *42 Code of Federal Regulations, part 455, subpart B*, and *405 IAC 1-19*. Long term care providers must comply with additional requirements found in *405 IAC 1-20*. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

34. Long term care providers must comply with additional requirements found in *405 IAC 1-20*. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

35. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through I to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

36. That subject to item 32, this Agreement shall be effective as of the date set out in the provider enrollment notification letter.

37. That this Agreement may be terminated as follows:
    a. *By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by IFSSA; or*
    b. *By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.*

38. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

39. For long term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with IHCP to bind the transferee to the terms of the previous agreement; and any existing plan of correction and pending audit findings in accordance with *405 IAC 1-20*.

40. To complete and submit the Electronic Funds Transfer (EFT) form for receipt of IHCP payments. The use of EFT as a payment vehicle allows direct deposit of IHCP payments into a provider's designated bank account. The EFT requirement may be waived at the discretion of the IHCP for those providers that can justify in writing that the EFT requirement places a burden upon their business operations. A written letter outlining reasons for an exclusion request must be submitted with the signed Agreement.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID OR CHIP RELATED OFFENSE AS SET OUT IN *42 USC 1320a-7b* MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider Agreement—Authorized Signature—All Schedules and applicable addendums	
The owner or an authorized representative of the business entity directly, or ultimately responsible for operating the business enterprise must complete this section. In addition, all rendering providers must sign this section	
Provider Name **(please print)**: _____	Tax ID: _____
Provider Signature: _____	Date: _____
Authorized Official's Name **(please print)**: _____	Title: _____
Authorized Official's Signature: _____	Date: _____

APPENDIX B
MEDICAID COVERED IEP HEALTH RELATED SERVICES PROVIDER QUALIFICATIONS SUMMARY

Medicaid will reimburse for the services if provided by individuals who meet the qualifications specified in the table below. In addition, school corporations must comply with applicable state licensure or registration laws and rules and applicable federal Medicaid regulations requiring a physician or other medical professional order or referral for covered services, as well as rules governing practice standards promulgated by the Division of Professional Standards.

State licensure or registration refers to licensure or registration by either the Health Professions Bureau or the Division of Professional Standards. A school corporation can bill for Medicaid-covered IEP/IFSP health-related services provided to a Medicaid-eligible student by a practitioner who is licensed or registered by either the Health Professions Bureau or the Division of Professional Standards, as long as he or she meets all other Medicaid provider requirements and is providing services within his/her scope of practice.

Covered Service	Provider Qualifications	Legal Authority
Audiology	- Licensed audiologist who has ASHA certification or is completing/has completed 350 hours supervised clinical experience and has performed at least 9 months of full-time supervised audiology services after obtaining a master's or doctoral degree in audiology or related field and has successfully completed an approved national examination in audiology. - Licensed otolaryngologist. - A person registered for his clinical fellowship year under the direct supervision of a licensed, ASHA certified audiologist. - A registered hearing aid specialist (hearing aid evaluation only)	42 CFR 440.110 IC 25-35.6 405 IAC 5-22-7(a) Division of Professional Standards rules at 515 IAC
Physical Therapy	- Licensed physical therapist - Certified physical therapist assistant under the direct supervision of a licensed physical therapist.	42 CFR 440.110 IC 25-27 405 IAC 5-22-8 844 IAC 6
Speech-Language Pathology	- Licensed speech-language pathologist who (1) has ASHA certification or (2) has completed the academic program and is acquiring supervised work experience to qualify for ASHA certification or (3) has completed equivalent educational requirements and work experience necessary for ASHA certification. - A registered speech-language pathology aide may provide services subject to 880 IAC 1-2 if supervised by an ASHA certified, licensed speech-language pathologist.	42 CFR 440.110 IC 25-35.6 405 IAC 5-22-9 880 IAC 1-2 Division of Professional Standards rules at 515 IAC
Occupational Therapy	- Registered therapist. - Certified therapy assistant under the direct on-site supervision of the registered therapist.	42 CFR 440.110 405 IAC 5-22-11 844 IAC 10
Behavioral Health	- Licensed physician (M.D. or D.O.). - Health Service Provider in Psychology (HSPP). The following practitioners under the direction of a licensed physician or HSPP: - Licensed psychologist. - Licensed independent practice school psychologist. - Licensed clinical social worker. - Licensed marital and family therapist. - Licensed mental health counselor. - A person holding a master's degree in social work, marital and family therapy, or mental health counseling.	405 IAC 5-20-1 405 IAC 5-20-8(2) IC 20-28-12 IC 25-33-1-5.1 Division of Professional Standards rules at 515 IAC

APPENDIX C
Indiana Laws, Rules and Policies Affecting Medicaid Reimbursement for IEP Services

Appendix C contains copies of Indiana Medicaid, Department of Education, Professional Licensing and Medical Board laws, rules and policies relevant to Medicaid billing for health-related IEP/IFSP services provided by public school corporations. A brief description in a blue text box precedes each group of documents.

Please note the copy of Indiana Health Coverage Programs (IHCP) Provider Bulletin #E98-20 at Page C2. The policy set out in bulletin #E98-20 recognizes the IEP or IFSP as the Prior Authorization for IEP or IFSP health-related services billed by school corporations. This means school corporations are exempt from other Medicaid Prior Authorization or Managed Care provider certification requirements when billing IEP services.

Please watch for recent Medicaid provider communications on Medicaid's Web site at http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx and check the *Indiana Register*, http://www.in.gov/legislative/register/irtoc.htm, for any changes to policies and rules that affect Medicaid billing for health-related IEP/IFSP services. See Appendix I for additional resources to help school corporations stay current on Medicaid policy and procedure changes.

Copies of documents included in Appendix C	**Page #**
Indiana Health Coverage Programs School Corporation Provider Bulletin #E98-20	*C2*
405 IAC 1-5-1 Medical records; contents and retention	*C4*
405 IAC 5-22-2 DRAFT *Proposed* Medicaid IEP Nursing Services Rule	*C6*
405 IAC 5-22-5 Indiana Medicaid Reimbursement Rule for Outpatient Therapies	*C8*
405 IAC 5-22-6 Indiana Medicaid Prior Authorization Rule for Outpatient Therapies	*C9*
405 IAC 5-22-8 Indiana Medicaid Physical Therapy Services Rule	*C11*
405 IAC 5-22-11 Indiana Medicaid Occupational Therapy Services Rule	*C12*
405 IAC 5-22-9 Indiana Medicaid Speech Pathology Services Rule	*C13*
405 IAC 5-22-7 Indiana Medicaid Audiology Services Rule	*C14*
880 IAC 1-2.1-1 Licensing Board Speech-language Pathology Support Personnel Rule	*C16*
405 IAC 5-20-1 Indiana Medicaid Mental Health Services Reimbursement Rule	*C24*
405 IAC 5-20-8 Indiana Medicaid Outpatient Mental Health Services Rule	*C25*
IC 20-28-12 Endorsement for Independent Practice School Psychologist Law	*C28*
515 IAC 2 Independent Practice School Psychologist Endorsement Rule	*C31*
IC 25-33-1-5.1 Health Service Provider in Psychology (HSPP) Endorsement Law	*C35*
IC 20-28-1-11 School Psychology Practice Act	*C37*
IC 25-33-1-5.1 IDOE School Psychologist Licensure Rule	*C38*
515 IAC 8-1-48 IDOE School Social Worker Licensure Rule	*C40*
405 IAC 5-30-11 DRAFT *Proposed* Medicaid IEP Transportation Rule	*C41*
IC 20-27-8 School Bus Driver Requirements Law	*C42*
575 IAC 1 IDOE School Bus Specifications Rules	*C47*
IC 9-25-4 Indiana Financial Responsibility Requirements for Vehicles Law	*C58*
Federal Requirement to Screen for Excluded Individuals, IHCP Bulletin # BT200934	*C61*

Indiana Medicaid Policy Recognizing IEP as Medicaid Prior Authorization: no other Medicaid "PA" required for IEP services

June 19, 1998

TO: **All Indiana Medicaid School Corporation Providers**

SUBJECT: **Exemptions from Medicaid Requirements Effective August 1, 1998**

Prior Authorization No Longer Required for Special Education Services

For Medicaid claims with Dates of Service August 1, 1998 and after, School Corporations enrolled as Indiana Medicaid Providers will no longer be required to obtain Medicaid Prior Authorization for those health-related Special Education services that would otherwise require Medicaid Prior Authorization. **Elimination of the Medicaid prior authorization requirement applies only to school corporations, since this provider type bills Medicaid only for those services that are furnished, by federal mandate, as part of a Medicaid-eligible student's Individualized Education Plan (IEP).** In the case of a Medicaid-eligible student receiving services listed in the "IEP," the Office of Medicaid Policy and Planning (OMPP) deems the IEP, kept in the school's records, to be the Medicaid prior authorization documentation for the "health-related" services billed to Indiana Medicaid. School corporation providers DO NOT NEED TO INCLUDE a copy of the IEP when submitting a claim to Indiana Medicaid; however, the school must maintain a copy of the IEP, along with the patient's medical records, as outlined in 405 IAC 1-5-1, for a period of three (3) years from the date on which the service is provided. (Consult Indiana Medical Assistance Programs Provider Manual Chapter 4 for additional information concerning record keeping requirements.)

Special Education Services Contained in an IEP Are Exempt from Medicaid Managed Care Referral Requirements

Effective August 1, 1998, school corporations enrolled as Indiana Medicaid Providers are exempt from the requirement to obtain the Primary Medical Provider (PMP) Certification Code in order to bill Medicaid for IEP services furnished to a Special Education student who is enrolled in Medicaid's Managed Care Program. Claims for IEP services provided to Special Education students enrolled in the "Hoosier Healthwise" Health Care program must be submitted on the HCFA 1500 claim form to Indiana Medicaid's claim processing contractor, EDS, at P.O. Box 68769, Indianapolis, Indiana 46268-0769. **Important Note: even if the student is enrolled in a Hoosier Healthwise Managed Care Organization (MCO), such as MaxiHealth or Managed Health Services, school corporation Medicaid providers should submit claims for IEP services to EDS and not to the student's MCO.**

E98-20 EDS P. O. Box 68420 Indianapolis, IN 46268-0420 1-800-577-1278

Although IEP services will be "carved out" of Medicaid's Managed Care program, YOUR COOPERATION IS STRONGLY ENCOURAGED in keeping Primary Medical Providers informed of the health-related services you provide to Medicaid-eligible Special Education students. Please arrange to send progress reports or some other type of documentation to each student's Primary Medical Provider in order to promote continuity and quality of care for each student.

Additional Information

Removal of these Medicaid Prior Authorization and PMP Certification Code requirements does not obviate the need to verify that a student is/was Medicaid-eligible on the dates of service. School corporation providers and their billing agents must continue to carefully read and follow the instructions in the Indiana Medical Assistance Programs Provider Manual, Section 2-4, for verifying Medicaid eligibility. Should you have questions concerning this bulletin or need additional information about Indiana Medicaid program requirements, please call Provider Assistance at 1-800-577-1278 or (317) 655-3240.

Indiana Medicaid Rule on Medical Records Retention

Document: Final Rule, **Register Page Number**: 28 IR 2134
Source: April 1, 2005, Indiana Register, Volume 28, Number 7
Disclaimer: This document was created from the files used to produce the official CD-ROM Indiana Register.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #04-219(F)
DIGEST

Amends 405 IAC 1-5-1 to increase the required time providers must retain medical records. Effective 30 days after filing with the secretary of state.

405 IAC 1-5-1

SECTION 1. 405 IAC 1-5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-5-1 Medical records; contents and retention
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program.

(b) All providers participating in the Indiana Medicaid program shall maintain, for a period of ~~three (3)~~ **seven (7)** years from the date Medicaid services are provided, such medical ~~and/or~~ **or** other records, **or both,** including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. A copy of a claim form ~~which~~ **that** has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records ~~which~~ **that** are independent of claims for reimbursement. Such medical ~~and/or~~ **or** other records, **or both,** shall include, at the minimum, the following information and documentation:

(1) **The** identity of the individual to whom service was rendered.
(2) **The** identity of the provider rendering the service.
(3) **The** identity and position of **the** provider employee rendering the service, if applicable.
(4) **The** date on which the service was rendered.
(5) **The** diagnosis of **the** medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.
(6) **A** detailed statement describing services rendered.
(7) **The** location at which services were rendered.
(8) **The** amount claimed through the Indiana Medicaid program for each specific service rendered.
(9) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.
(10) When a recipient is enrolled in therapy, and when required under Medicaid program rules, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy program.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-110; filed Aug 16, 1979, 3:30 p.m.: 2 IR 1383; filed Sep 23, 1982, 9:55 a.m.: 5 IR 2351; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3298; readopted filed

Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:15 a.m.: 28 IR 2134) NOTE: Transferred from the Division of Family and Children (470 IAC 5-5-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-5-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

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D R A F T
Proposed Indiana Medicaid Rule on IEP Nursing Services

405 IAC 5-22-2 Nursing services; prior authorization requirements

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) Medicaid reimbursement is available for services rendered by registered nurses, licensed practical nurses, and home health agencies who are Medicaid providers, subject to the following:

(1) Prior authorization is required for all nursing services, except services ordered in writing by a physician prior to the recipient's discharge from an inpatient hospital, which may continue for a period not to exceed one hundred twenty (120) units within thirty (30) days of discharge without prior authorization and except as noted in (c) below. Prior authorization requests may be submitted by an authorized representative of the home health agency. The prior authorization form must contain the information specified in 405 IAC 5-3-5. In addition, the following information must be submitted with the prior authorization request form:

(A) A copy of the written plan of treatment, signed by the attending physician.

(B) An estimate of the costs for the requested services as ordered by the physician and as set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.

(2) Prior authorization shall include consideration of the following:

(A) Written order of a physician.

(B) Services must be provided according to a plan of treatment developed in coordination with the attending physician.

(C) The attending physician must review the plan of treatment every sixty (60) days and reorder the service if medically reasonable and necessary.

(D) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of nursing services, must be attached to the prior authorization request and available for post payment audit purposes.

(E) Additional hours of nursing service may be authorized for ventilator dependent patients who have a developed plan of home health care providing it is cost effective and prevents repeated or prolonged stays in an acute care facility.

(b) Reimbursement is not available for care provided by family members or other individuals residing with the recipient.

(c) Medicaid reimbursement is available for Individualized Education Program (IEP) nursing services rendered by a registered nurse who is employed by or under contract with a Medicaid-participating school corporation provider, when the services are medically necessary and provided pursuant to a Medicaid-enrolled student's IEP.

(1) The IEP is the prior authorization for IEP nursing services, when provided by a school corporation Medicaid provider.

(2) School corporations must bill for the appropriate start and stop time(s) of IEP nursing services.

(A) Documentation of IEP nursing services must note the start and stop time(s) for each IEP nursing service provided per date of service. Documentation of IEP

nursing services provided off-site or during a school field trip must note the place of service and include a description of the beginning and ending dates and times of the school field trip.

(3) The student's IEP must specifically authorize the Medicaid-covered IEP service, ~~and~~ for which there is a demonstrated medical need, in order for the school corporation Medicaid provider to be reimbursed for the service.

(4) The reimbursement rate will be set by the Office of Medicaid Policy and Planning.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; filed Sep 27, 1999, 8:55a.m.: 23 IR 317; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

DRAFT

Indiana Medicaid Rules Describing Coverage and Reimbursement for Outpatient Therapy and Audiology Services

405 IAC 5-22-5 Audiology, occupational, and physical therapy and speech pathology; reimbursement

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 5. Audiology, occupational and physical therapy, and speech pathology may be reimbursed directly to an individual provider by Medicaid.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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Note: Indiana Medicaid policy recognizes the IEP as the Prior Authorization for IEP services, and no further Prior Authorization (as described in this rule) is required. Note also: with the exception that a school psychologist may write the order/referral for speech language pathology or occupational therapy services pursuant to state law IC 20-28-1-11, IEP services provided by school corporations are subject to the coverage criteria, documentation requirements and provider qualifications in this rule, as set out in Chapters 4 through 6 of this Medicaid Billing Tool Kit for health-related IEP services.

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 6. (a) Prior authorization is required for all therapy services with the following exceptions:
(1) Initial evaluations.
(2) Emergency respiratory therapy.
(3) Any combination of therapy ordered in writing prior to a recipient's discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.
(4) The deductible and copay for services covered by Medicare, Part B.
(5) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.
(6) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate.
(7) Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in sections 8, 10, and 11 of this rule.
(b) Unless specifically indicated otherwise, the following criteria for prior authorization of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:
(1) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a physician (doctor of medicine or doctor of osteopathy). A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization request and available for audit purposes.
(2) Therapy must be provided by a qualified therapist or qualified assistant under the direct supervision of the therapist as appropriate.
(3) Therapy must be of such a level of complexity and sophistication and the condition of the recipient must be such that the judgment, knowledge, and skills of a qualified therapist are required.
(4) Medicaid reimbursement is available only for medically reasonable and necessary therapy.
(5) Therapy rendered for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel, is not covered by Medicaid.
(6) Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy. Habilitative services for a recipient under eighteen (18) years of age

may be prior authorized for a longer period on a case-by-case basis. Respiratory therapy services may be prior authorized for a longer period of time on a case-by-case basis.
(7) Maintenance therapy is not a covered service.
(8) When a recipient is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. Ongoing evaluations are not separately reimbursed under the Medicaid program.
(9) One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.
(10) Therapy services will not be approved for more than one (1) hour per day per type of therapy.
(11) A request for therapy services, which would duplicate other services provided to a patient, will not be prior authorized. Therapy services will not be authorized when such services duplicate nursing services required under 410 IAC 16.2-3.1-17.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; filed Sep 27,1999, 8:55 a.m.: 23 IR 318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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405 IAC 5-22-8 Physical therapy services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. Physical therapy services are subject to the following restrictions:
(1) The physical therapy service must be performed by a licensed physical therapist or certified physical therapist's assistant under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(e) for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified physical therapist's assistant who must be under the direct supervision of a licensed physical therapist. Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Medicaid:

(A) Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment.
(B) Assembling and disassembling equipment.
(C) Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.
(D) Following established procedures pertaining to the care of equipment and supplies.
(E) Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.
(F) Transporting:
(i) patients;
(ii) records;
(iii) equipment; and
(iv) supplies;
in accordance with established policies and procedures.
(G) Performing established clerical procedures.

(2) Certified physical therapists' assistants may provide services only under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(e).
(3) Evaluations and reevaluations are limited to three (3) hours of service per recipient evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(4) Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.
(5) Physical therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's per diem rate, do not require prior authorization.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902)

405 IAC 5-22-11 Occupational therapy services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 11. Occupational therapy services are subject to the following restrictions:
(1) The occupational therapy service must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the **direct on-site supervision** of a registered occupational therapist (*emphasis added*). Evaluation must be performed by the registered occupational therapist for reimbursement.
(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include occupational therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(3) General strengthening exercise programs for recuperative purposes are not covered by Medicaid.
(4) Passive range of motion services are not covered by Medicaid as the only or primary modality of therapy.
(5) Medicaid reimbursement is not available for occupational therapy psychiatric services.
(6) Occupational therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.
(7) Occupational therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate, do not require prior authorization.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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405 IAC 5-22-9 Speech pathology services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 9. Speech pathology services are subject to the following restrictions:
(1) The speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services subject to 880 IAC 1-2.
(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include speech pathology orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(3) Group therapy is covered in conjunction with, not in addition to, regular individual treatment. Medicaid will not pay for group therapy as the only or primary means of treatment.
(4) Speech therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate, do not require prior authorization.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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405 IAC 5-22-7 Audiology services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 7. (a) Audiology services are subject to the following restrictions:
(1) The physician must certify in writing the need for audiological assessment or evaluation.
(2) The audiology service must be rendered by a licensed audiologist or a person registered for his clinical fellowship year who is supervised by a licensed audiologist. A registered audiology aide can provide services under the direct **on-site supervision** of a licensed audiologist under 880 IAC 1-1 **(*emphasis added*).**
(3) When a recipient is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aid specialist, a medical clearance and audiometric test form must be completed in accordance with instructions given below and submitted with the request for prior authorization. This form must be complete and must include the proper signatures, where indicated, before the prior authorization request will be reviewed by the department.
(4) Initial audiological assessments are limited to one (1) assessment every three (3) years per recipient. If more frequent audiological assessments are necessary, prior authorization is required.
(b) Provision of audiology services are subject to the following criteria:
(1) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.
(2) Recipient history must be completed by any involved professional.
(3) The referring physician must complete Part 2 of the Medical Clearance and Audiometric Test Form no earlier than six (6) months prior to the provision of the hearing aid. Children fourteen (14) years of age and under must be examined by an otolaryngologist; older recipients may be examined by a licensed physician if an otolaryngologist is not available.
(4) All testing must be conducted in a sound-free enclosure. If a recipient is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing. The audiological assessment must be conducted by a licensed audiologist, clinical fellowship year audiologist, or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by Medicaid. If the audiological evaluation reveals one (1) or more of the following conditions, the recipient must be referred to an otolaryngologist for further evaluation:
(A) Speech discrimination testing indicates a score of less than sixty percent (60%) in either ear.
(B) Pure tone testing indicates an air bone gap of fifteen (15) decibels or more for two (2) adjacent frequencies in the same ear.
(5) The hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist. The results must be documented on the prior authorization request and indicate that significant benefit can be derived from amplification before prior authorization may be granted.
(6) The hearing aid contract portion of the audiometric test form must be signed by a registered hearing aid specialist.
(7) Audiological assessments rendered more frequently than every three (3) years will be assessed on a case-by-case basis, based upon documented otological disease.
(c) Audiologic procedures cannot be fragmented and billed separately. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otorhinolaryngologic services and cannot be reported separately.
(1) Basic comprehensive audiometry include pre tone, air and bone threshold and discrimination. The above descriptions refer to testing of both ears.

(2) All other audiometric testing procedures will be reimbursed on an individual basis, based on only the medical necessity of such test procedures.
(d) The following audiological services do not require prior authorization:
(1) A screening test indicating the need for additional medical examination. Screenings are not reimbursed separately under the Medicaid program.
(2) The initial assessment of hearing.
(3) Determination of suitability of amplification and the recommendation regarding a hearing aid.
(4) The determination of functional benefit to be gained by the use of a hearing aid.
(5) Audiology services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3340; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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Indiana Speech-Language Pathology and Audiology Board Rule on Speech-language Pathology Support Personnel

Rule 2.1. Support Personnel
880 IAC 1-2.1-1 Definitions
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2; P.L.212-2005, SECTION 80
Sec. 1. The following definitions apply throughout this rule:
(1) "Board" means the speech-language pathology and audiology board.
(2) "Direct supervision" of support personnel means on-site, in-view observation and guidance by the supervising speech language pathologist while an assigned therapeutic activity is being performed.
(3) "Licensing agency" means the Indiana professional licensing agency.
(4) "SLP" means a speech-language pathologist.
(5) "SLP aide" means a speech-language pathology aide.
(6) "SLP assistant" means a speech-language pathology assistant.
(7) "SLP associate" means a speech-language pathology associate.
(8) "SLP support personnel" means the following:
(A) Speech-language pathology aides.
(B) Speech-language pathology associates.
(C) Speech-language pathology assistants.
(9) "Supervisor", when referring to support personnel, means a person who:
(A) holds a current Indiana license as a speech-language pathologist issued by the board or the professional standards board as provided for in P.L.212-2005, SECTION 80; and
(B) has been approved by the board to supervise support personnel as provided by IC 25-35.6-1-2(g).
(10) "Support personnel" means a person employed under the direction and authority of the supervising licensed speech language pathologist. This rule applies to all SLP aides, SLP associates, and SLP assistants when providing direct client services in the area of speech-language pathology intervention.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-1; filed Oct 6, 2003, 5:15 p.m.: 27 IR 534; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)
880 IAC 1-2.1-2 Educational requirements for SLP aide
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 2. The minimum educational requirement for an SLP aide shall be a high school degree or equivalent. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-2; filed Oct 6, 2003, 5:15 p.m.: 27 IR 534; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*
880 IAC 1-2.1-3 Educational requirements for SLP associate
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 3. (a) The minimum educational requirement for an SLP associate is an associate degree or its equivalent from an accredited institution in the area for which the applicant is requesting to be registered.
(b) As used in this section, "equivalent" means having completed the following:
(1) A minimum of a sixty (60) semester credit hours in a program of study that includes the following:

(A) General education.
(B) The specific knowledge and skills for a speech-language pathology associate.
(2) A minimum of twenty-four (24) credit hours of the sixty (60) semester hours required must be completed in general education. The general education curriculum shall include, but is not limited to, the following:
(A) Oral and written communication.
(B) Mathematics.
(C) Computer applications.
(D) Social sciences.
(E) Natural sciences.
(3) A minimum of twenty-four (24) credit hours of the sixty (60) semester credit hours required must be completed in technical content areas. Technical content course work provides students with knowledge and skills to assume the job responsibilities and core technical skills for the speech-language pathology associate and must include the following:
(A) Instruction about normal processes of communication.
(B) Instruction targeting the practices and methods of service delivery that are specific to speech-language pathology associates.
(C) Instruction regarding the treatment of communication disorders.
(D) Instruction targeting the following workplace behavior and skills:
(i) Working with clients or patients in a supportive manner.
(ii) Following supervisor's instructions.
(iii) Maintaining confidentiality.
(iv) Communicating with oral and written forms.
(v) Following established health and safety precautions.
(E) Clinical observation.
(F) A minimum of one hundred (100) clock hours of supervised field experience that provides the applicant with appropriate experience for learning speech-language pathology associate-specific:
(i) job responsibilities; and
(ii) workplace behaviors;
of the speech-language pathology associate.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-3; filed Oct 6, 2003, 5:15 p.m.: 27 IR 534; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-3.1 Educational requirements for SLP assistant

Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 3.1. (a) The minimum educational requirement for an SLP assistant is a bachelor's degree or its equivalent in communication disorders from an accredited institution in the area for which the applicant is requesting to be registered.
(b) One hundred (100) hours of clinical practicum is required and must be supervised by an SLP licensed by the board. These hours may be completed before the degree is conferred or during a paid experience. Of the one hundred (100) hours obtained, seventy-five (75) shall be obtained with direct face-to-face patient/client contact, and the remaining twenty-five (25) hours may be obtained through observation of assessment and therapy. The direct face-to-face patient/client contact hours must be obtained in the
following categories:
(1) A minimum of twenty (20) hours in speech disorders.
(2) A minimum of twenty (20) hours in language disorders.

(3) The remaining hours may be obtained in any of the following areas:
(A) Speech disorders.
(B) Language disorders.
(C) Hearing disorders.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-3.1; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-4 Application for registration

Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 4. (a) The application for approval of SLP support personnel must be:
(1) made on a form provided by the licensing agency; and
(2) submitted to the board by the SLP support personnel with all documentation as requested.
(b) The application must contain the following information:
(1) The supervisor's:
(A) name;
(B) address;
(C) phone number; and
(D) current Indiana license number.
(2) The name and location of where services will be performed.
(3) A detailed description of the responsibilities assigned to the SLP support personnel.
(4) A certified statement from the supervisor that the SLP support personnel will be supervised as required by IC 25-35.6-1-2 and this rule.
(5) A certified statement from the SLP support personnel that he or she may not perform any activity as specified in section 7 of this rule.
(6) A certified statement from the supervisor listing which of the tasks specified in section 8 of this rule the SLP support personnel may perform.
(7) An application fee as specified in section 5 of this rule.
(8) Official transcripts from an educational institution documenting the following:
(A) SLP aide: Proof of a high school degree or equivalent.
(B) SLP associate: Proof of an associate's degree in communication disorders or its equivalent from an accredited institution.
(C) SLP assistant: Proof of a bachelor's degree in communication disorders or its equivalent from an accredited institution.
(9) Any other information as required by the board.
(c) When an application has been approved by the board, a certificate of registration will be issued by the licensing agency.
(d) An SLP aide, SLP associate, or SLP assistant may not begin work before his or her application has been approved by the board. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-4; filed Oct 6, 2003, 5:15 p.m.: 27 IR 534; filed Aug 25,2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

880 IAC 1-2.1-5 Report change of information

Authority: IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 5. The supervisor must report any change in activities or supervision at the time the change occurs by submitting a new application and fee as specified in section 4 of this rule within fourteen (14) days. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-5; filed Oct 6, 2003, 5:15 p.m.: 27 IR 535*

880 IAC 1-2.1-6 Renewal of registration
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 6. (a) A registration issued under section 2 of this rule expires on December 31 of each year. Support personnel must renew the registration by submitting the following:
(1) A renewal form provided by the licensing agency.
(2) A fee as specified in 880 IAC 1-1-5.
(b) In order to avoid any interruption of work activity, a registration must be renewed before December 31 of each year.
(c) Information submitted with the renewal form shall include the following:
(1) The nature and extent of the:
(A) functions performed; and
(B) training completed;
by the SLP support personnel during the preceding year.
(2) Any other information required by the board.
(d) The supervisor must report any change in information required by subsection (a) to the board at the time the change occurs by submitting the following:
(1) A new application.
(2) The fee as specified in 880 IAC 1-1-5.
(e) SLP support personnel may not continue working after their registration has expired. Any such continuation will constitute a violation of this section.
(f) If a supervisor does not renew the SLP support personnel registration on or before December 31, the registration becomes invalid. The supervisor must submit the following:
(1) A new application.
(2) The fee as specified in section 4 of this rule.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-6; filed Oct 6, 2003, 5:15 p.m.: 27 IR 535; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-7 Activities prohibited by the SLP support personnel
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 7. SLP support personnel may not perform any of the following activities:
(1) Administer:
(A) standardized or nonstandardized diagnostic tests; or
(B) formal or informal evaluations;
or interpret test results.
(2) Participate in:
(A) parent conferences;
(B) case conferences; or
(C) any interdisciplinary team;
without the presence of the supervisor or other licensed speech-language pathologist designated by the supervisor.
(3) Provide patient/client or family counseling.
(4) Write, develop, or modify a patient's or client's individualized treatment plan in any way.
(5) Assist with a patient or client without:
(A) following the individualized treatment plans prepared by the supervisor; or
(B) access to supervision.
(6) Sign any formal documents, for example, any of the following:

(A) Treatment plans.
(B) Reimbursement forms.
(C) Reports.
However, the SLP support personnel may sign or initial informal treatment notes for review and cosignature by the supervisor if specifically asked to do so by the supervisor.
(7) Select patients or clients for services.
(8) Discharge a patient or client from services.
(9) Disclose clinical or confidential information either orally or in writing to anyone other than the supervisor.
(10) Make referrals for additional service outside the scope of the intervention setting.
(11) Communicate with:
(A) the patient;
(B) the client;
(C) the family; or
(D) others;
regarding any aspect of the patient or client status or service without the specific consent of the supervisor.
(12) Counsel or consult with:
(A) the patient;
(B) the client;
(C) the family; or
(D) others;
regarding the patient or client status or service.
(13) Represent himself or herself as a speech-language pathologist.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-7; filed Oct 6, 2003, 5:15 p.m.: 27 IR 535; filed Aug 25, 2008,3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-8 Tasks that may be delegated to the SLP support personnel

Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 8. The following tasks may be delegated to SLP support personnel if the tasks have been planned by the supervisor and the SLP support personnel have been provided with adequate training to perform the task competently:
(1) Assist the supervisor with speech-language and hearing screenings (without interpretation).
(2) Follow documented treatment plans or protocols developed by the supervisor.
(3) Document patient or client performance and report information to the supervising SLP, for example, the following:
(A) Tallying data for the speech-language pathologist.
(B) Preparing the following:
(i) Charts.
(ii) Records.
(iii) Graphs.
(4) Assist the supervisor during assessment of patients or clients.
(5) Assist with informal documentation as directed by the supervisor.
(6) Assist with clerical duties, such as:
(A) preparing materials; and
(B) scheduling activities;
as directed by the supervisor.

(7) Perform checks and maintenance of equipment.
(8) Support the supervisor in the following:
(A) Research projects.
(B) Inservice training.
(C) Public relations programs.
(9) Assist with the following departmental operations:
(A) Scheduling.
(B) Record keeping.
(C) Safety and maintenance of supplies and equipment.
(10) Collect data for quality improvement.
(11) Exhibit compliance with the following:
(A) Regulations.
(B) Reimbursement requirements.
(C) SLP aide, SLP associate, and SLP assistant job responsibilities.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-8; filed Oct 6, 2003, 5:15 p.m.: 27 IR 536; filed Aug 25, 2008,3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-9 Supervisors; responsibilities

Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2

Sec. 9. (a) Before utilizing SLP support personnel, the supervisor shall carefully delineate the role and tasks of the SLP support personnel, including the following:
(1) Specific lines of responsibility and authority.
(2) Assurance that the SLP support personnel are responsible only to the supervisor in all patient/client activities. The supervisor must assess individual patient/client needs when deciding the appropriateness of a support personnel service delivery model.
(b) When SLP support personnel assist in providing treatment, the supervisor of the SLP support personnel shall do the following:
(1) The supervisor of the SLP aide shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. The supervisor must:
(A) be physically present within the same building as the SLP aide whenever direct client care is provided; and (B) directly provide a minimum of thirty-three percent (33%) of the patient's or client's treatment weekly.
(2) The supervisor of the SLP associate shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. Supervision days and times should be alternated to ensure that all patients/clients receive direct treatment from the supervisor at least once every two (2) weeks. At no time should an SLP associate perform tasks when a supervisor cannot be reached by:
(A) personal contact;
(B) telephone;
(C) pager; or
(D) other immediate means.
(3) The supervisor for the SLP assistant shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. Supervision days and times should be alternated to ensure that all patients/clients receive direct treatment from the supervisor at least once every two (2) weeks. At no time should an SLP assistant perform tasks when a supervisor cannot be reached by:

(A) personal contact;
(B) telephone;
(C) pager; or
(D) other immediate means.
(4) The supervisor must determine supervision needs. The amount of supervision may be increased depending on the:
(A) competency of the SLP support personnel;
(B) needs of the patients or clients served; and
(C) nature of the assigned tasks.
However, the minimum standard must be maintained. Indirect supervision activities may include, but are not limited to, record review, phone conferences, or audio/video tape review.
(5) Determine the responsibilities assigned to the SLP support personnel based upon the:
(A) educational level;
(B) training; and
(C) experience;
of the support personnel.
(6) Evaluate each patient or client before treatment.
(7) Outline and direct the specific program for the clinical management of each client serviced by the SLP support personnel.
(8) Every five (5) working days, review all data and documentation on clients seen for treatment by the SLP support personnel.
(9) Ensure that, at the termination of services, the case is reviewed by the speech-language pathologist responsible for the client.
(c) The supervisor shall not permit SLP support personnel to make decisions regarding the:
(1) diagnosis;
(2) management; or
(3) future disposition;
of clients.
(d) The supervisor must officially designate SLP support personnel as such on all clinical records.
(e) The supervisor must be present when the SLP support personnel provide direct client treatment outside the designated practice setting.
(f) The supervisor may designate a licensed speech-language pathologist to supervise SLP support personnel under his or her supervision during vacation periods or illness, but for not longer than a thirty (30) day period.
(g) Within ten (10) days after the termination of the supervision of SLP support personnel, the supervisor:
(1) shall notify the board, in writing, of the:
(A) termination; and
(B) date of the termination; and
(2) may designate a licensee to serve as an interim supervisor for a period not to exceed thirty (30) days upon approval of the board. An interim supervisor is not required to pay a fee for the thirty (30) day period.
(h) A supervisor may not supervise more than two (2) SLP support personnel at one (1) time.
(i) In order to supervise SLP support personnel, a speech-language pathologist must:
(1) hold a current license as a speech-language pathologist as issued by the board for a minimum of two (2) years before registering and supervising SLP support personnel; and
(2) have at least three (3) years of clinical experience.

(j) A supervisor assumes professional responsibility for services provided under their supervision. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-9; filed Oct 6, 2003, 5:15 p.m.: 27 IR 536; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

880 IAC 1-2.1-10 SLP aides previously registered under 880 IAC 1-2

Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2

Sec. 10. SLP aides previously registered under 880 IAC 1-2, which meet the educational requirements of:
(1) section 2 of this rule, shall be registered as an SLP aide;
(2) section 3 of this rule, shall be registered as an SLP associate; and
(3) section 3.1 of this rule, shall be registered as an SLP assistant;
without the necessity of filing an additional application under section 4 of this rule. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-10; filed Oct 6, 2003, 5:15 p.m.: 27 IR 537; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

Indiana Medicaid Rules on Coverage and Reimbursement for Mental Health Services

Rule 20. Mental Health Services
405 IAC 5-20-1 Reimbursement limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15
Sec. 1. (a) Medicaid reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in this rule.
(b) Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a recipient under sixty-five (65) years of age unless the recipient is under twenty-one (21) years of age, or under twenty-two (22) years of age and had begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday.
(c) Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between twenty-two (22) and sixty-five (65) years of age in a certified psychiatric hospital of sixteen (16) beds or less.
(d) Prior authorization is required for all inpatient psychiatric admissions, including admissions for substance abuse.
(Office of the Secretary of Family and Social Services; 405 IAC 5-20-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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NOTE: Indiana Medicaid recognizes the IEP as the Prior Authorization for IEP Services, and no further Prior Authorization (as described in this rule) is necessary.

405 IAC 5-20-8 Outpatient mental health services

Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3
Sec. 8. Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:
(1) Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.
(2) Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.
(3) The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:
(A) The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven (7) days of the intake process.
This review by the physician, psychiatrist, or HSPP must be documented in writing.
(B) The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.
(4) Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:
(A) Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable *[sic]* and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.

(B) Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.
(C) Services may be provided for consumers of all ages who are not at imminent risk to harm to *[sic]* self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers must have a diagnosed or suspected behavioral health condition and one (1) of the following:
(i) A short-term deficit in daily functioning.
(ii) An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.
(D) Program standards shall be as follows:
(i) Services must be ordered and authorized by a psychiatrist.
(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).
(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twentyfour (24) hours following admission to the program.
(iv) A psychiatrist must actively participate in the case review and monitoring of care.
(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.
(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.
(vii) For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record.
(viii) For consumers under eighteen (18) years of age, a minimum of one (1) family encounter per five (5)
business days of episode of care is required.
(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
(x) Programs must not mix consumers receiving partial hospitalization services with consumers receiving
outpatient behavioral health services.
(E) Exclusions shall be as follows:
(i) Consumers at imminent risk of harm to self or others are not eligible for services.
(ii) Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.
(iii) Consumers who cannot actively engage in psychotherapy are not eligible for services.
(iv) Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be
managed at this level of care or who need detoxification services.
(v) Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.
(5) Medicaid will reimburse for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.
(6) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:
(A) A physician.
(B) An HSPP.

(C) A practitioner listed in subdivision (7).
(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision
of a physician or HSPP:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a master's degree in a mental health field and one (1) of the following:
(i) A certified specialist in psychometry (CSP).
(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.
(8) The physician and HSPP are responsible for the interpretation and reporting of the testing performed.
(9) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed in subdivision (7).
(10) Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization as stated in subdivision (4)(D)(ii).
(11) The following are services that are not reimbursable by the Medicaid program:
(A) Daycare.
(B) Hypnosis.
(C) Biofeedback.
(D) Missed appointments.
(12) All outpatient services rendered must be identified and itemized on the Medicaid claim form. Additionally, the length of time of each therapy session must be indicated on the claim form. The medical record documentation must identify the services and the length of time of each therapy session. This information must be available for audit purposes.
(13) A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization form and available for audit purposes.
(14) For psychiatric diagnostic interview examinations, Medicaid reimbursement is available for one (1) unit per recipient, per provider, per rolling twelve (12) month period of time, except as follows:
(A) A maximum of two (2) units per rolling twelve (12) month period of time per recipient, per provider, may be reimbursed without prior authorization, when a recipient is separately evaluated by both a physician or HSPP and a midlevel practitioner.
(B) Of the two (2) units allowed without prior authorization, as stated in clause (A), one (1) unit must be provided by the physician or HSPP and one (1) unit must be provided by the midlevel practitioner.
(C) All additional units require prior authorization.
(Office of the Secretary of Family and Social Services; 405 IAC 5-20-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; filed Sep 27, 1999, 8:55 a.m.: 23 IR 315; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2707; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 61; errata filed Nov 21, 2001, 11:33 p.m.: 25 IR 1184; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA)

Indiana Law on School Psychologist Independent Practice Endorsement (IPE)

IC 20-28-12
Chapter 12. Endorsement for Independent Practice School Psychologists

IC 20-28-12-1
Application of chapter
Sec. 1. This chapter does not apply to a psychologist who is licensed under IC 25-33.
As added by P.L.1-2005, SEC.12.

IC 20-28-12-2
Compliance with requirements for endorsement
Sec. 2. In order to:
(1) practice school psychology; and
(2) receive an endorsement as an independent practice school psychologist;
a school psychologist must comply with this chapter.
As added by P.L.1-2005, SEC.12.

IC 20-28-12-3
Requirements for endorsement
Sec. 3. An individual who applies for an endorsement as an independent practice school psychologist must meet the following requirements:
(1) Be licensed as a school psychologist by the department.
(2) Be employed by a:
(A) developmental center;
(B) state hospital;
(C) public or private hospital;
(D) mental health center;
(E) rehabilitation center;
(F) private school; or
(G) public school;
at least thirty (30) hours per week during the contract period unless the individual is retired from full-time or part-time employment as a school psychologist or the individual has a medical condition or physical disability that restricts the mobility required for employment in a school setting.
(3) Furnish satisfactory evidence to the department that the applicant has received at least a sixty (60) graduate semester hour or ninety (90) quarter hour master's or specialist degree in school psychology from:
(A) a recognized postsecondary educational institution; or
(B) an educational institution not located in the United States that has a program of study that meets the standards of the department.
(4) Furnish satisfactory evidence to the department that the applicant has demonstrated graduate level competency through the successful completion of course work and a one thousand two hundred (1,200) hour supervised internship of school psychology, of which at least six hundred (600) hours must be in a school setting.

(5) Furnish satisfactory evidence to the department that the applicant has successfully completed at least one thousand two hundred (1,200) hours of school psychology experience after completion of graduate degree requirements and not including the supervised internship for degree or licensing requirements. At least six hundred (600) hours must be in a school setting under the supervision of any of the following:

(A) A physician licensed under IC 25-22.5.

(B) A psychologist licensed under IC 25-33.

(C) A school psychologist endorsed under this chapter or currently holding a national certification from the National Association of School Psychologists.

(6) Furnish satisfactory evidence to the department that the applicant has completed, in addition to the requirements in subdivision (5), at least:

(A) twelve (12) hours of training provided by a health service professional in psychology licensed under IC 25-33-1 or a psychiatrist licensed as a physician under IC 25-22.5 in the identification and referral of mental and behavioral disorders; and

(B) ten (10) case studies or evaluations requiring the identification or referral of mental or behavioral disorders. Case studies or evaluations may include the following:

(i) Consultations with teachers and parents.

(ii) Intervention services, excluding psychotherapy.

(iii) Functional behavior assessments.

(iv) Behavior improvement plans.

(v) Progress monitoring.

(7) Furnish satisfactory evidence to the department that the applicant has completed, in addition to the requirements of subdivisions (5) and (6), thirty (30) hours of supervision with a physician licensed under IC 25-22.5, a psychologist licensed under IC 25-33, or a school psychologist endorsed under this chapter or currently holding national certification from the National Association of School Psychologists that meets the following requirements:

(A) The thirty (30) hours must be completed within at least twenty-four (24) consecutive months but not less than six (6) months.

(B) Not more than one (1) hour of supervision may be included in the total for each week.

(8) Furnish satisfactory evidence to the department that the applicant does not have a conviction for a crime that has a direct bearing on the applicant's ability to practice competently.

(9) Furnish satisfactory evidence to the department that the applicant has not been the subject of a disciplinary action by a licensing or certification agency of any jurisdiction on the grounds that the applicant was not able to practice as a school psychologist without endangering the public.

(10) Pass the examination provided by the department.

As added by P.L.1-2005, SEC.12. Amended by P.L.246-2005, SEC.169; P.L.2-2007, SEC.219; P.L.177-2009, SEC.9.

IC 20-28-12-4

Provision of services on private basis

Sec. 4. (a) A school psychologist who is not employed or excused from employment as described in section 3(2) of this chapter may not provide services on a private basis to an individual unless the school psychologist receives a referral from one (1) of the following:

(1) A developmental center.

(2) A public school or private school.

(3) A physician licensed under IC 25-22.5.
(4) A health service professional in psychology licensed under IC 25-33-1.
(b) A school psychologist who is endorsed under this chapter may not provide services on private basis to a student:
(1) who attends a school (including a nonpublic school) to which the school psychologist is assigned; or
(2) whom the school psychologist would normally be expected to serve.
As added by P.L.1-2005, SEC.12.

IC 20-28-12-5
School psychologist; disclosure of information
Sec. 5. A school psychologist who is endorsed under this chapter may not disclose any information acquired from persons with whom the school psychologist has dealt in a professional capacity, except under the following circumstances:
(1) Trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide.
(2) Proceedings:
(A) to determine mental competency; or
(B) in which a defense of mental incompetency is raised.
(3) Civil or criminal actions against a school psychologist for malpractice.
(4) Upon an issue as to the validity of a document.
(5) If the school psychologist has the express consent of the client or, in the case of a client's death or disability, the express consent of the client's legal representative.
(6) Circumstances under which privileged communication is lawfully invalidated.
As added by P.L.1-2005, SEC.12.

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Indiana Department of Education Rules on School Psychologist Independent Practice Endorsement (IPE)

ARTICLE 2. ENDORSEMENT OF SCHOOL PSYCHOLOGISTS AS INDEPENDENT PRACTICE SCHOOL PSYCHOLOGISTS

Rule 1. General Provisions

515 IAC 2-1-1 Purpose
Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 20-28-12
Sec. 1. The purpose of this article is to establish procedures for the board to follow in the endorsement of school psychologists as independent practice school psychologists and to provide criteria for exemptions from endorsement requirements. *(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-1; filed May 28, 1998, 5:10 p.m.: 21 IR 3835; readopted filed Sep 25, 2001,9:43 a.m.: 25 IR 529)*

515 IAC 2-1-2 Applicability
Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 25-33
Sec. 2. (a) In order to:
(1) practice school psychology; and
(2) receive an endorsement as an independent practice school psychologist;
a school psychologist must comply with the requirements of this article.
(b) This article does not apply to a psychologist who is licensed under IC 25-33. *(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-2; filed May 28, 1998, 5:10 p.m.: 21 IR 3835; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)*

515 IAC 2-1-3 Definitions
Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 16-19-6; IC 20-28-1-11
Sec. 3. The following definitions apply throughout this article:
(1) "Developmental center" means any facility that offers developmentally appropriate psychological, educational, social, adaptive, language, or motor skills training or psychoeducational and multidisciplinary diagnostic services to special needs children or developmentally disabled adults.
(2) "Rehabilitation center" means:
(A) a state or privately owned and accredited institution, hospital, or facility offering diagnostic, rehabilitative, or habilitative services to children or adults who are cognitively impaired, developmentally delayed, head injured, or learning disabled that is located in Indiana or supported by a hospital located in Indiana and accredited by the joint commission on accreditation of healthcare organizations (JCAHO);
(B) a penal or correctional facility operated by the department of corrections;
(C) an institution operated by the department of health under IC 16-19-6; or
(D) a private facility offering vocational or diagnostic services to the mentally retarded, developmentally delayed, brain injured, or physically handicapped that is accredited by the council on accreditation of rehabilitation facilities (CARF), JCAHO, or certified by the state.
(3) "School psychology" has the same meaning set forth in IC 20-28-1-11.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-3; filed May 28, 1998, 5:10 p.m.: 21 IR 3835; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529; errata filed Jul 11, 2005, 10:00 a.m.: 28 IR 3308)

515 IAC 2-1-4 Criteria for endorsement of independent practice school psychologists
Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 20-28-2; IC 25-22.5; IC 25-33
Sec. 4. An individual who applies for an endorsement as an independent practice school psychologist must meet the following requirements:
(1) Be licensed as a school psychologist by the professional standards board (board).
(2) Be employed by a:
(A) developmental center;
(B) state hospital;
(C) public or private hospital;
(D) mental health center;
(E) rehabilitation center;
(F) private school; or
(G) public school;
at least thirty (30) hours per week during the contract period unless the individual is retired from full-time or part-time employment as a school psychologist or the individual has a medical condition or physical disability that restricts the mobility required for employment in a school setting.
(3) Furnish satisfactory evidence to the board that the applicant has received at least a sixty (60) semester hour master's or specialist degree in school psychology from:
(A) a recognized institution of higher learning; or
(B) an educational institution not located in the United States that has a program of study that meets the standards of the board.
(4) Furnish satisfactory evidence to the board that the applicant has demonstrated graduate level competency through the successful completion of course work and a practicum in the areas of assessment and counseling.
(5) Furnish satisfactory evidence to the board that the applicant has at least one thousand two hundred (1,200) hours of school psychology experience beyond the master's degree level. At least six hundred (600) hours must be in a school setting under the supervision of any of the following:
(A) A physician licensed under IC 25-22.5.
(B) A psychologist licensed under IC 25-33.
(C) A school psychologist licensed under IC 20-28-2.
(6) Furnish satisfactory evidence to the board that the applicant has completed, in addition to the requirements in subdivision (5), at least four hundred (400) hours of supervised experience in identification and referral of mental and behavioral disorders, including at least one (1) hour each week of direct personal supervision by a:
(A) physician licensed under IC 25-22.5;
(B) psychologist licensed under IC 25-33; or
(C) school psychologist endorsed under this article;
with at least ten (10) hours of direct personal supervision.
(7) Furnish satisfactory evidence to the board that the applicant has completed, in addition to the requirements of subdivisions (5) and (6), fifty-two (52) hours of supervision with a physician licensed under IC 25-22.5, a psychologist licensed under IC 25-33, or a school psychologist endorsed under this article that meets the following requirements:
(A) The fifty-two (52) hours must be completed within at least twenty-four (24) consecutive months but not less than twelve (12) months.
(B) Not more than one (1) hour of supervision may be included in the total for each week.

(C) At least nine hundred (900) hours of direct client contact must take place during the total period under clause (A).
(8) Furnish satisfactory evidence to the board that the applicant does not have a conviction for a crime that has a direct bearing on the applicant's ability to practice competently.
(9) Furnish satisfactory evidence to the board that the applicant has not been the subject of a disciplinary action by a licensing or certification agency of any jurisdiction on the grounds that the applicant was not able to practice as a school psychologist without endangering the public.
(10) Pass the examination provided by the board.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-4; filed May 28, 1998, 5:10 p.m.: 21 IR 3836; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529; errata filed Jul 11, 2005, 10:00 a.m.: 28 IR 3308)

515 IAC 2-1-5 Provision of services on private basis

Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 25-22.5; IC 25-33-1
Sec. 5. (a) A school psychologist who is not employed or excused from employment as described in section 4(2) of this rule shall not provide services on a private basis to a person unless the school psychologist receives a referral from one (1) of the following:
(1) A developmental center.
(2) A public school or private school.
(3) A physician licensed under IC 25-22.5.
(4) A health service professional in psychology licensed under IC 25-33-1.
(b) A school psychologist who is endorsed under this article shall not provide services on a private basis to a student:
(1) who attends a school (including a nonpublic school) to which the school psychologist is assigned; or
(2) whom the school psychologist would normally be expected to serve.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-5; filed May 28, 1998, 5:10 p.m.: 21 IR 3836; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)

515 IAC 2-1-6 Disclosure of information

Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 20-28-12
Sec. 6. A school psychologist who is endorsed under this article may not disclose any information acquired from persons with whom the school psychologist has dealt in a professional capacity, except under the following circumstances:
(1) Trials for homicide when the disclosure related directly to the fact or immediate circumstances of the homicide.
(2) Proceedings:
(A) to determine mental competency; or
(B) in which a defense of mental incompetency is raised.
(3) Civil or criminal actions against a school psychologist for malpractice.
(4) Upon an issue as to the validity of a document.
(5) If the school psychologist has the expressed consent of the client or, in the case of a client's death or disability, the express consent of the client's legal representative.
(6) Circumstances under which privileged communication is lawfully invalidated.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-6; filed May 28, 1998, 5:10 p.m.: 21 IR 3837; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)

Rule 2. Exemptions from Endorsement
515 IAC 2-2-1 Criteria for exemption of school psychologists from endorsement
Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 25-22.5; IC 25-33-1
Sec. 1. (a) The professional standards board (board) shall exempt an individual from the endorsement requirements of this article if the individual:
(1) is licensed on or before June 30, 1996, as a school psychologist by the board;
(2) is employed by a:
(A) developmental center;
(B) state hospital;
(C) public or private hospital;
(D) mental health center;
(E) rehabilitation center;
(F) private school; or
(G) public school;
at least thirty (30) hours per week during the contract period; and
(3) furnishes satisfactory evidence to the board that the applicant:
(A) has received at least sixty (60) semester hours of graduate level course work in a school psychology program;
(B) has at least one thousand (1,000) supervised hours of school psychology;
(C) does not have a conviction for a crime that has a direct bearing on the applicant's ability to practice competently;
(D) has not been the subject of a disciplinary action by a licensing or certification agency of another jurisdiction on the grounds that the applicant was not able to practice as a school psychologist without endangering the public; and
(E) has at least five (5) years of experience as a school psychologist within the ten (10) years preceding the date of application.
(b) Subsection (a)(2) does not apply to a school psychologist who:
(1) is retired from full-time or part-time employment as a school psychologist; or
(2) has a:
(A) medical condition; or
(B) physical disability;
that restricts the mobility required for employment in a school setting.
(c) A school psychologist who is not excused from employment as described in subsection (b) or is not employed as described in subsection (a)(2) shall not provide services on a private basis to a person unless the school psychologist receives a referral from one (1) of the following:
(1) A developmental center.
(2) A public school or private school.
(3) A physician licensed under IC 25-22.5.
(4) A health service professional in psychology licensed under IC 25-33-1.
(d) An individual seeking an exemption under this section must apply to the board before July 1, 1998. *(Advisory Board of the Division of Professional Standards; 515 IAC 2-2-1; filed May 28, 1998, 5:10 p.m.: 21 IR 3837; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)*

Indiana Law on Health Service Provider in Psychology (HSPP) Endorsement

Health Service Provider in Psychology (HSPP)

IC 25-33-1-5.1

Issuance of license; endorsement as health service provider in psychology; preceptorship program

Sec. 5.1. (a) Except as provided in section 5.3 of this chapter, the board shall issue a license to an individual who meets the following requirements:

(1) Applies to the board in the form and manner prescribed by the board under section 3 of this chapter.

(2) Is at least eighteen (18) years of age.

(3) Has not been convicted of a crime that has a direct bearing upon the applicant's ability to practice competently.

(4) Possesses a doctoral degree in psychology:

(A) granted from an institution of higher learning recognized by the board; and

(B) from a degree program approved by the board as a psychology program at the time the degree was conferred.

(5) Is not in violation of this chapter or rules adopted by the board under section 3 of this chapter.

(6) Has paid the fee set by the board under section 3 of this chapter.

(7) Has passed the examination required and administered by the board.

(b) If an applicant has been disciplined by a licensing agency in another state or jurisdiction on the ground that the applicant was unable to competently practice psychology, the applicant must submit proof, satisfactory to the board, that the reasons for disciplinary sanction by the other licensing agency are no longer valid.

(c) The board shall endorse as a health service provider in psychology an individual who:

(1) has a doctoral degree in clinical psychology, counseling psychology, school psychology, or another applied health service area of psychology;

(2) is licensed under this section, section 5.3, or section 9 of this chapter;

(3) has at least two (2) years of experience in a supervised health service setting in which one (1) year of experience was obtained in an organized health service training program and in which at least one (1) year of experience was obtained after the individual received the individual's doctoral degree in psychology; and

(4) complies with the continuing education requirements under IC 25-33-2 (*emphasis added*)**.**

(d) An individual who received a doctoral degree in clinical psychology, counseling psychology, school psychology, or other applied health service area in psychology before September 1, 1983, may satisfy one (1) year of the two (2) year supervised health setting experience requirement under subsection (c) by successfully completing a preceptorship program. The individual must apply in writing to the board and the board must approve the program. The preceptorship program must:

(1) consist of at least one thousand eight hundred (1,800) hours of clinical, counseling, or school psychology work experience;

(2) consist of at least one hundred (100) hours of direct supervision of the individual by a psychologist, at least fifty (50) hours of which must involve the diagnosis of mental and behavioral disorders and at least fifty (50) hours of which must involve the treatment of mental and behavioral disorders;

(3) be completed in a health service setting that provides services in the diagnosis and treatment of mental and behavioral disorders;

(4) be under the supervision of a psychologist who meets the requirements for endorsement under this section; and

(5) be completed within two (2) years after the date the program is started.

(e) If an individual applies to the board under subsection (d), the board shall apply each hour of work experience the individual completes after applying to the board and before the board approves the preceptorship program to the one thousand eight hundred (1,800) hour work experience requirement under subsection (d)(1).

As added by P.L.249-1985, SEC.4. Amended by P.L.149-1987, SEC.97; P.L.152-1988, SEC.27; P.L.96-1990, SEC.16; P.L.33-1993, SEC.68; P.L.140-1993, SEC.11; P.L.1-1994, SEC.128.

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Indiana Law on the Practice of School Psychology

IC 20-28-1-11
"School psychology"

Sec. 11. "School psychology" means the following:

(1) Administering, scoring, and interpreting educational, cognitive, career, vocational, behavioral, and affective tests and procedures that address a student's:

(A) education;
(B) developmental status;
(C) attention skills; and
(D) social, emotional, and behavioral functioning;

as they relate to the student's learning or training in the academic or vocational environment.

(2) Providing consultation, collaboration, and intervention services (not including psychotherapy) and providing referral to community resources to:

(A) students;
(B) parents of students;
(C) teachers;
(D) school administrators; and
(E) school staff;

concerning learning and performance in the educational process.

(3) Participating in or conducting research relating to a student's learning and performance in the educational process:

(A) regarding the educational, developmental, career, vocational, or attention functioning of the student; or
(B) screening social, affective, and behavioral functioning of the student.

(4) Providing inservice or continuing education services relating to learning and performance in the educational process to schools, parents, or others.

(5) Supervising school psychology services.

(6) Referring a student to:

(A) a speech-language pathologist or an audiologist licensed under IC 25-35.6 for services for speech, hearing, and language disorders; or
(B) an occupational therapist licensed under IC 25-23.5 for occupational therapy services;

by a school psychologist who is employed by a school corporation and who is defined as a practitioner of the healing arts for the purpose of referrals under 42 CFR 440.110.

The term does not include the diagnosis or treatment of mental and nervous disorders, except for conditions and interventions provided for in state and federal mandates affecting special education and vocational evaluations as the evaluations relate to the assessment of handicapping conditions and special education decisions or as the evaluations pertain to the placement of children and the placement of adults with a developmental disability.

As added by P.L.1-2005, SEC.12. Amended by P.L.157-2006, SEC.9; P.L.99-2007, SEC.175; P.L.197-2007, SEC.14.

Indiana Department of Education Rule on School Psychologist Licensure

For more information go to http://www.doe.in.gov/educatorlicensing/ and click Current Indiana Educators, then School Services Licensure, School Counselor, and School Psychologist License.

515 IAC 1-1-76.1 School psychologist; school services license
Authority: IC 20-28-2-6
Affected: IC 20-19; IC 20-33-2; IC 20-34-3-6
Sec. 76.1. (a) Candidates will be qualified for the school services standard license–school psychologist when they have done the following:
(1) Completed a master's, specialist's, or doctoral degree program in school psychology with a minimum of sixty (60) graduate semester hours from an institution regionally accredited to offer such a degree or hold a current credential, Nationally Certified School Psychologist (NCSP).
(2) Completed course work in the following areas:
(A) Psychological foundations to include:
(i) biological bases of behavior;
(ii) cultural diversity;
(iii) child and adolescent development;
(iv) human exceptionalities;
(v) human learning; and
(vi) social bases of behavior.
(B) Education foundations to include:
(i) education of exceptional learners;
(ii) instructional and remedial techniques; and
(iii) organization and operation of schools.
(C) Assessment.
(D) Interventions to include:
(i) consultation;
(ii) counseling; and
(iii) behavior management.
(E) Statistics and research design.
(F) Professional school psychology to include:
(i) the history and foundations of school psychology;
(ii) legal and ethical issues;
(iii) professional issues and standards; and
(iv) role and functions of the school psychologist.
(3) Completed a supervised internship in school psychology of one thousand two hundred (1,200) clock hours of which six hundred (600) hours must be in a school setting.
(4) Been recommended by the accredited institution where the approved qualifying program was completed.
(b) The holder of the school services license–school psychologist is eligible to serve as a school psychologist at all levels.
(c) The school services standard license–school psychologist may be renewed as specified in 515 IAC 1-3-1 *[515 IAC 1-3 was repealed filed Sep 30, 2003, 9:45 a.m.: 27 IR 505.]*.

(d) The school service standard license–school psychologist may be professionalized when the holder has completed five (5) years of experience in accredited schools as a school psychologist.
(e) The requirements of this section apply to all candidates accepted to a school psychologist program on or after September 1, 1996. *(Advisory Board of the Division of Professional Standards; 515 IAC 1-1-76.1; filed Dec 15, 1993, 5:00 p.m.: 17 IR 994; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529; readopted filed Jul 18, 2007, 11:42 a.m.: 20070808-IR-515070238RFA).*

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Indiana Department of Education Rule on School Social Worker Licensure

For more information go to http://www.doe.in.gov/educatorlicensing/ and click Current Indiana Educators, then School Services Licensure, and School Social Worker License.

515 IAC 8-1-48 School services; school social worker, school services license
Authority: IC 20-28-2-6
Affected: IC 20-28
Sec. 48. (a) The applicant for the initial practitioner license as a social worker must meet the following requirements:
(1) Successfully meet the standards for the school service professional and the specialty standards for school social worker adopted by the board as set forth in 515 IAC 11 *[sic.]*.
(2) Successfully meet all developmental standards adopted by the board as set forth in 515 IAC 11 *[sic.]*.
(3) Obtain a master's degree from an institution of higher education approved by the board to offer such a degree in a school social work or related field.
(4) Be recommended by the licensing advisor of the accredited institution where the applicant's approved qualifying program was completed.
(b) The holder of the school services; school social worker license is only eligible to serve as a school social worker in any school setting.
(c) The holder of a school services; school social worker license may obtain the accomplished practitioner license when he or she has:
(1) completed an educational specialist or higher degree in a social work-related field at an institution approved by the board to offer the appropriate course work; and
(2) been recommended for the accomplished practitioner license by the licensing advisor at the institution where the approved program was completed.
(Advisory Board of the Division of Professional Standards; 515 IAC 8-1-48; filed Aug 11, 2003, 3:15 p.m.: 27 IR 180)

515 IAC 12-1-2 Accomplished practitioner administration or school services license
Authority: IC 20-28-2-6
Affected: IC 20-28
Sec. 2. An accomplished practitioner administration or school services license is a renewable license that may be issued to an administrator or school services applicant who holds a proficient practitioner administration or school services license, as noted in 515 IAC 8-1-40 through 515 IAC 8-1-48 and completes the requirements as outlined in this rule. *(Advisory Board of the Division of Professional Standards; 515 IAC 12-1-2; filed Feb 14, 2005, 10:20 a.m.: 28 IR 2135)*

D R A F T
***Proposed* Indiana Medicaid Rule on IEP Transportation Services**

405 IAC 5-30-11 Reimbursement for school corporation IEP transportation services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected:

Sec. 11 Covered Services

(1) Special education transportation services provided by a school corporation with the following limitations:

a. Special education transportation services must be listed in child's individualized education program (IEP) and must be provided to enable child to receive another Medicaid-covered service listed in the child's IEP.

b. Special education transportation involves a trip from home to school and the return trip on a day when the child receives another Medicaid-covered IEP service other than transportation or from school or home to an off-site Medicaid service provider and the return trip on a day when the child receives a Medicaid-covered IEP service other than transportation. Special education transportation also includes transportation of a child who resides in an area that does not typically have school bus service when that child's IEP stipulates a medical need for transportation and all other Medicaid requirements are met.

c. Special education transportation must be rendered only by school corporation personnel or their contractor.

   i. Special education transportation is not covered when provided by a member of the child's family if that person is not an employee of the school corporation.

d. Special education transportation services shall be provided using a type of vehicle that is appropriate for the child's disability and which meets the specifications established in:

   i. 575 IAC 1- 5;
   ii. 575 IAC1- 5.5; or
   iii. 575 IAC 1-1-1 (a) through (h).

e. Additional payment is available for an attendant, subject to the limitations in 405 IAC 5-30-8(1) and (2), provided the student's IEP includes the need for an attendant and all other Medicaid requirements are met.

f. Documentation for transportation service claims, such as an ongoing trip log maintained by the provider of the special education transportation, must be maintained for purposes of an audit trail.

g. Reimbursement is available for special education transportation services subject to the requirements set forth in this rule and when provided in accordance with provider communications, including banners, bulletins, provider manuals, and the provider agreement.

h. School corporations are exempt from the enrollment requirements set out in 405 IAC 5-4-2, when transportation services provided are in conformance with 405 IAC 5-30-11.

DRAFT

Indiana Law on School Bus Driver Requirements

IC 20-27-8
Chapter 8. School Bus Drivers

IC 20-27-8-1
School bus driver or school bus monitor; requirements
Sec. 1. (a) An individual may not drive a school bus for the transportation of students or be employed as a school bus monitor unless the individual satisfies the following requirements:
(1) Is of good moral character.
(2) Does not use intoxicating liquor during school hours.
(3) Does not use intoxicating liquor to excess at any time.
(4) Is not addicted to any narcotic drug.
(5) Is at least:
(A) twenty-one (21) years of age for driving a school bus; or
(B) eighteen (18) years of age for employment as a school bus monitor.
(6) In the case of a school bus driver, holds a valid public passenger chauffeur's license or commercial driver's license issued by the state or any other state.
(7) Possesses the following required physical characteristics:
(A) Sufficient physical ability to be a school bus driver, as determined by the committee.
(B) The full normal use of both hands, both arms, both feet, both legs, both eyes, and both ears.
(C) Freedom from any communicable disease that:
(i) may be transmitted through airborne or droplet means; or
(ii) requires isolation of the infected person under 410 IAC 1-2.3.
(D) Freedom from any mental, nervous, organic, or functional disease that might impair the person's ability to properly operate a school bus.
(E) Visual acuity, with or without glasses, of at least 20/40 in each eye and a field of vision with one hundred fifty (150) degree minimum and with depth perception of at least eighty percent (80%).
(b) This subsection applies to a school bus monitor. Notwithstanding subsection (a)(5)(B), a school corporation or school bus driver may not employ an individual who is less than twenty-one (21) years of age as a school bus monitor unless the school corporation or school bus driver does not receive a sufficient number of qualified applicants for employment as a school bus monitor who are at least twenty-one (21) years of age. A school corporation or school bus driver shall maintain a record of applicants, their ages, and their qualifications to show compliance with this subsection.
As added by P.L.1-2005, SEC.11.

IC 20-27-8-2
School bus driver driving summary
Sec. 2. (a) Before a school corporation enters into a:
(1) contract with a school bus driver; or
(2) fleet contract under IC 20-27-5;
the school corporation shall obtain, at no fee from the bureau of motor vehicles, a copy of

the school bus driver's driving summary for the last seven (7) years as maintained by the bureau of motor vehicles or the equivalent agency in another state.

(b) To obtain a copy of the school bus driver's driving summary as required under subsection (a), the school corporation shall provide the bureau of motor vehicles with the following information:

(1) The school bus driver's name.

(2) The school bus driver's Social Security number.

(3) Any other information required by the bureau of motor vehicles.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-3

Consumption or possession of controlled substance; offense

Sec. 3. (a) As used in this section, "controlled substance" has the meaning set forth in IC 35-48-1.

(b) An individual who is a school bus driver and who knowingly and intentionally:

(1) consumes a controlled substance or an intoxicating liquor within six (6) hours before:

(A) going on duty; or

(B) operating a school bus; or

(2) consumes or possesses a controlled substance or an intoxicating liquor while on duty or while operating a school bus;

commits a Class A misdemeanor.

(c) It is a defense in a prosecution under this section if a controlled substance is consumed or possessed in accordance with a medical prescription issued by an Indiana physician to the individual who consumes or possesses the controlled substance.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-4

School bus driver; physical examination certificate

Sec. 4. An individual who is or intends to become a school bus driver must obtain a physical examination certificate stating that the individual possesses the physical characteristics required by section 1(a)(7) of this chapter. The certificate shall be made by a physician who is licensed in Indiana or a state bordering Indiana after the physician has conducted a physical examination of the school bus driver or prospective school bus driver. The physician shall be chosen by the school bus driver or prospective driver, who shall pay for the examination.

As added by P.L.1-2005, SEC.11. Amended by P.L.82-2009, SEC.1.

IC 20-27-8-5

School bus driver; public passenger chauffeur license; physical examination timing

Sec. 5. (a) When an individual holds a contract to serve or is serving as a school bus driver at the time the individual obtains a public passenger chauffeur's license, the individual shall undergo the physical examination required by section 4 of this chapter at about the same time as the individual acquires the chauffeur's license. The certificate of examination and qualification shall be filed not more than seven (7) days after the examination.

(b) When an individual executes a contract to drive a school bus or begins serving as a school bus driver after obtaining a public passenger chauffeur's license, the individual may not drive a school bus unless:

(1) the individual files a certificate of a physical examination made at the time the individual last secured a public passenger chauffeur's license; or

(2) if a certificate was not made at the time of the prior examination or is unobtainable, the individual undergoes a new physical examination and files a certificate from that examination.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-6

School bus driver; additional physical examination

Sec. 6. A governing body may, at any time, require a school bus driver operating a school bus for the school corporation to submit to a physical examination by an Indiana physician selected by the corporation. The school corporation shall pay the cost of an examination under this section.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-7

Transportation or fleet contract; compensation

Sec. 7. When a school bus driver operates under a transportation or fleet contract, the compensation for the school bus driver or fleet contractor is determined and fixed by the contract on a per diem basis for the number of days on which:

(1) the calendar of the school corporation provides that students are to attend school;

(2) the driver is required by the school corporation to operate the bus on school related activities; and

(3) inservice training is required by statute or authorized by the school corporation, including the safety meeting workshops required under section 9 of this chapter.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-8

School bus driver employment contract; compensation

Sec. 8. The compensation of a school bus driver who is employed by a school corporation on a school year basis under an employment contract shall be fixed in the employment contract. *As added by P.L.1-2005, SEC.11.*

IC 20-27-8-9

Annual safety meeting; attendance required

Sec. 9. A school bus driver, including a school bus driver who drives a bus for a nonpublic school, shall attend an annual safety meeting or workshop. A safety meeting or workshop may not exceed two (2) days in any one (1) calendar year.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-10

Preservice school bus driver safety experience and education requirements

Sec. 10. (a) An individual who does not have at least thirty (30) days experience in driving a school bus during the three (3) year period immediately preceding the effective date of the individual's assignment as a school bus driver for a public or nonpublic school that is accredited by the state board within Indiana shall satisfactorily complete a preservice school bus driver safety education training course. The course may not exceed forty (40) hours.

(b) Course attendance must be completed:

(1) before the assignment of an individual required to take the course as a school bus driver; or

(2) if immediate assignment is necessary, upon the completion of the next scheduled course following the assignment.

(c) The state superintendent shall provide instructors, adequate meeting facilities, registration forms, a uniform course of instruction, and all other necessary materials for the preservice school bus driver safety education meetings.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-10.5

Special purpose bus driver safety plan

Sec. 10.5. (a) Not later than September 1, 2009, the department shall:

(1) develop;

(2) provide to the general assembly and the public; and

(3) implement;

a plan to promote safe driving practices for drivers of special purpose buses.

(b) The plan developed under subsection (a) must provide clear, concise information concerning statutes and rules that affect special purpose buses and special purpose bus drivers.

(c) The department shall update the plan developed under subsection (a) as necessary.

(d) The department shall distribute the plan developed under subsection (a) in the most cost effective manner, as determined by the department.

As added by P.L.146-2009, SEC.5.

IC 20-27-8-11

Annual safety meeting; time and place

Sec. 11. The committee shall fix the date, time, and place for the annual safety meetings or workshops.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-12

Conduct of annual safety meeting

Sec. 12. The committee and the superintendent of the state police department shall provide instructors, adequate meeting facilities, and all other necessary facilities for the annual school bus driver safety meetings or workshops. The committee and the state police superintendent shall also prepare and furnish a uniform course of instruction to be used in the meetings or workshops.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-13

Annual safety meeting; registration

Sec. 13. (a) The committee shall provide a uniform system for the registration of school bus drivers who are required to attend the annual safety meetings or workshops. This registration system must do the following:

(1) Accurately reflect the attendance of each school bus driver at each session of the annual meeting or workshop.

(2) Provide a registration form indicating the school bus driver's name and legal address, and the name of the school the school bus driver represents.

(b) The state superintendent shall supervise registration of school bus drivers at the annual safety meetings or workshops.

(c) The principal of each school shall prepare and collect the attendance records of school bus drivers who attend any safety meeting or workshops and shall make a written report of the attendance records to the state superintendent not more than ten (10) days after the meeting or workshop.

(d) Records of attendance shall be filed in the office of the state superintendent and maintained there as public records for at least three (3) years.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-14
Annual safety meeting; nonattendance

Sec. 14. If a school bus driver for a school corporation fails or refuses to attend a school bus driver meeting or workshop, the governing body of the school corporation shall deduct one (1) day's compensation for each day of absence.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-15
School bus driver training certification

Sec. 15. (a) The driver of a school bus for a public or nonpublic school that is accredited by the state board shall have in the school bus driver's possession, while transporting passengers, a certificate that states the school bus driver has:

(1) enrolled in or completed a course in school bus driver safety education as required under sections 9 and 10 of this chapter; or

(2) operated a school bus at least thirty (30) days during the three (3) year period preceding the effective date of the school bus driver's employment.

(b) A certificate of enrollment in or completion of the course or courses in school bus driver safety education shall be prescribed by the committee and completed by the designated representative of the committee.

(c) A driver of a school bus who fails to complete the school bus driver safety education course or courses, as required, shall be reported by the person who conducted the course to the committee and to the school corporation where the school bus driver is employed or under contract.

(d) A driver of a school bus who fails to complete the school bus driver safety education course or courses, as required, may not drive a school bus within Indiana while transporting a student.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-16
Violation

Sec. 16. Except as provided in section 3(b) of this chapter, a person who knowingly, intentionally, or recklessly violates this chapter commits a Class C misdemeanor.

As added by P.L.1-2005, SEC.11. Amended by P.L.231-2005, SEC.39.

Indiana Department of Education Rules on School Bus Specifications

575 IAC 1-1-1 Applicability of specifications; definitions
Authority: IC 20-27-3-4
Affected: IC 20-27-2-8
Sec. 1. (a) The definitions in this section apply throughout this article.
(b) "School bus" means any motor vehicle, other than a special purpose bus as defined in IC 20-27-2-8, designed and constructed for the accommodation of more than ten (10) passengers that is used for the transportation of Indiana school children. The term includes either the chassis or the body, or both the chassis and the body.
(c) "School children" means children enrolled in private schools in grades kindergarten through twelve (12) and all children enrolled in public school corporations.
(d) "Type A school bus" means a conversion or body constructed upon a van-type or cutaway front-section vehicle with a left side driver's door, designed for carrying more than ten (10) persons. The term includes two (2) classifications:
(1) Type A-1, with a gross vehicle weight rating of ten thousand (10,000) pounds and under; and
(2) Type A-2, with a gross vehicle weight rating over ten thousand (10,000) pounds.
(e) "Type B school bus" means a conversion or body constructed and installed upon a van or front-section vehicle chassis or stripped chassis with a vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. Part of the engine is beneath and/or behind the windshield and beside the driver's seat. The entrance door is behind the front wheels.
(f) "Type C school bus" means a body installed upon a flat back cowl chassis with a gross vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. All of the engine is in front of the windshield. The entrance door is behind the front wheels.
(g) "Type D school bus" means a body installed upon a chassis with the engine mounted in the front, midship, or rear with a gross vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. The engine may be behind the windshield and beside the driver's seat, at the rear of the bus, behind the rear wheels, or midship between the front and rear axles. The entrance door is ahead of the front wheels.
(h) "Vehicles for transporting handicapped students" means vehicles designed and constructed to meet the requirements for the appropriate size school buses with specialized equipment as prescribed under 575 IAC 1-5. *(State School Bus Committee; Sec I; filed Feb 10, 1978, 3:31 p.m.: Rules and Regs. 1979, p. 323; filed Apr 14, 1981, 11:30 a.m.: 4 IR 778, eff Jul 1, 1981; filed Jun 20, 1988, 8:50 a.m.: 11 IR 3819; filed Mar 19, 2001, 11:32 a.m.: 24 IR 2467; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; errata filed Jun 27, 2005, 1:45 p.m.: 28 IR 3583; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)*

Rule 5. Vehicles for Transporting the Handicapped Ordered for Purchase and Initially Placed in Service on or after July 1, 1988

575 IAC 1-5-1 General requirements

Authority: IC 20-27-3-4
Affected: IC 20-27-3-4; IC 20-27-5-9; IC 20-27-9
Sec. 1. General Requirements
(1) Vehicles constructed and designed for transporting handicapped children shall comply generally with the standards for school buses, but due to the need for special equipment, modifications to these minimum standards must be made.
(2) All buses, whether modified or constructed for the transportation of handicapped children must meet or exceed the requirements, as set forth for the applicable type school bus except as provided herein under Special Equipment.
(State School Bus Committee; Sec V, General Requirements; filed Feb 10, 1978, 3:31 pm: Rules and Regs. 1979, p. 398; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)

575 IAC 1-5-2 Special equipment

Authority: IC 20-27-3-4
Affected: IC 20-27-3-4; IC 20-27-5-9; IC 20-27-9
Sec. 2. Special Equipment
(1) Special Service Door
(A) Special service door opening shall be located on right side of bus and far enough to the rear to prevent door, when open, from obstructing right front service door. Door opening shall be not less than 30 inches in width.
(B) Door shall be constructed of two (2) panels of approximate equal width, equipped with hinges and securely hinged to side of bus and each panel shall open outward. Forward panel shall be flush with rear panel or provided with overlapping flange to close space where door panels meet and weather seal shall be provided to close all door edges.
(i) Special service door may be one (1) single panel meeting all requirements set forth under 1.a and 1.b (subsections (1)(A) and (1)(B) of this section).
(C) Two (2) panel door shall be equipped with at least two-point fastening device to floor level and header on, both, rear door panel and forward door panel and single door panel shall be equipped with two-point fastening device to floor level and header, all manually controlled or operated.
(D) Door shall be equipped with device that will actuate audible signal, located in driver compartment, when doors are not securely closed. Exception: When two-panel door is used, with front panel overlapping rear panel, audible signal shall be actuated when front panel is opened but may be deactivated when rear panel is opened.
(E) Each door shall contain fixed or movable window, aligned with lower line of other windows of bus and as nearly as practicable, of same size as other bus windows.
(F) Each door panel shall open outward and positive fastening device shall be installed to hold each door panel in open position.
(G) Door panel shall be constructed so as to be equivalent in strength and materials to other school bus doors.

(H) When ramps are used, door panels shall cover ramp container opening. When specific construction requires an opening in the floor, door panels shall extend below to full length of skirt.
(I) Floor shall be adequately supported at front and rear of door opening to support front with same strength as other floor portions.
(2) Ramp
(A) If ramp is used, it shall be of sufficient strength and rigidity to support wheel chair, occupant and attendant. It shall be equipped with protective flange on each longitudinal side to keep wheel chair on ramp.
(B) Ramp floor shall be unflattened expanded metal, covered by flat plate, except in the walking area of ramp. In addition, the flat plate area shall be covered with a non-skid material.
(C) Ramp shall be of such weight and equipped with handle or handles, to permit one person to put ramp in place or return it to storage position.
(D) Provisions shall be made to secure ramp to side of bus for use without danger of detachment and ramp shall be connected to bus at floor level in such a manner as to permit easy access of wheels of wheel chairs to floor of bus.
(E) Ramp shall be of at least 80 inches in length for Type II buses and at least 88 inches in length for Type I buses, and width shall conform generally to width of door opening.
(F) Dustproof and waterproof enclosed container shall be provided if ramp is stored under the floor.
(3) Power Lift
(A) If power lift is used, it shall be of sufficient strength, rigidity, and capacity to lift a minimum of 500 pounds and shall be designed so as to be operable through four complete full load cycles with engine off.
(B) Power lift platform shall be not less than 26 inches in width nor less than 45 inches long for double-door installation and not less than 26 inches in width nor less than 41 inches long for single door installation, including guard panels or rails.
(C) Power lift platform shall be covered with non-skid material.
(D) Self-adjusting steel (or equivalent) ramp of sufficient width to minimize incline to lift platform shall be attached to lift platform. Ramp shall be equipped with non-skid material.
(E) Power lift shall be controlled from panel within the bus or by a portable control unit which shall be adjacent to the lift and shall be capable of operation by attendant standing upon lift when lift is in any position.
(F) A device shall be installed which will prevent operation of lift until doors are in open position.
(G) All chains, wires, and other mechanisms, except lift control panel, necessary to effect upward and downward movement of lift platform, shall be concealed and installed in such a manner so as to prevent accessibility by children.
(4) Guard Panel
(A) Guard panels shall be installed at both rear and front edges of special service door opening, extending into bus. If power lifts are used, and when construction requires opening in the floor, a chain shall be installed between guard panels to enclose area of power lift.
(B) Restraining barriers shall be installed immediately to the rear of the driver's platform and immediately to the rear of the step-well on buses which are constructed and equipped so as the wheel chair spaces are located in front portion of bus.
(5) Wheel Chairs

(A) Positive fastening devices shall be provided, attached to floor or walls, or both, that will securely hold wheel chair in position when in bus.
(B) Distance between the rearmost extremeties of the wheelchair (measured at floor line) when the wheelchair is in any position and the outside rear of the bus shall be not less than eight (8) inches on Type I buses and not less than six (6) inches on Type II buses.
NOTE: Parents or guardians of wheel chair pupils are encouraged to provide pupil restraining devices, attached to the wheel chair.
(6) Seat Restraining Devices
(A) Seat frames shall be equipped with rings or other devices to which belts or restraining harness for each passenger may be attached or otherwise equipped so as to be in full compliance with any applicable Federal Motor Vehicle Safety Standard.
(7) Aisle
(A) All aisles, including aisle leading to emergency door shall have a minimum clearance of not less than 12 inches.
(8) Special Seats
(A) Longitudinal seats, not exceeding 45 inches in length are permissible over the wheel housings. If used, such seats shall be securely fastened and equipped with seat arm rests and positive pupil restraining devices.
(9) Fuel System
(A) The fuel tank shall be manufacturers' standard; mounted, filled, and vented outside of body and shall conform to all requirements set forth under Federal Motor Vehicle Safety Standard (FMVSS) No. 301.
(10) Battery
(A) Battery shall be 12 volt of either Conventional a (lead-antimony) or Maintenance Free Sealed (lead-calcium) design.
(B) Minimum capacity shall be 100 reserve minutes and 430 CCA (cold cranking amperes) at 0 degrees F. per S-537A standard. (Essentially meets 70 amperes per hour capacity.)
(C) Handicapped vehicles equipped with power lifts shall have storage battery capacity sufficient, when fully charged, to satisfy electrical demand of lift through (4) complete full load cycles, with engine off and have sufficient capacity left to re-start engine.
(11) Special Light
(A) Light shall be placed inside bus, over special service door, and shall be operated from door area to adequately illuminate the special service door area.
(12) Grab Handle
(A) Grab handles shall be provided on each side of front right service door on buses constructed for the transportation of handicapped children.
(State School Bus Committee; Sec V, Special Equipment; filed Feb 10, 1978, 3:31 pm: Rules and Regs. 1979, p. 398; filed Apr 14, 1981, 11:30 am: 4 IR 796, eff Jul 1, 1981; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)

Rule 5.5. Vehicles for Transporting the Handicapped Ordered for Purchase and Initially Placed in Service on or after July 1, 1990
575 IAC 1-5.5-1 General requirements
Authority: IC 20-27-3-4
Affected: IC 20-27; IC 20-35

Sec. 1. (a) A bus constructed and designed for transporting handicapped children must comply with the standards outlined in 575 IAC 1-1 through 575 IAC 1-4. Modifications to some of the standards are necessary to accommodate the special equipment necessary to transport handicapped students.
(b) Any school bus used to transport a child confined to a wheelchair or other device that prohibits the use of the regular passenger service door, must be equipped with a power lift. If a special unloading device is needed for unusual circumstances, a waiver from the school bus committee is required.
(c) A bus transporting more than two (2) wheelchair-confined students must have at least a one hundred (100) amp alternator.
(d) All special needs children must be properly and appropriately restrained for safe transportation. Special needs children means children defined under IC 20-35.
(e) Federal Motor Vehicle Safety Standards referred to in this rule are found at 49 CFR Ch. V (10-1-89 Edition), Part 571, and are herein incorporated and made a part of this rule by reference. Copies of these federal standards are on file with the department of education or may be obtained from the U.S. Government Printing Office, Washington, D.C. *(State School Bus Committee; 575 IAC 1-5.5-1; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; errata filed Jun 27, 2005, 1:45 p.m.: 28 IR 3583; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-2 Aisles

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 2. The aisle leading from the wheelchair area to all emergency doors must be at least thirty (30) inches wide. *(State School Bus Committee; 575 IAC 1-5.5-2; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-3 Wheelchairs

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 3. (a) A student who can reasonably be moved from the student's wheelchair, stroller, or special seating device must be transferred during transportation to and from school to:
(1) an original equipment manufacturer forward facing vehicle seat equipped with dynamically tested occupant restraints; or
(2) a child seat that complies with the requirements of Federal Motor Vehicle Safety Standard (FMVSS) 213.
(b) A wheelchair must be adequately secured during transportation. An occupied wheelchair must face forward.
(c) Occupied three-wheeled, cart-type units and other stroller-type devices may not be transported in a school bus unless there is impact test evidence to demonstrate that the unit can be secured under impact loading conditions using a four-point strap-type tiedown.
(d) Manufacturers of the three-wheeled, cart-type units and other stroller-type devices must verify that the unit can be secured under impact loading conditions.
(e) A wheelchair or stroller-type unit designed and approved by the manufacturer for use during transportation must be used according to the manufacturer's instructions.

(f) The distance between the rearmost part of a secured wheelchair and the outside rear of the bus must be at least the following:
(1) Six (6) inches on Type A and Type B buses.
(2) Eight (8) inches on Type C and Type D buses.
(State School Bus Committee; 575 IAC 1-5.5-3; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; filed May 21, 1992, 5:00 p.m.: 15 IR 2220; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1649; readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

575 IAC 1-5.5-4 Wheelchair and occupant restraint systems

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 4. (a) A strap-type wheelchair securement system must be provided that meets the following requirements:
(1) Anchors to the floor of the bus at four (4) or more places.
(2) Attaches to the wheelchair at a minimum of two (2) front and two (2) rear securement points.
(3) Complies with Society of Automotive Engineers Recommended Practice J-2249.
(4) A wheelchair that weighs two hundred (200) pounds or greater, transported on a school bus, ten thousand (10,000) pounds or less in gross vehicle weight, must be secured with more than two (2) rear tiedown straps.
(5) A wheelchair that weighs two hundred fifty (250) pounds or greater, transported on a school bus exceeding ten thousand (10,000) pounds in gross vehicle weight, must be secured with more than two (2) rear tiedown straps.
(b) An occupant restraint system must be provided for each wheelchair occupant that complies with Society of Automotive Engineers Recommended Practice J-2249 such that it meets the following requirements:
(1) Includes upper and lower torso restraints.
(2) Has been tested at thirty (30) miles per hour and twenty (20) G frontal impact conditions which have been verified by the manufacturer of the occupant restraint system.
(3) If the occupant restraining devices are incorporated in the wheelchair restraining devices, the load imposed on the anchorage system is the sum of the loads specified for the wheelchair restraint devices and the occupant restraint system.
(4) Has a lap belt attached to the wheelchair or tiedown system at an angle of forty-five (45) degrees or greater to the horizontal.
(5) Has a shoulder belt attached to the tiedown strap at or below the hip point of the occupant, or has a shoulder belt attached to the lap belt.
(6) Has the upper end of the shoulder belt attached to the vehicle at or above the height of the occupant's shoulder.
(7) Does not transfer occupant forces to the wheelchair.
(c) Static load tests must be as follows:
(1) Conducted with appropriate size washers and steel plating or with actual tiedown/restraint washers and backing plates on the underside of sheet metal floors to adequately distribute the applied loads.
(2) Verified by the school bus manufacturer or other engineering test facility.
(State School Bus Committee; 575 IAC 1-5.5-4; filed May 24, 1990, 4:20 p.m.: 13 IR 1856; errata, 13 IR 2005; filed May 21, 1992, 5:00 p.m.: 15 IR 2221; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1649;

readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.:20070725-IR-575070225ACA)

575 IAC 1-5.5-5 Power lift

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 5. (a) The lifting mechanism must:
(1) be able to lift a minimum load of eight hundred (800) pounds;
(2) have a battery that, when the bus engine is off, will sustain the electrical demand of the lift through four (4) complete full load cycles and then restart the bus engine;
(3) be located on the right side of the bus body;
(4) have manual controls in the event of a power failure;
(5) not permit the platform to fall if the power fails while the lift is in operation;
(6) have controls that enable the operator to activate the lift while standing on the platform;
(7) have a circuit breaker or fuse connecting the lift motor to the power source; and
(8) have limit switches or bypass valves to prevent excess pressure from building in the hydraulic system when the platform is upright or extended.
(b) The power lift must:
(1) have a clear horizontal opening and platform large enough to accommodate a thirty (30) inch wide wheelchair on the bus;
(2) be confined within the perimeter of the bus body when not in use;
(3) mechanically lock when the lift is in the upright position by means other than a support or lug on the door;
(4) move smoothly and rest solidly on the ground;
(5) have sides at least one and one-half (1½) inches high on the platform;
(6) be designed to prevent the operator from being entangled in the lift during raising and lowering of the platform;
(7) have a skid-resistant platform surface;
(8) have a self-adjusting, skid-resistant inclined plate on the outer edge to facilitate movement from the ground to the platform;
(9) have a plate or panel on the outer edge to prevent a wheelchair from rolling off when the platform is raised; and
(10) have padding on the crossbar on the top of the lift, if the lift is equipped with a crossbar.
(c) The power lift may have a handrail. *(State School Bus Committee; 575 IAC 1-5.5-5; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; filed May 21, 1992, 5:00 p.m.: 15 IR 2221; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-6 Regular service entrance door

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 6. (a) There must be three (3) riser steps approximately equal in height in the entrance well of Type C and Type D buses. The first step must not be less than ten (10) inches or more than fourteen (14) inches from the ground based on standard chassis specifications.
(b) An additional fold-out lower step may be provided to make the lowest step no more than six (6) inches from the ground.

(c) A bus constructed for transportation of handicapped children must have grab handles located on each side of the regular service door. *(State School Bus Committee; 575 IAC 1-5.5-6; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-7 Special light

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 7. A bus must have interior light(s) that:
(1) are automatically or manually activated;
(2) sufficiently illuminate the lift area; and
(3) are activated from the door area.
(State School Bus Committee; 575 IAC 1-5.5-7; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

575 IAC 1-5.5-8 Special service entrance

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 8. (a) Bus bodies may have a special service entrance to accommodate a wheelchair lift. The special service entrance must meet the following specifications:
(1) The entrance opening must be on the right side of the bus.
(2) The entrance must be located so the doors, when open, do not obstruct the right front regular service door.
(3) If the entrance extends below the floor of the body skirt, reinforcements must be installed at the front and back of the floor opening to support the floor and give the same strength as other floor openings.
(4) A drip molding must be located above the opening that diverts water from the entrance.
(5) The entrance must be wide enough to accommodate a mechanical lift, lift accessories, and the lift platform.
(6) Entrance door posts and headers must be reinforced.
(b) A school corporation may purchase a bus with a special service entrance with the intention of using it to transport handicapped students in the future. While the bus is used to transport nonhandicapped students the special service door must:
(1) be sealed and inoperable;
(2) have no handles; and
(3) have the words NOT AN EXIT placed in black letters at least two (2) inches high above the door on the interior and exterior of the bus.
(c) When a school corporation decides to use a bus under subsection (b) to transport handicapped students, it must remove the words NOT AN EXIT from above the door.
(d) The entrance must have interior padding at least three (3) inches wide and one (1) inch thick covering the full width of the top of each door opening. *(State School Bus Committee; 575 IAC 1-5.5-8; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-9 Special service entrance door

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 9. (a) The special service entrance door(s) must meet the following specifications:
(1) All doors must open outward.
(2) The door(s) must have an opening wide enough to permit proper operation of a lift meeting the requirements of section 5 of this rule, but may not exceed forty-three (43) inches in width.
(3) If the special service entrance opening is more than forty-three (43) inches wide, two (2) doors must be used.
(4) The door must have fastening devices to hold it open.
(5) The doors must be weather sealed.
(6) Buses with two (2) doors must have a flange on the forward door that overlaps the edge of the rear door when closed.
(7) Power doors may be used, but the design must provide for manual operation from inside the bus.
(8) The door materials, colors, lettering, and other exterior features must correspond with or match adjacent sections of the bus body, except for rub rails.
(9) The door materials, panels, and structural strength must be equivalent to the regular service and emergency doors.
(10) The door must have a switch that prevents the power lift from operating when the platform door is closed.
(b) If manually operated dual doors are used, the following specifications must be met:
(1) The rear door must have at least a one-point fastening device that fastens to the header.
(2) The forward mounted door must have at least three (3) fastening devices which fasten to:
(A) the header;
(B) the floor line of the body; and
(C) the rear door.
(3) The fastening devices must provide maximum safety when the doors are closed.
(4) The door and hinge mechanisms must be constructed to withstand the same use as a regular service door.
(c) The doors must have windows that are:
(1) set in rubber; and
(2) within one (1) inch of the lower line of the adjacent sash.
(d) There must be a device in the driver's compartment that activates a red, flashing visible signal when the ignition is on and the special service door is not securely closed.
(e) Seats may be placed in front of an inoperable door of a bus described under section 8(b) of this rule. *(State School Bus Committee; 575 IAC 1-5.5-9; filed May 24, 1990, 4:20 p.m.: 13 IR 1858; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-10 Panels

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 10. (a) A restraining barrier or seat back that meets FMVSS 222 must be located in front of any forward facing seat.
(b) A bus with wheelchair spaces located in the front portion of the bus must have padded protection panels behind the driver's platform and in back of the front step well. The bottom of the panel cannot be more than three (3) inches from the floor of the bus.

(c) If modification for a power lift requires an opening in the floor, a chain must be installed between the protection panels to enclose the lift area.
(d) A protection panel must be located between the inner lift frame structure and the bus sidewall. The panel must extend from the top of the window to no more than three (3) inches from the floor. *(State School Bus Committee; 575 IAC 1-5.5-10; filed May 24, 1990, 4:20 p.m.: 13 IR 1858; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-11 Special requirements

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 11. (a) Any passenger seat that has a child safety seat or restraint system attached to it must:
(1) have a reinforced frame; and
(2) meet the requirements of FMVSS 208, 209, and 210.
(b) All child safety seats or restraint systems used in a school bus must be secured to a bus seat in a manner prescribed and approved by the manufacturer, and must meet safety specifications as follows:
(1) A child weighing less than fifty (50) pounds must be transported in a child safety seat or restraint system meeting FMVSS 213.
(2) A child weighing less than thirty (30) pounds must be transported in a car seat meeting FMVSS 213.
(3) A child weighing less than thirty (30) pounds with a tracheostomy must be transported in a car seat without a shield or armrest.
(4) A safety seat used to transport a child under twenty (20) pounds must be attached to the bus seat in a rearward facing position.
(c) Lap boards attached to wheelchairs or to adaptive equipment must be removed and secured separately during transport.
(d) All respiratory related equipment, such as oxygen, aspirators, and ventilators, must be securely mounted or fastened to a wheelchair, bus seat, bus floor, or to the bus wall below the window line during transit.
(e) Tanks of compressed oxygen transported in a school bus may be no larger than twenty-two (22) cubic feet and must be securely mounted inside the bus. Tanks must have valves and regulators that are protected against breakage. Tanks must be secured to avoid exposure to intense heat, flames, sparks, or friction.
(f) Any liquid oxygen container transported in a school bus may be no larger than thirty-eight (38) cubic feet and must be securely mounted and fastened to prevent damage and exposure to intense heat.
(g) Subsection (a) applies to school buses ordered for purchase and initially placed in service on or after July 1, 1990. School buses ordered for purchase and initially placed in service prior to July 1, 1990, may comply with subsection (a). *(State School Bus Committee; 575 IAC 1-5.5-11; filed May 24, 1990, 4:20 p.m.: 13 IR 1859; filed May 21, 1992, 5:00 p.m.: 15 IR 2222; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-75070225ACA)*

575 IAC 1-5.5-12 Applicability of rule

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 12. (a) The revisions of 575 IAC 1-5, effective July 1, 1981, apply to all school buses ordered for purchase or placed in production for use in Indiana before June 30, 1990.
(b) The requirements of this rule apply to all school buses ordered for purchase and initially placed in service on or after July 1, 1990.
(c) Sections 3(a), 3(c) through 3(e), and 11(b) through 11(f) of this rule apply to all school buses regardless of when the school buses were ordered or placed in service. *(State School Bus Committee; 575 IAC 1-5.5-12; filed May 24, 1990, 4:20 p.m.: 13 IR 1859; filed May 21, 1992, 5:00 p.m.: 15 IR 2222; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1650; readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

Indiana Law Regarding Financial Responsibility Requirements for Vehicles

IC 9-25-4 Chapter 4. Financial Responsibility

IC 9-25-4-1 Persons, generally, who must meet minimum standards; violation; suspension of license or vehicle registration Sec. 1. (a) This section does not apply to an electric personal assistive mobility device. (b) A person may not: (1) register a vehicle; or (2) operate a vehicle on a public highway; in Indiana if financial responsibility is not in effect with respect to the motor vehicle under section 4 of this chapter. (c) A person who violates this section is subject to the suspension of the person's current driving license or vehicle registration, or both, under this article. *As added by P.L.2-1991, SEC.13. Amended by P.L.105-1991, SEC.1; P.L.59-1994, SEC.3; P.L.143-2002, SEC.8.*

IC 9-25-4-2 Recovery vehicle operators; duty to meet minimum standards; registration of recovery vehicles; proof of financial responsibility; retention of records Sec. 2. A person who operates a recovery vehicle must meet the minimum standards for financial responsibility that are set forth in section 6 of this chapter. A recovery vehicle may be registered only if proof of financial responsibility in amounts required under this section is produced at the time of registration. The bureau shall retain a record of that proof in the bureau's files. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-3 Continuous maintenance Sec. 3. Financial responsibility in one (1) of the forms required under this chapter must be continuously maintained as long as a motor vehicle is operated on a road, street, or highway in Indiana. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-4 When financial responsibility in effect; necessary provisions in and approval of insurance policies Sec. 4. (a) For the purposes of this article, financial responsibility is in effect with respect to a motor vehicle if: (1) a motor vehicle liability insurance policy issued with respect to the vehicle; (2) a bond executed with respect to the vehicle under section 7 of this chapter; or (3) the status of the owner or operator of the vehicle as a self-insurer, as recognized by the bureau through the issuance of a certificate of self-insurance under section 11 of this chapter; provides the ability to respond in damages for liability arising out of the ownership, maintenance, or use of the motor vehicle in amounts at least equal to those set forth in section 5 or 6 of this chapter. (b) A motor vehicle liability policy under this article must contain the terms, conditions, and provisions required by statute and must be approved by the state insurance commissioner. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-5 Minimum amounts of financial responsibility Sec. 5. Except as provided in section 6 of this chapter, the minimum amounts of financial responsibility are as follows: (1) Subject to the limit set forth in subdivision (2), twenty-five thousand dollars ($25,000) for bodily injury to or the death of one (1) individual. (2) Fifty thousand dollars ($50,000) for bodily injury to or the death of two (2) or more individuals in any one (1) accident. (3) Ten thousand dollars ($10,000) for damage to or the destruction of property in one (1) accident. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-6 Recovery vehicles; minimum amounts of financial responsibility Sec. 6. (a) The minimum standards for financial responsibility for a Class A recovery vehicle are a combined single limit of seven hundred fifty thousand dollars ($750,000) for bodily injury and property damage in any one (1) accident or as follows: (1) Subject to the limit set forth in subdivision (2), five hundred thousand dollars ($500,000) for bodily injury to or the death of one (1) individual. (2) One million dollars ($1,000,000) for bodily injury to or the death of

two (2) or more individuals in any one (1) accident. (3) One hundred thousand dollars ($100,000) for damage to or the destruction of property in one (1) accident. (b) The minimum standards for financial responsibility for a Class B recovery vehicle are a combined single limit of three hundred thousand dollars ($300,000) for bodily injury and property damage in any one (1) accident or as follows: (1) Subject to the limit set forth in subdivision (2), one hundred thousand dollars ($100,000) for bodily injury to or the death of one (1) individual. (2) Three hundred thousand dollars ($300,000) for bodily injury to or the death of two (2) or more individuals in any one (1) accident. (3) Fifty thousand dollars ($50,000) for damage to or the destruction of property in one (1) accident. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-7 Methods of proving financial responsibility Sec. 7. Proof of financial responsibility when required under this article may be given by any of the following methods: (1) Proof that a policy or policies of motor vehicle liability insurance have been obtained and are in full force and effect. (2) Proof that a bond has been duly executed. (3) Proof that deposit has been made of money or securities. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-8 Proof of financial responsibility; filing insurance policy certificate Sec. 8. Proof of financial responsibility may be made by filing with the bureau the written certificate of an insurance carrier authorized to do business in Indiana certifying that the carrier has issued to or for the benefit of the person furnishing the proof and named as the insured a motor vehicle liability policy meeting the requirements of this chapter and having the terms, conditions, and specifications that the bureau requires. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-9 Bonds as proof of financial responsibility; notice of bond cancellation; recovery on claims arising before cancellation Sec. 9. (a) A person required to give proof of financial responsibility may file with the bureau a bond under this section. The bond shall be executed by the person giving the proof and by a surety company authorized to transact business in Indiana. (b) The bureau may not accept a bond unless the bond is conditioned for payments in amounts and under the same circumstances as would be required in a motor vehicle liability policy furnished by the person giving proof of financial responsibility under this article. (c) A bond filed under this section may not be canceled unless ten (10) days written notice of cancellation is given to the bureau. Cancellation of a bond under this subsection does not prevent recovery on the bond due to a right or cause of action arising before the date of cancellation. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-10 Deposits with treasurer of state as proof of financial responsibility; grounds for and amount of limitations on execution; proof of absence of unsatisfied judgments Sec. 10. (a) A person required to give proof of financial responsibility under this article may give proof of financial responsibility by delivering to the bureau a receipt from the treasurer of state showing a deposit with the treasurer of state of one (1) of the following: (1) Forty thousand dollars ($40,000) in cash or securities that may legally be purchased by savings banks. (2) Trust funds with a market value of forty thousand dollars ($40,000). (b) Money and securities deposited under this section are subject to execution to satisfy a judgment under this article within the limits of coverage and subject to the limits on amounts required by this chapter for motor vehicle liability policies. Money and securities deposited under this section are not subject to attachment or execution for a reason not listed under this article. (c) The treasurer of state may not accept a deposit or issue a receipt for a deposit under this section, and the bureau may not accept a receipt for a deposit under this section, unless the person making the deposit provides evidence that there are no unsatisfied judgments against the person making the deposit registered in the office of the

circuit court clerk of the county where the person making the deposit resides. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-11 Certificate of self-insurance; cancellation Sec. 11. (a) The bureau may, upon the application of a person, issue a certificate of self-insurance when the bureau is satisfied that the person making the application is possessed and will continue to be possessed of the ability to pay a judgment obtained against the person making the application. A certificate may be issued authorizing a person to act as a self-insurer for property damage, bodily injury, or death. (b) After not less than five (5) days notice and a hearing concerning the notice, the department may upon reasonable grounds cancel a certificate of self-insurance. Failure to pay a judgment within thirty (30) days after the judgment becomes final constitutes a reasonable ground for the cancellation of a certificate of self-insurance. (c) The bureau may only issue a certificate of self-insurance under rules adopted to implement this section. *As added by P.L.2-1991, SEC.13.*

Indiana Medicaid Bulletin on Obligation to Screen for Individuals and Entities Excluded from Medicaid Participation

INDIANA HEALTH COVERAGE PROGRAMS

P R O V I D E R B U L L E T I N

B T 2 0 0 9 3 4 S E P T E M B E R 2 3 , 2 0 0 9

To: **All Providers**

Subject: **Requirement to Screen for Excluded Individuals and Entities**

Overview

The purpose of this bulletin is to remind all providers of their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and to review the calculation of overpayments to excluded individuals or entities.

General

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal healthcare programs (as defined in *Section 1128B(f)* of the *Social Security Act* – the Act), based on the authority contained in various sections of the Act, including *Sections 1128, 1128A, and 1156*.

Payment Ban for Excluded Providers

When the HHS-OIG has excluded a provider, Federal healthcare programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (*Section 1905(i)(2)* of the Act; and *42 CFR section 1001.1901(b)*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- Payment to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether the individual or entity provides direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

For more information visit http://www.indianamedicaid.com

Page 1 of 4

knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded (*42 CFR section 1001.1901(b)*).

The listing below[1] sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by healthcare entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients, and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901(c)*). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections *1903(d)(2)(A)* and *1903(i)(2)* of the Act, and are therefore subject to recoupment.

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[1] *This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.*

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (*Section 1128A(a)(6)* of the Act; and *42 CFR section 1003.102(a)(2)*)

Provider Requirements for Determination of Excluded Individuals or Entities

All current providers and providers applying to participate in the Medicaid program shall take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Providers shall screen all employees and contractors to determine whether any of them have been excluded.
- Providers are required to agree to comply with this obligation as a condition of enrollment.
- Providers can search the HHS-OIG Web site by the names of any individual or entity. Providers must search the HHS-OIG Web site monthly to capture exclusions and reinstatements that have occurred since the last search.
- Providers are required to immediately report to the State any exclusion information discovered by contacting the Provider and Member Concern Line at 317-347-4527 in the Indianapolis local area or toll free at 1-800-457-4515.

Where Providers Can Look for Excluded Parties

The HHS-OIG maintains the List of Excluded Individuals and Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal healthcare programs. The LEIE Web site is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The online search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal healthcare programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds.

Additional Information

The latest information regarding the IHCP can be found in the IHCP newsletters at http://www.indianamedicaid.com/ihcp/Publications/newsletters.asp. IHCP bulletins and banners pages can be accessed at http://www.indianamedicaid.com/ihcp/index.asp.

Contact Information

Questions regarding this bulletin may be directed to Customer Assistance at (317) 655-3240 or toll free at 1-800-577-1278.

APPENDIX D –Indiana Medicaid Program Contact Information

Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization			
ADVANTAGE Health Solutions℠ Prior Authorization – Medical FFS P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720 Fax: 1-800-689-2759	**Automated Voice Response (AVR) System** (including eligibility verification) (317) 692-0819 or 1-800-738-6770	**HP Member Hotline** (317) 713-9627 or 1-800-457-4584 Opt 1 = Member Services – English Opt 2 = Member Services – Spanish	**HP Customer Assistance** (317) 655-3240 or 1-800-577-1278 Opt 1 = Member Opt 2 = Pharmacy Provider Opt 3 = All Other Services
HP Electronic Solutions Help Desk (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@hp.com	**HP Forms Requests** P.O. Box 7263 Indianapolis, IN 46207-7263	**HP Administrative Review Written Correspondence** P.O. Box 7263 Indianapolis, IN 46207-7263	**HP Omni Help Desk** (317) 488-5051 or 1-800-284-3548
HP TPL (317) 488-5046 or 1-800-457-4510 Fax: (317) 488-5217	**HP Provider Enrollment and Waiver** P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	**HP Provider Written Correspondence** P.O. Box 7263 Indianapolis, IN 46207-7263	**IHCP Provider and Member Concern Line (Fraud and Abuse)** (317) 234-7598 or 1-800-457-4515
IHCP SUR Department P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515	**Premium Collection Services Package C Payment Line** 1-866-404-7113 **Package C Payment Mailing Address** Hoosier Healthwise P.O. Box 3127 Indianapolis, IN 46206-3127	**M.E.D. Works** 1-866-273-5897 **M.E.D. Works Payment Mailing Address** P.O. Box 946 Indianapolis, IN 46206	
Pharmacy Services Contact Information			
ACS Drug Rebate **ACS State Healthcare** **ACS – Indiana Drug Rebate** P.O. Box 2011332 Dallas, TX 75320-1332	**HP Pharmacy Services Help Desk for POS Claims Processing** (317) 655-3240 or 1-800-577-1278 Opt 2 = Pharmacy INXIXPharmacy@hp.com	**HP Pharmacy Claims** P.O. Box 7268 Indianapolis, IN 46207-7268	**HP Pharmacy Claims Adjustments** P.O. Box 7265 Indianapolis, IN 46207-7265
Pharmacy Benefit Management Inquiries PDL@fssa.in.gov	**Indiana Administrative Review/Pharmacy Claims** **HP Pharmacy Claims Admin. Review** P.O. Box 7263 Indianapolis, IN 46207-7263	**PA for Pro-DUR and Preferred Drug List – ACS Clinical Call Center** 1-866-879-0106 Fax: 1-866-780-2198	**To make refunds to the IHCP for pharmacy claims, send check to:** HP Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303
Enrollment Broker Helplines (MAXIMUS)	**Hoosier Healthwise Managed Care Organizations (MCOs)**		
Hoosier Healthwise http://www.healthcareforhoosiers.com 1-800-889-9949 ***Care Select*** http://www.indianacareselect.com 1-866-963-7383 **HIP** http://www.HIP.in.gov 1-877-438-4479 **Pharmacy Customer Assistance** (317) 655-3240 or 1-800-577-1278 Opt 1 = **Pharmacy**	**Anthem** http://www.anthem.com **Claims** 1-888-232-9613 **Member Services** 1-866-408-6131 **Medical PA** 1-866-408-7187 Fax: 1-866-406-2803 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198 **Provider Services** 1-866-408-6132 Fax: 1-866-408-7087 **Prospective Providers** 1-800-618-3141 Fax: 1-866-408-7087 **Transportation** 1-800-508-7230	**MDwise** http://www.mdwise.org **Claims, Member Services Medical PA /Medical Management, and Provider Services** (317) 630-2831 or 1-800-356-1204 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198	**Managed Health Services (MHS)** https://www.managedhealthservices.com **Claims, Member Services, Medical PA/Medical Management, Provider Services, and Nursewise** 1-877-MHS-4U4U or 1-877-647-4848 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198

Indiana Health Coverage Programs Quick Reference

Care Select – Care Management Organizations (CMOs)		Healthy Indiana Plan (HIP) Organizations	
ADVANTAGE Health Solutions℠ http://www.advantageplan.com/ **Member Services** 1-800-784-3981 **Provider Services** 1-866-504-6708 **Medical PA** 1-800-784-3981 Fax: 1-800-689-2759 P.O. Box 80068 Indianapolis, IN 46280 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198 **Hospice Member Disenrollment** Fax: (317) 810-4488	**MDwise** http://www.mdwise.org **Member Services and Provider Services** 1-866-440-2449 **Member Services Fax** 1-877-822-7188 **Medical PA** 1-866-440-2449 Fax: 1-877-822-7186 P.O. Box 44214 Indianapolis, IN 46244-0214 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198	**MDwise** **Healthy Indiana Plan** http://www.mdwise.org **Member Services and Provider Services** P.O. Box 44236 Indianapolis, IN 46244-0236 1-877-822-7196 or (317) 822-7196 Fax: 1-877-822-7192 or (317) 822-7192 **Medical Claims** P.O. Box 33049 Indianapolis, IN 46203-0049 Payer ID: MDWIS **Behavioral Health Claims/HIP** 1-800-818-6872 P.O. Box 33049 Indianapolis, IN 46203 Payer ID MDWIS **Customer Service/Provider Service** 1-877-822-7196 or (317) 822-7196 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198	**Anthem** http://www.anthem.com **Member Services** 1-800-553-2019 **Provider Inquiry** 1-800-345-4344 P.O. Box 37010 Louisville, KY 40233-7180 **Medical PA** 1-866-398-1922 **Pharmacy PA** 1-866-879-0106 Fax: 1-866-780-2198
Pharmacy See Pharmacy Services Contact Information above	**HP Claims** **Providers** (317) 655-3240 1-800-577-1278 **Members** (317) 713-9627 1-800-457-4584	**HIP – Enhanced Services Plan (ESP) Organizations**	
		ACS – Non-Pharmacy P.O. Box 33077 Indianapolis, IN 46203-0077 1-866-674-1461 or (317) 614-2032 **PA – Medical** 1-877-217-7150	**Pharmacy PA ACS** 1-866-879-0106 Fax: 1-866-780-2198 **HP Pharmacy Claims** P.O. Box 7268 Indianapolis, IN 46207-7268 1-800-577-1278 or (317) 655-3240

Paper Claim Filing				
HP 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	**HP Adjustments** P.O. Box 7265 Indianapolis, IN 46207-7265	**HP Medical Crossover Claims** P.O. Box 7267 Indianapolis, IN 46207-7267	**HP Dental Claims** P.O. Box 7268 Indianapolis, IN 46207-7268	**HP CMS-1500 Claims** P.O. Box 7269 Indianapolis, IN 46207-7269
HP Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259	**HP Waiver Programs Claims** P.O. Box 7269 Indianapolis, IN 46207-7269		**HP Institutional Crossover/UB-04 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims** P.O. Box 7271 Indianapolis, IN 46207-7271	

Check Submission				
To make refunds to the IHCP HP Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	**To make refunds for CA-PRTF** HP/CA-PRTF Refunds P.O. Box 7247 Indianapolis, IN 46207	**To make refunds for MFP** HP/MFP Refunds P.O. Box 7194 Indianapolis, IN 46207	**To Return Uncashed IHCP Checks** HP Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	**Pharmacy** See Pharmacy Services Contact Information above

Right Choices Program (formerly the Restricted Card Program)			
ADVANTAGE Health Solutions – *Care Select* and FFS P. O. Box 40789 Indianapolis, IN 46240-0789 1-800-784-3981 Fax: 1-800-689-2759	**Managed Health Services – HHW** 1099 N. Meridian Street, Suite 400 Indianapolis, Indiana 46204-4287 1-877-647-4848 Fax: 1-866-753-7240	**MDwise – HHW** P.O. Box 441423 Indianapolis, IN 46244-1423 1-800-356-1204 Fax: (317) 829-5530 or 1-877-822-7190	**MDwise – HIP** P.O. Box 44236 Indianapolis, IN 46244-0236 1-877-822-7196 Fax: (317) 822-7192 or 1-877-822-7192
MDwise – *Care Select* P.O. Box 44214 Indianapolis, IN 46244-0214 1-866-440-2449 Fax: (317) 822-7519 or 1-877-822-7188	**Anthem – HHW** P.O. Box 6144 Indianapolis, IN 46206-6144 1-866-902-1690 – Option 3 Fax: 1-866-387-2959	**Anthem – HIP** P.O. Box 6144 Indianapolis, IN 46206-6144 1-866-902-1690 – Option 3 Fax: 1-866-387-2959	

For updates of this contact information, please visit the Provider site at www.indianamedicaid.com and click on the News, Bulletins and Banners link at the top of the Home Page. A link to the latest "Quick Reference" is typically included on the final page of each monthly provider newsletter stored under the "View Newsletters" link.

Contact Information

HP Medicaid Provider Relations Field Consultants

Consultant Name	Telephone	Counties Served
Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, and Starke
Rhonda Rupel	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, and Whitley
Relia Manns	(317) 488-5363	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White - State Presumptive Eligibility and Notice of Pregnancy Consultant
Daryl Davidson	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, and Wells
Mona Green	(317) 488-5309	Marion
Shantel Silnes	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, and Washington
Virginia Hudson	(317) 488-5148	Clay, Greene, Hendricks, Johnson, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, and Vigo
Ken Guth	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick
Jenny Atkins	(317) 488-5340	Out-of-State

Supervisor

Name	Title	Telephone
Tina King	Provider Relations Supervisor	(317) 488-5154

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APPENDIX E
CMS-1500 BILLING INSTRUCTIONS

Please refer to **Chapter 8, Section 3 of the Indiana Health Coverage Programs (IHCP) Provider Manual** for detailed instructions on completing the CMS-1500 claim form (see sample claim form on following page, *E1-S*). The IHCP will return any claims not submitted on the standardized red claim forms because the Optical Character Recognition (OCR) program used to read the necessary data for claim processing on the red drop-out standardized paper claim forms: CMS-1500, version 08-05,UB-04, ADA 2006. Appendix E of this Tool Kit highlights specific claim form completion details applicable only to school corporations billing Medicaid for Medicaid-covered IEP/IFSP services.

Billing and Rendering Provider Numbers

Medicaid-participating school corporations enter the corporation's Medicaid provider number in both the Billing and Rendering Provider Number fields on the medical claim form.

Billing Provider Number (Required Field): The Billing Provider Number means the specific Medicaid provider number (National Provider Identifier) assigned to the public school corporation or state-operated school. This billing provider number is entered in Locator 33 on the CMS-1500 form or 837P electronic transaction. Reminder: The school corporation's Medicaid Provider Number can only be used to bill Medicaid for services listed in the IEPs/IFSPs of Medicaid-eligible students.

Rendering Provider Number: The school corporation's Medicaid provider number is also entered as the "rendering provider" number in Locator 24K on the CMS-1500 or 837P. Practitioners who are rendering Medicaid-covered IEP/IFSP services to Medicaid-eligible students in the school setting are not required to be separately enrolled in the Medicaid program if their services are being billed by the school corporation on its Medicaid Provider Number.

To bill Medicaid for IEP/IFSP services provided by its employed or contracted practitioners, the school corporation must ensure that the individuals delivering Medicaid services meet the criteria for Medicaid-qualified providers of the services billed. Chapter 4, Section 3 of the Indiana Health Coverage Programs (IHCP) Provider Manual sets out, by provider type and specialty, the criteria for Medicaid-qualified providers in Indiana. Chapter 4 of the IHCP Provider Manual is available online at:

http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter04.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

PROCEDURE CODE DESCRIPTIONS, ASSOCIATED MODIFIERS AND REIMBURSEMENT

The following tables provide a list of procedure codes and potentially applicable modifiers that school corporations may use to bill Indiana Medicaid for covered IEP/IFSP services provided to Medicaid-eligible students. While not all inclusive, the following tables list the most commonly used code and modifier combinations for typical IEP/IFSP services. Please note that codes are billed on a per service per day basis unless otherwise noted in the code description (for instance, the code description may instruct billing per every 15 minutes of service provided).

School corporations must bill the most appropriate procedure code, with or without a modifier as appropriate, based on the service performed, the Current Procedural Terminology ® code definitions, coding conventions and ethical coding guidelines (AMA, 2005), and any updates thereto. Furthermore, school corporations must maintain documentation to support the codes billed, irrespective of the reimbursement amount associated with the code/modifiers. Effective 1-27-2011 the Indiana Medicaid agency instituted National Correct Coding Initiative (NCCI) claims edits [see Medicaid provider bulletin #BT 201036 at www.indianamedicaid.com]. Please see Tables 1-6 for details on use of Modifier 59 to denote separate and distinct services provided to the same individual on the same date of service. Medicaid reimbursement amounts for covered procedure codes are available in the IHCP fee schedule available at www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp.

For assistance or additional information regarding Medicaid billing, coding and payment questions, please contact HP Customer Assistance at 317-655-3240 or 800-577-1278. To schedule an on-site consultation with the HP Provider Field Consultant assigned to serve your local area, use the contact information on Page D2 in Appendix D. Other helpful Medicaid contact information is available in the Quick Reference guide on Page D1.

For Medicaid-participating providers that file that file their own claims, the Indiana Health Coverage Programs (IHCP) recommends reviewing the following **Quick Tips to Speed Claims Processing and Payment:**

• **Tip #1**: Always forward paper medical claim submissions directly to the HP Claims Unit/traditional Medicaid. If you submit claims to the HP Written Correspondence Unit, it delays processing of your claims by 10 business days. Please submit claims directly to: HP CMS-1500 Claims P.O. Box 7269 Indianapolis, Indiana 46207-7269
• **Tip #2**: If you add a letter of explanation in front of your claim, the claim will automatically be forwarded to the HP Written Correspondence Unit, which, again, delays processing of your claim by 10 business days. Attach any documentation behind the claim, not in front of it.
• **Tip #3**: The fastest, easiest way to check claim status is to use Web interChange or Automated Voice Response (AVR), or to call Customer Assistance. Submitting questions about claim status in writing slows the response time.
Note: The **best** *way to speed claim processing and payment is to submit claims electronically. If you are not already set up to submit claims via the Web, go to https://interchange.indianamedicaid.com/Administrative/logon.aspx, and click* ***How to Obtain a Web interChange User ID and Password****.* Please note: If you use Web interChange, you are required to change your password every 90 days. If you forget your password, you can reset it yourself via the password reset page provided in Web interChange for this purpose. You can find the Reset Password button on the Web interChange logon screen.

Table 1. Behavioral Health Services – bill service(s) per day unless otherwise noted (e.g., per time interval)

Behavioral Health Services CPT Codes		Behavioral Health Services (BHS) Modifiers for use with BHS CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
90801	Psychiatric diagnostic interview examination	AH	Clinical psychologist	Processing	Paid at 75% of allowable rate
90804	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	AJ	Clinical social worker	Processing	Paid at 75% of allowable rate
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	HE	Mental Health Program	Processing (See IHCP provider manual p.8-251 for mid-level practitioners identified by this modifier)	Paid at 75% of allowable rate
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	HE with SA	Mental Health Services by nurse practitioner/clinical nurse specialist	Processing	Paid at 75% of allowable rate
90846	Family psychotherapy (without the patient present)	HO	Master's degree level	Informational (See p.8-149 of IHCP Provider Manual)	None-informational only
90847	Family psychotherapy (conjoint psychotherapy)(with patient present)	TM	IEP-See Table 4	Informational-required	To Identify an IEP service
90853	Group psychotherapy (other than of a multiple-family group)	59	Separate and distinct service on same date	Informational	Required to identify a therapy service that is separate and distinct from another therapy service provided to the same patient on the same date
*96101	Psychological testing (includes psycho diagnostic 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 with the patient and time interpreting test results and preparing the report.	TM	IEP-See Table 4	Informational-required	To identify an IEP service
*96116	Neurobehavioral Status Exam: Clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.				

***New codes replacing 96100 and 96115 effective 1/1/06. Bill only for physician or HSPP services, *only the TM (IEP service) modifier applies (see Table 4)*.**

Table 2. Physical and Occupational Therapy – bill service(s) per day unless otherwise noted

Physical Therapy/Occupational Therapy Services CPT Codes		Physical Therapy/Occupational Therapy Modifiers for use with PT/OT CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Medicaid reimbursement policy**
97001	Physical therapy evaluation	GP	Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.	Informational--required for services provided pursuant to an outpatient PT plan of care (IHCP Manual p.8-117)	Paid at 100% of allowable rate (modifier does not affect reimbursement). Physical therapy services must be performed by a licensed PT or certified PTA under direct supervision of a licensed PT. PTAs may not perform/interpret tests, conduct assessments or develop treatment plans. Please refer to IHCP provider bulletin BT200611.
97002	Physical therapy re-evaluation				
97003	Occupational therapy evaluation	GO	Service delivered personally by an OT or under an outpatient OT plan of care.	Informational--required for services provided pursuant to an outpatient OT plan of care (IHCP Manual p.8-117)	Paid at 100% of allowable rate (modifier does not affect reimbursement). "Occupational therapy service must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct, on-site supervision of a registered occupational therapist." IHCP Provider Manual Ch. 8 pg. 240.
97004	Occupational therapy re-evaluation				
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	GP, GO or HM	HM - Service delivered personally by a certified physical or occupational therapy assistant	HM - Processing-required for services provided pursuant to an outpatient plan of care. (See IHCP Provider Bulletin BT200611.)	HM - Paid at 75% of allowable rate. Service must be performed by a certified PTA under the direct supervision of a licensed physical therapist or by an OTA under the direct *on-site* supervision of a licensed occupational therapist. The PTA and OTA may not perform/interpret tests, conduct assessments, or develop treatment plans and must consult with the supervising therapist daily to review treatment. See IHCP Provider Manual Chapter 8, pages 280-282 and IHCP provider bulletin BT200611.
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	TM	IEP-See Table 4, General Modifiers; include TM (IEP) for all IEP services		
		59	Informational Modifier required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date		
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)				
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)				

Table 2 continued. Physical Therapy/Occupational Therapy Services – bill per day unless otherwise noted				
Physical Therapy/Occupational Therapy Services CPT Codes		**Physical Therapy/Occupational Therapy Modifiers for use with PT/OT CPT Codes**		
97150	Therapeutic procedure(s), group (2 or more individuals).	GP, GO or HM		
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	TM	IEP-See Table 4	
		59	Informational	Required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.	GP and GO		
		TM	IEP-See Table 4	
97542	Wheelchair management/propulsion training, each 15 minutes.	59	Informational	Required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date

Table 3. Speech/Language/Hearing Disorder Services – bill service(s) per day unless otherwise noted

Speech/Language/Hearing Disorders Services CPT Codes		Modifiers for use with Speech/Language/Hearing Disorders Services CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	GN	Services delivered under an outpatient speech-language plan of care.	Informational	Paid at 100% of allowable rate. See 405 IAC 5-22-9
92507	Treatment of speech , language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation)– Individual	HM	HM - Service delivered personally by a registered SLP aide, associate or assistant under required supervision.	HM - Processing-required for services provided per an outpatient plan of care.	HM - Paid at 75% of allowable rate. Service must be performed by registered SLP support personnel subject to supervision requirements of 880 IAC 1-2.1.*
92508	Treatment of speech , language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation)– -Group, two or more individuals	TM	IEP-See Table 4	Informational-required	To identify an IEP service
92551	Screening test, pure tone—air only	59	Informational	Required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date	
92552	Pure tone audiometry threshold—air only				
92553	Pure tone audiometry threshold—air and bone				
92555	Speech audiometry threshold				
92556	Speech audiometry, threshold; with speech recognition				
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)				
92559	Audiometric testing of groups				
92567	Tympanometry (Impedance testing)				
92592	Hearing aid check—one ear monaural				
92593	Hearing aid check—both ears binaural				

* HM modifier-related reimbursement for SLP services implemented in Medicaid claims processing system effective for dates of service beginning 1/1/09.

Table 4. General Modifiers to Use in Billing IEP/IFSP Services

Use these and modifiers from Tables 1-3 to give additional information about IEP/IFSP services billed.

Code up to 4 modifiers per CPT code billed on the CMS 1500 claim form.

Modifier	Modifier Description	Modifier Type	Impact on reimbursement
TL	Early Intervention/**IFSP** services	TL, TM & TR are informational.	No affect on the Medicaid reimbursement rate for the service billed.
TM	**IEP** services		
TR	IEP/IFSP health related services provided outside the district in which the student is enrolled.	TM must be used to identify an IEP service	

Table 5. Nursing Services Provided by an R.N. – bill in 15-minute increments unless otherwise noted

Nursing Services CPT and HCPCS Codes		Modifiers for use with Nursing Services CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
99600*	Indiana Medicaid is defining this code as "IEP Related Nursing Services." The standardized code book description for the code with TD modifier is an R.N. Visit Not Otherwise Specified [TM = IEP service]	*Required* TD	Service provided by an R.N. to indicate R.N. is provider	Informational-required	Paid at 100% of allowable rate.
		TM *	Indicates service is in an IEP *See important note below*	Informational-required	None
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	TM	Indicates service is in an IEP	Informational-required	None
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		See also Table 4 General Modifiers; include TM (IEP) for all IEP services.		

* IMPORTANT NOTE: 99600 TD TM is used for *all* IEP nursing services *except* DSMT, as described above. When billing 99600 TD TM for IEP Nursing Services other than DSMT, *please note that the order of the modifiers is critical* for appropriate reimbursement.

Table 6. Special Education Transportation Services– bill service(s) per trip unless otherwise noted

Special Ed Transportation Services CPT Codes	Modifiers for use with Special Education Transportation Services CPT Codes
HCPCS Code	**Description**
A0425 U3 TM	Ground mileage, per statute mile; Commercial or Common Ambulatory Services (CAS); IEP Related
T2003 TM	Non-emergency transportation, encounter/trip Commercial or Common Ambulatory Services (CAS); IEP Related
A0425 U5 TM	Ground mileage, per statute mile; Non-Ambulatory Services (NAS); IEP Related
A0130 TM	Non-emergency transportation, wheel chair van base rate; IEP Related

APPENDIX F

BILLING MEDICAID FOR HEALTH-RELATED SERVICES IN STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM (IEP) OR INDIVIDUALIZED FAMILY SERVICE PROGRAM (IFSP)

Request for Consent to Bill Medicaid

This consent form allows the school corporation to bill Medicaid for covered health-related services in your child's Individualized Education Program. The funds received from Medicaid help pay the State's costs to provide Special Education and related services.
We appreciate your cooperation and support.

Your Child's Rights to Special Education

- Your child's right to receive the services listed in his or her IEP will continue, without interruption and at no cost to you, whether or not you sign this form.
- Giving consent will not impact your child's Medicaid coverage.
- You have the right to change this consent at any time.

Consent for the School Corporation to Bill Medicaid for Student's Health-Related Educational Services

Student Name: _____ Student Date of Birth: _____

I have reviewed this student's Individualized Education Program (IEP), dated:

_____,
(date of IEP)

and give my consent for the school corporation to bill Medicaid, in accordance with state and federal laws, for health-related educational services in this student's IEP. By signing this consent I authorize the school corporation to release this student's records to Medicaid as necessary for eligibility determination, billing and auditing. I understand that, upon request, I may receive copies of records disclosed pursuant to this authorization.

Parent/Guardian Signature:

_____	_____	_____
Print Name	Signature	Date

This form must be maintained and made available for audit purposes.

Spanish translation of Request for Consent to Bill Medicaid

EMISION DE FACTURA A MEDICAID POR SERVICIOS RELACIONADOS CON LA SALUD EN EL PROGRAMA EDUCATIVO INDIVIDUALIZADO (IEP) DEL ESTUDIANTE O EN EL PROGRAMA DE SERVICIO INDIVIDUALIZADO PARA LA FAMILIA (IFSP)

Pedido de autorización para cargar gastos a Medicaid

Esta forma de autorización avala a la corporación escolar cargar a Medicaid por los servicios relacionados con la salud indicados en el programa educativo individualizado (IEP) de su hijo(a). Los fondos recibidos de Medicaid ayudan a pagar los gastos del Estado por proveer los programas de Educación Especial y otros servicios relacionados. Apreciamos su cooperación y su ayuda.

Los derechos de su hijo(a) a la Educación Especial

- El derecho de su hijo(a) a recibir los servicios indicados en su IEP continuará sin interrupción y sin costo alguno para usted, independientemente de si usted firme o no esta forma.
- La autorización dada por usted no tendrá ningún impacto en la cobertura de su hijo(a) otorgada por Medicaid.
- Usted tiene el derecho de cambiar esta autorización cuando usted lo disponga.

Autorización para que la corporación escolar pueda cargar a Medicaid por los servicios educacionales relacionados con la salud otorgados al estudiante

Nombre del Estudiante: _____ Fecha de Nacimiento: _____

He revisado el programa educativo individualizado (IEP) del estudiante, con fecha:

_____,
(fecha del IEP)

Y doy mi autorización para que la corporación escolar pueda cargar a Medicaid, de acuerdo a las leyes estatales y federales, por los servicios educacionales relacionados con la salud indicados en el IEP del estudiante. Al firmar esta forma yo autorizo a la corporación escolar a que proporcione a Medicaid el historial de este estudiante cual sea necesario para determinar elegibilidad, cargar gastos, y para auditorías. Yo entiendo que al pedirlo, puedo recibir copias de todos los documentos revelados de acuerdo con esta autorización.

Firma del Padre o Tutor:

_____	_____	_____
Nombre	Firma	Fecha

Esta forma debe guardarse y estar disponible para propósitos de auditoría.

This form must be maintained and made available for audit purposes.

Approval for Behavioral Services

To be completed by a licensed physician or psychologist endorsed as a health service provider in psychology (HSPP).

Student Name: _____ Date of Birth: _____

Therapist: _____

____I certify that a qualified mid-level practitioner has conducted an initial intake/evaluation of the above named student within the past seven (7) days, that the student meets criteria for behavioral services, and that approval is given for the delivery of those services as specified in the student's *Individualized Education Program* (IEP).

____I certify that the above named student continues to meet the criteria for behavioral services and that this approval is being granted within ninety (90) days of the most recent review.

Authorized Signature: _____

Print Name/Title: _____

License Number: _____

Date: _____

Physical Therapy Referral

To be completed by licensed physician.

Student Name: _____ Date of Birth: _____
Parent's: _____
Address: _____
_____

Diagnosis:
_____

Physical Therapy: ____ Evaluation
____ Treatment Services: _____
_____
_____
____ Other: _____

Precautions: _____
_____
_____

Additional Comments:
_____
_____
_____

Authorized Signature: _____

Print Name & Title: _____

Date: _____

SPEECH LANGUAGE/OCCUPATIONAL THERAPY REFERRAL

To be completed by Physician or other licensed Practitioner of the Healing Arts, in accordance with 42 CRF 440.110.

Student Name: _____ Date of Birth: _____

Speech-Language Referral:____ Evaluation
____ Treatment Services: _____

_____

____ Other: _____

Occupational Therapy Referral: ____ Evaluation
____ Treatment Services: _____

_____

_____ Other: _____

Precautions:
_____
_____
_____

Additional Comments:
_____
_____
_____

Authorized Signature: _____

Print Name & Title: _____

Date: _____

AUDIOLOGY REFERRAL

To be completed by licensed physician (M.D. or D.O.).

Student Name: _____ Date of Birth: _____

Physician certification of need for audiological assessment or evaluation:

_____ Evaluation

_____ Treatment Services: _____

_____

_____ Other: _____

Precautions:

_____

_____

_____

Additional Comments:

_____

_____

_____

Authorized Signature: _____

Print Name & Title: _____

Date: _____

Sample Criteria for Determining a Health-Related Need for Special Education Transportation Services

Includes considerations for special accommodations to meet the student's identified need(s)

To Bill Medicaid for Special Education Transportation:
the IEP must describe the specialized transportation need, and the service must be provided on a day when the student receives a Medicaid-covered IEP service other than transportation.

The IEP must identify/document the specific need to provide Special Ed Transportation:

Orthopedic/Physical Impairment:
- non-ambulatory
- wheelchair bound
- needs assistive devices to maintain a sitting position
- needs assistance walking and going up and down stairs
- extremely brittle bones

Behavior Impairment:
- unusually problematic responses to sensory experiences
- self-abusive
- runs away

Communication Impairment:
- deaf
- hard of hearing
- nonverbal
- impaired in processing linguistic information through hearing
- other communication disorder

Visual Impairment:
- partial sight
- blindness

Health needs:
- seizures
- extreme fatigue
- requires oxygen or other breathing equipment
- high risk of a medical emergency requiring immediate emergency medical procedures
- traumatic brain injury-related cognitive, sensory, perceptual, motor, problem-solving, reasoning, attention, judgment, information processing or abstract thinking impairment

Potential additional considerations to meet the identified need. After identifying the need the case conference committee may also consider accommodations to meet the need, e.g.:

Accommodations for specialized vehicle, equipment, etc:
- brace, car seat, seat belt, safety vest
- manual or power wheelchair lift
- accompanying service animal
- medical equipment

- assistive technology device
- adapted bus, e.g., ramp, kneeling capability

Adult supervision, medical monitoring or other services required:

- specialized bus driver training
- bus attendant
- specialized bus attendant training
- one-on-one bus attendant for a designated purpose described in IEP
- nursing services
- special monitoring
- interpreter

Type of transportation or specialized accommodation:

- door-to-door pick up and drop off
- a small bus with few students
- individual transportation
- air conditioned vehicle

Other accommodations:

- permission to carry/use personal electronic devices or other such items

Sample Special Education Transportation Trip Log – for off-site medical service (pg *F8*); to/from school—see pg *F9*

Special Needs Transportation Log for off-site trips to a medical service

Student First & Last Name [office to add ID #]	Trip Date (mmddyy)	Destination: name & address of medical service provider	Start Location	Return Location	Mileage * (rounded to nearest mile)	Start & Stop of Wait Time [if applicable]
Driver Printed Name			Driver Signature and Date			

* Record round trip mileage for each round trip. For one-way trips, record the mileage and note "one-way" in the "Return Location" column.

Sample Special Education Transportation Trip Log – to/from School (pg *F9*); for off-site medical service—see pg *F8*

Special Needs Transportation Log for Trips between School and Home

Student First & Last Name [office to add ID #]	Trip Date (mmddyy)	Destination: name of school bldg	Start Location	Return Location (enter "same" if = start location)	Mileage * (rounded to nearest mile)	Student Rode (Y or N)
Driver Printed Name			Driver Signature and Date			

* Record round trip mileage for each round trip. For one-way trips, record the mileage and note "one-way" in the "Return Location" column.

Sample Nursing Services Documentation Form to Adapt for Local Use

[see back of this 2-sided form copied on page *F11*]

NURSING SERVICES DOCUMENTATION

Student Name _____ DOB _____ Schl Corp/Bldg _____

Check *ONE* if applicable: This student has an Individualized Education Program (IEP) □ -OR- a Section 504 Plan □

				PROCEDURES: ENTER # MINUTES SPENT ON EACH								
				Assessment								
Date of Service (DOS)	Start Time	Stop Time	Total Service Time (minutes)	develop / revise IHP	v physical / mental status	cathe-teriza-tion	respite care	spclz feed ing	hlth supp syst othr	meds admn	DSMT	Nurse's Notes & Initials

Nurse's Signature, Credentials _____ Date _____ Nurse's Signature, Credentials _____ Date _____

Copy of Information Printed on Back of 2-Sided Sample Nursing Documentation Form on Page *F10*

EXAMPLES OF MEDICAID-COVERED IEP NURSING SERVICES PROVIDED BY A REGISTERED NURSE (R.N.)

Catheterization:

- Education and monitoring self catheterization
- Intermittent urinary catheterization
- Indwelling catheter irrigation, reinsertion, and care

Health Support Systems Care / "Other" (incl Specimen Collection):

- Apnea assessment, monitoring, and care
- Central line care, dressing change, emergency care
- Dressing and treatment
- Dialysis monitoring and care
- Shunt monitoring and care
- Ventilator monitoring, care, and emergency plan
- Wound and skin integrity assessment, monitoring, and care
- Ostomy care, dressing, and monitoring
- Ostomy irrigation, insertion, removal, and care
- Specimen collection: blood, sputum, stool or urine

Medications Administration:

- Administration of medications by injection (intra-venous, intramuscular, subcutaneous), rectal or bladder instillation, ostomy, tube, or, only under certain circumstances by mouth
- Nebulizer treatment if child not able to self-administer

Specialized Feeding:

- Ostomy feeding
- Parenteral nutrition (intravenous)
- Specialized feeding procedures
- Stoma care and dressing changes

Respiratory care:

- Oxygen monitoring and care
- Postural drainage and percussion treatments
- Suctioning
- Tracheostomy tube replacement
- Tracheostomy monitoring and care
- Ventilator care

APPENDIX G
PARENTAL CONSENT

Federal regulations at 34 CFR § 300.154[d][2][iv][A]) require LEAs to obtain parental consent to bill Medicaid each time that access to public benefits or insurance is sought. (See 34 CFR § 300.9 for the federal definition of "consent.") Similarly, Indiana Special Education rules at 511 IAC 7 (commonly referred to as Article 7), require LEAs to obtain informed parental consent as defined by 511 IAC 7-32-17 (copied below) when seeking to access public benefits or insurance for services identified in a student's IEP and to notify the parent that refusal to grant consent does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent. See Appendix F for a sample form for requesting consent.

511 IAC 7-32-17 "Consent" defined

Authority: IC 20-19-2-8; IC 20-19-2-16
Affected: IC 20-19-2; IC 20-35

Sec. 17. "Consent" means the following:
(1) The parent has been fully informed, in the parent's native language or other mode of communication, of all information relevant to the activity for which consent is sought.
(2) The parent understands and agrees in writing to the activity for which consent has been sought, and the consent:
    (A) describes that activity; and
    (B) lists the records, if any, that will be released and to whom.
(3) The parent understands that:
    (A) granting consent is voluntary on the part of the parent; and
    (B) the consent may be revoked at any time.
If the parent revokes consent, the revocation is not retroactive, that is, it does not negate an action that has occurred after the consent was given and before the consent was revoked.
(Indiana State Board of Education; 511 IAC 7-32-17; filed Jul 14, 2008, 1:24 p.m.: 20080813-IR-511080112FRA)

On the following pages of Appendix G there are copies of letters from the United States Department of Education which include additional discussion and background information on the topic of parental consent to bill Medicaid.

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

MAR - 8 2007

John D. Hill, Chairman
Governmental Affairs Committee
National Alliance for Medicaid in Education, Inc.
Indiana Department of Education
Room 229 State House
Indianapolis, IN 46204-2798

DATE RECEIVED
MAR 12 2007
DIV. OF EXCEPTIONAL LEARNERS

Dear Chairman Hill:

This is in response to your letter to me on behalf of the National Alliance for Medicaid in Education (NAME) asking for a written clarification regarding the policy interpretation of the requirement at 34 CFR §300.154 of the "federal regulations interpreting the reauthorized Individuals with Disabilities Education Act (IDEA)." Specifically, you ask that I put in writing, and make publicly available, the clarification provided at the August 2006 Office of Special Education Programs (OSEP) Leadership Conference regarding the meaning of the words "each time" as used in 34 CFR §300.154(d)(2)(iv)(A). Below is the question to which you refer:

Question:

Section 300.154 states that parental consent must be obtained each time that access to public benefits or public insurance is sought. Does this mean parental consent must be obtained each time the service is offered, every time new billing occurs, when the IEP [individualized education program] is generated, when there is a change in the type of service, or only when there is a change in the amount of a particular service? Finally, the Analysis of Comments and Changes section stated that "a public agency could satisfy parental consent requirements under FERPA and section 617(c) of the Act if the parent provided the required parental consent to the State Medicaid agency…." Does this mean the local educational agency (LEA) does not have to obtain consent and, if so, must the LEA maintain a copy of the consent given to the Medicaid agency?

Answer:

The IDEA, Part B regulations at 34 CFR §300.154(d)(2)(iv) state that each time the public agency proposes to access the child or parent's public benefits or insurance to provide or pay for services required to provide a free appropriate public education (FAPE) to an eligible child, the agency must obtain parental consent, consistent with 34 CFR §300.9. However, we do not interpret this provision to require that a separate written parental consent be obtained prior to each individual delivery of services for which payment will be requested or every time a billing occurs. In this context, "parental consent" means -

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Page 2 - John D. Hill, Chairman

- The parent has been fully informed of all information relevant to the activity for which the consent is sought, in his or her native language or other mode of communication;
- The parent understands and agrees in writing to the carrying out of the activity for which his or her consent is sought, and the consent describes that activity and lists the records that will be released and to whom;
- The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time; and
- If a parent revokes consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent is given and before it is revoked).

This consent may be obtained one time for the specific services and duration of services identified in a child's IEP. For example, if it is known that a child is to receive three hours of occupational therapy (OT) each week for 36 weeks, parents could be asked to give consent once to the public agency's billing of the child or parent's public benefits or public insurance for up to 108 hours of OT service for that 36- week period. (The amount billed would depend on the amount of OT service that was actually provided.) While this consent may be obtained at an IEP meeting, it could also be obtained at some point after the IEP is developed.

If however, the public agency seeks to use the child's or parent's public benefits or public insurance to pay for additional hours of service (due to the IEP being revised or extended) or the public agency is charging different amounts for such services, and would like to again charge the child or parent's public benefits or public insurance for those costs, the public agency must obtain parental consent, covering the additional amount of service or costs to be charged to the child's or parent's public benefits or public insurance. The Part B regulation provisions in 34 CFR §300.154(d)(2) are intended to ensure that the parent is fully informed of a public agency's proposed access of the child's or parent's benefits under a public benefits or public insurance program and provide written parental consent prior to the public agency's access to those public benefits or public insurance.

If parental consent is given directly to another agency, such as the State Medicaid agency, the LEA does not have to independently obtain a separate parental consent, as long as the parental consent provided to the other agency meets the requirements of 34 CFR §§300.9 and 300.154(d). The public agency seeking parental consent to access public benefits or public insurance programs is also obligated, under 34 CFR §300.154(d)(2)(iv), to notify the parent that the parent's refusal to allow access to their public benefits or public insurance does not relieve the public agency of its responsibility to ensure that all required FAPE services are provided at no cost to the parent. If another agency obtains the parental consent required by 34 CFR §§300.9 and 300.154(d)(2), the LEA must maintain a copy of the parental consent to both demonstrate its compliance under Part B of the IDEA and to ensure that it is available for the parent or child to review.

Based on section 607(e) of the IDEA, we are informing you that our response is provided as informal guidance and is not legally binding, but represents an interpretation by the U.S. Department of Education of the IDEA in the context of the specific facts presented.

Page 3 - John D. Hill, Chairman

You indicate that your second reason for writing is to seek the input and active collaboration of OSEP in the important and ongoing national dialogue about access to Medicaid funding for direct medical services and administrative activities performed in school-based settings. OSEP agrees that the collaboration between OSEP and the office administering the Medicaid program, Centers for Medicare and Medicaid Services (CMS), is critical and over the years, the Department has had an ongoing working relationship with that office and has had staff from the Department working with CMS on issues such as transportation, the Administrative Claiming Guide, bundling of services as well as other issues of mutual interest.

However, we will be happy to meet with you to receive suggestions for other areas of collaboration. If you wish to set up a meeting, please feel free to call my office assistant, Betty McMahon, to schedule an appointment. Her telephone number is 202-245-7441.

I hope this letter will be helpful to you and your colleagues. Let me know if I can be of further assistance.

Sincerely,

Alexa Posny

Alexa Posny, Ph.D.
Director
Office of Special Education
Programs

cc: Stephen DeMougin
Indiana Family and Social Services Administration
Robert Marra
Indiana Department of Education

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF MANAGEMENT

JUL 2 2 1997

Dr. John T. Benson
Superintendent of Public Instruction
Wisconsin Department of Public Instruction
P.O. Box 7841
Madison, Wisconsin 53707

Dear Dr. Benson:

This is in response to your recent telephone conversations with Ellen Campbell of my staff concerning a request by the Wisconsin Department of Public Instruction (WDPI) for technical assistance. Specifically, the WDPI has asked whether parental written consent is required under the Family Educational Rights sad Privacy Act (FERPA) before school districts disclose information from student education records is order to determine which students with disabilities are Medicaid eligible and to seek reimbursement from the State's Medicaid agency for services provided to those students. This letter also responds to letters dated March 20, April 18, May 9, and June 25. 1997, from Dr. Juanita S. Pawlisch, Assistant Superintendent, Division for Learning Support: Equity and Advocacy, and to information provided this office by Ms. Phyllis D. Thompson of Covington & Burling and from Mr. Frederick D. Cheney of Kinney & Associates. Inc. This Office administers FERPA and is responsible for providing technical assistance to educational agencies and institutions on the law. 20 U.S.C. §1232g; 34 CFR Part 99.

In Dr. Pawlisch's March 20 letter, she states the following:

> We have received multiple requests for clarification regarding parent consent requirements when a school district wants to (as certified care providers) access medical assistance funds for reimbursement for school-based services. These requests have been from local school districts, parents, billing agencies, and other interested parties. In Wisconsin, the state medical assistance plan allows use of medical assistance [(MA)] funds for MA eligible students who receive MA services at school pursuant to an individualized educational program (IEP).
>
> After considerable analysis by program staff and legal counsel from both our agency and our state MA agency, Department of Health and Family Services (DHFS), we have

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Page 2 - Dr. John Benson

> advised school districts that FERPA and [the Individuals with Disabilities Education Act (IDEA)] require them to obtain informed written parental consent prior to releasing to the state MA agency records which 1) identify students as disabled to determine MA eligibility and 2) identify the nature and extent of services provided to individual disabled pupils . . . . Are we correct in our understanding that FERPA and IDEA require written parental consent to release this information for these purposes?

In her letter, Dr. Pawlisch also refers to a July 6, 1993, letter of advice from this Office to Mr. Gary M. Sherman, Director of Special Education, Nebraska Department of Education, in which we advise Mr. Sherman on a similar issue, as follows:

> The consent for release of information included on the [Nebraska] Application for Assistance form includes the information required by the FERPA regulations and can therefore be considered to be sufficient consent for schools to submit claims containing information from education records to [the Department of Social Services (DSS), Nebraska's Medicaid agency]. However, before making any disclosures pursuant to a consent provided to a party other than the educational agency or institution itself, in this case to the DSS, the educational agency or institution should assure itself that the consent has been signed and dated in accordance with the above discussed requirements.

In this regard, Dr. Pawlisch asks the following questions:

> Assuming that Wisconsin's MA application does meet the requirements of informed consent under FERPA and IDEA, or if it were modified to do so, must the [local educational agency (LEA)] have a copy of this signed form in its possession prior to releasing information? Are there other acceptable ways in which a school may confirm that informed consent has been given via an MA application? May a school or its billing agent send a list identifying all disabled students to the MA agency and request a determination of which students are MA eligible?

Both Ms. Thompson and Mr. Cheney have provided us analyses concluding that FERPA would not preclude school districts from disclosing information from student education records to the DHFS in order to be reimbursed under Medicaid. Notwithstanding their analyses, we concur with the WDPI in its conclusion that, under FERPA and IDEA, school districts are prohibited from disclosing information from student education records to the State Medicaid agency (DHFS), absent prior written parental consent.

Page 3 - Dr. John Benson

FERPA applies to educational agencies or institutions that receive federal funds under any program administered by the Secretary of Education. As you are aware, FERPA is a Federal law that protects a parent's privacy interest in his or her child's "education records." In particular, FERPA affords parents the right to inspect and review their children's education records, the right to seek to have the records amended, and the right to have some control over the disclosure of information from the records. The term "education records" is broadly defined as:

> [T]hose records, files, documents, and other materials, which (i) contain information directly related to a student; and (ii) are maintained by an educational agency or institution or by a person acting for such agency or institution.

20 U.S.C. §1232g(a)(4). See also 34 CPR §99.3 "Education records." FERPA provides that education records, or personally identifiable information from such records, may be disclosed by educational agencies and institutions only after obtaining prior written consent of the parent, except in several statutorily specified circumstances. 20 U.S.C. §1232g(b)(1) and (d). See also 34 CPR 5 99.30.

FERPA generally prohibits the nonconsenual disclosure of information derived from education records, except in certain circumstances. 20 U.S.C. §1232g(b); 34 CFR §99.31. Accordingly, if one or more of the exceptions are met, an educational agency or institution can disclose education records, or personally identifiably information from education records, without prior written consent. However, from the information your office has provided, as well as the information provided by. Ms. Thompson and Mr. Cheney, it does not appear that any of FERPA's exceptions to the prior written consent provisions would permit the nonconsenual disclosure by school districts of personally identifiable information from education records to the State Medicaid agency.

Specifically, Ms. Thompson and Mr. Cheney provided this office their opinions that FERPA would not preclude school districts from disclosing information from student education records to the DHFS in order to be reimbursed under Medicaid. A discussion of some of the issues raised by them, as well as other issues that relate to your inquiry, follows:

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Directory Information

In a draft document entitled "Parental Consent Issues," prepared by Kinney & Associates and faxed to this Office on July 8 by Mr. Cheney, it was concluded that under Wisconsin law (Chapter 118 of General School Operations), schools may disclose "directory data" without parental consent. The document states: "Once the directory information has been utilized to determine Medicaid eligibility it falls upon the Wisconsin Application for Assistance to provide the school with the necessary consent."

Under FERPA, schools may disclose "directory information" under 34 CPR §99.31 (a)(11), in accordance with the requirements of 34 CFR §99.37. Section 99.37 requires the educational agency or institution to notify parents of the agency's or institution's intent to disclose specific information as directory information without consent unless otherwise notified by the parent. The name and address of the student are generally considered directory information which can be disclosed without prior written consent as long as the conditions in §99.37 have been met and the parent has not refused disclosure of directory information.

However, this office has consistently advised that directory information cannot be disclosed linked to other, non-directory information about a student, such as special education status. Thus, a list of the names of students who are disabled and/or who are receiving services under Part B cannot be considered "directory information" under FERPA and disclosed to an unauthorized third party, such as the DHFS for the purposes of ascertaining MA eligibility.

Health Records

In this same document provided by Mr. Cheney, it was suggested that medical records maintained by schools were not "education records" subject to FERPA or, in some circumstances, could be considered excluded from the FERPA definition of "education records." The document states:

> The school based services currently being provided are a development of the [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] program which was intended to provide *medically necessary services* to needy children in any setting appropriate. In many cases the only setting which children could reasonably be expected to receive services on a regular basis was in the school setting. Based on this fact it is not unreasonable to conclude that schools would have, and maintain, *health care records* for those students in receipt of services. By implementing the EPSDT

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> requirements the school becomes a *health care provider,* the student then may be looked upon as a *patient,* and therefore the records pertaining 'to that student's services become *patient health care records.* The very fact that in order to file claims for Medicaid a school must register as a Medicaid *provider* with the state Medicaid agency lends credibility to this reasoning . . . . Under this section the records may be released without informed consent "[t]o the extent that the records are needed for billing, collection or payment of claims" or, if "[a]ccess to the patient health care records is necessary to comply with a requirement in federal or state law." In light of the mandate present in EPSDT. and the IDEA amendment[s] of 1997 the use of Medicaid funding in exceptional education programs is very much a requirement of federal law. [Emphasis provided.]

Consistent with the general purpose of FERPA to protect parents' privacy rights in their children's education records, Congress provided a broad definition of "education records" that includes any type of material directly related to a student in whatever physical form the institution decides to maintain it. The use of the terms "records, files, documents, and other materials" indicates the broad scope and general nature, of items that are subject to the statute. Neither the legislative history nor the statute supports this argument that because certain education records are used for a particular purpose, i.e., to provide "medically necessary services," they lose their definition as "education records" under FERPA. Therefore, any records relating to a minor student's health, such as medical or psychological records, which are maintained by an educational agency or institution or a party acting for the agency or institution are "education records" under FERPA. As such, parents have the right under FERPA to consent to the disclosure of those records.[1]

Financial Aid

in a letter dated April 7, 1997, Ms. Thompson states:

> The [Family Policy Compliance Office] reportedly has expressed the view that none of the exceptions [under FERPA] would permit schools to release special education students'

---

[1]Please note that records of a student which pertain to services provided to that student under Part B are "education records" under FERPA and are subject to the confidentiality provisions under IDEA (see 34 CFR § 300.560-300.576) and to all of the provisions of FERPA.

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> health services records to a State Medicaid agency without parental consent. [Footnote refers to a February 17, 1989, letter from this Office.] By their literal terms, however, section 1232g(b)(1)(D) and 34 C.F.R. §99.31(a)(4)(i) create an exception that arguably is applicable. Section 99.31(a)(4)(i) provides that parental consent for disclosure is not required if the disclosure is "in connection with financial aid for which the student has applied or which the student has received, if the information is necessary for such purposes as to (A) [d]etermine eligibility for the aid." Id.; see also 20 U.S.C. §1232g(b)(1)(D). Further, section 99.31(a)(4)(ii) defines "financial aid" to denote a "payment of funds provided to an individual (or a payment in kind of tangible or intangible property to the individual) that is conditioned on the individual's attendance at an educational agency or institution." Medicaid reimbursement of school-based services can fairly be described as financial assistance that is conditioned on a child's school attendance. Therefore, we believe that the exception described in section 99.31(a)(4) could reasonably be applied to permit a school to release records to a Medicaid agency without parental consent, to enable the Medicaid agency to determine whether the services provided are eligible for Medicaid reimbursement. We are not aware of any inquiry requesting a formal opinion from DOE as to the applicability of this specific exception in the context of Medicaid reimbursement claims.

FERPA permits the nonconsensual disclosure of education records when the disclosure is "in connection with a student's application for, or receipt of, financial aid." 20 U.S.C. § 1232g(b)(1)(D). The regulations provide that consent is not required when:

> [t]he disclosure is in connection with financial aid for which the student has applied or which the student has received, if the information is necessary for such purposes as to --
>
> (A) Determine eligibility for the aid;
> (B) Determine the amount of the aid;
> (C) Determine the conditions for the aid; or
> (D) Enforce the terms and conditions of the aid.

34 CFR §99.31(a)(4). The Department has always interpreted this provision to apply to financial aid such as student loans and scholarships. Further, as Ms. Thompson noted, the FERPA regulations define "financial aid" to mean "a payment of funds provided to an individual . . . that is conditioned on the individual's attendance at an educational agency or institution." (Emphasis added.) Because the State Medicaid agency provides

APPENDIX H

MEDICAID MEDICAL CLEARANCE AND AUDIOMETRIC TEST

Instructions: The Medical Clearance and Audiometric Test Form must be used for all hearing aid fittings under the Indiana Medicaid Program. This form must be completed and carry the proper signature where indicated, before requests will be considered for prior authorization.

PART I Recipient History		
Recipient's Name		Medicaid Number
Address		Age
If Institution, Admission Date	Previous Institution	
If unable to independently maintain your hearing aid, are there resources available to assist in maintenance? Yes No Explain:		
Medical Diagnosis		
Hearing Diagnosis		
Has this recipient worn A hearing aid previously? Yes No	If so, purchase dates	Medicaid Purchased?
If recipient previously owns/wears amplification give the model and status of the instrument and settings.		

PART II Medical Clearance *(to be completed by physician)*		
A hearing aid will not be approved for a patient prior to that patient's having had a medical examination. *Preferably, this examination should be conducted by an otolaryngologist, if available and accessible, but a basic medical survey as indicated below can be performed by a licensed physician.* *All children under fifteen (15) years of age must be seen by an otolaryngologist before the hearing aid is fitted.* *The following minimal assessment is required before the fitting of any hearing aid:*		
1. Is there any evidence of infection or drainage from either ear?	Yes	No
2. Is there any significant headache, vertigo, or dizziness, nausea, or vomiting?	Yes	No
3. Has the hearing loss been sudden in onset?	Yes	No
4. Is the patient able to hear and understand speech at conversational level?	Yes	No
5. Presence of pus in the ear drum?	Yes	No
6. Perforation of the ear drum?	Yes	No
7. Impacted cerumen?	Yes	No
8. Presence of external ear canal infection?	Yes	No
9. The possibility of the complete closure of the ear canal?	Yes	No
Remarks:		
I certify that I have examined the patient mentioned above and to my knowledge there is no medical or surgical contraindication to wearing a hearing aid.		
Otologic Diagnosis		

I recommend the patient to be fitted for a hearing aid I recommend the patient be referred for future medical evaluation	Signature of ENT or MD	Date

Figure 6.4 – Audiometric Test Clearance Form (Part 1 of 2)

PART III Audiological Assessment *(to be completed by audiologist/otolaryngologist)*

Recipient's Name	Age	Medicaid Number

RE ANSI 1969

Frequency	250	500	1000	2000	4000	8000	Speech	Right	Left
Left-Air									
Left-Bone									
Right-Air									
Right-Bone									

Validity of Test Results:	Special Tests or Conditions:
Hearing aid recommended for (left - right) ear	Hearing aid NOT recommended
Recommendation information:	
Signature (Testing conducted by audiologist or otolaryngologist)	
Title	Date

If pure tone testing indicates a bone-air gap of 15 decibels (dB) or more for two (2) adjacent frequencies on the same ear, or if speech discrimination tests indicate a score of less than 60 percent in either ear, or if hearing loss in one (1) ear is greater than the other ear by 20 decibels (dB) in the pure tone average or 20 percent in the discrimination score, the patient must be referred for further assessment by an otolaryngologist, providing the physician has not already considered these conditions.

***Test IV Hearing Aid Evaluation* (to be completed by hearing aid dealer)**

Ear					
Make/Model			*UNAIDED*		
Tone Setting					
Volume Setting					
SRT					
MCL					
PB Quiet					
PB Noise					
PB Level					

Signature (Evaluation conducted by Audiologist, Otolaryngologist or Hearing Air Dealer) *Date*

***PART V Hearing Aid Contract* (to be completed by hearing aid dealer)**

Should there be complaints from a recipient and/or other responsible persons directly interested in the recipient, as to the user's failure to receive satisfactory benefits from the instruments, the Indiana State Registered Hearing Aid Dealer must attempt to make satisfactory adjustment or follow the recommendation as deemed advisable by the Medicaid Program. Failure to do so may cause payment to be withheld. If payment has been received by the Indiana State Registered hearing Aid Dealer, the full refund will be made to the contractor.

There is to be no solicitation of Medicaid patients, for the purpose of fitting hearing aids. As a general policy, there are to be no replacement hearing aid fittings for Medicaid patients where the hearing aid in use is less than five (5) years old.

"I have read the regulations and standards adopted and approved by the Indiana Department of Public Welfare, for the fitting and dispensing of hearing aids for Medicaid cases, and I have followed the procedures provided therein."

Hearing Aid Dealer's Signature	*Indiana Registration No.*	*Date*

Figure 6.4 – Audiometric Test Clearance Form - Reverse Side (Part 2 of 2)

APPENDIX I
MEDICAID RESOURCES

State Laws

1. Indiana law (statute) governing the Medicaid program can be found in Title 12, Article 15 of the Indiana Code, available at www.in.gov/legislative/ic/code/title12/ar15. Select the appropriate Chapter (e.g. Chapter 2—Eligibility, Chapter 4—Application for Assistance, Chapter 5—Services, etc.).

2. To view bills for current or most recently completed session of the Indiana General Assembly, go to www.in.gov/apps/lsa/session/billwatch/billinfo. This website provides:

   - Bills by Subject Listing (PDF)
   - Complete Information for All Bills
   - List of "Live" Information for Bills
   - Enrolled Acts Approved by Both Houses
   - Action on Vetoed Bills
   - Resolutions
   - Fiscal Impact Statements
   - Additional Bill Information
   - You may also search for bills related to a particular topic by typing in a "keyword."

An archive of past sessions of the Indiana General Assembly is available at www.in.gov/legislative/session/archives.html.

State Rules

1. Medicaid Covered Services Rules, Title 405 of the Indiana Administrative Code, Article 5, is available at www.in.gov/legislative/iac. Select Title 405, go to Article 5 in the Table of Contents, and select the rule relevant to the topic you are searching, for example:
   a. Rule 2—Definitions
   b. Rule 4—Provider Enrollment
   c. Rule 20—Mental Health Services
   d. Rule 22—Nursing and Therapy Services

2. Any proposed and final changes (i.e., Proposed Rules and Final Rules) to the Medicaid Covered Services Rule, will be published in the *Indiana Register*, on the first day of the month. The Indiana Register is available at www.in.gov/legislative/register/index-27.html. Check the table of contents on the first day of each month for any upcoming rule changes, including public hearings.

Federal Regulations

1. Medicaid eligibility, coverage and payment regulations, 42 CFR, Part 430, et seq., are available at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfrv3_02.html. From the index, select the relevant Part (e.g., Services: General Provisions), then choose a

2. specific section by topic, for example: Section 440.110—Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders.

3. Federal rule changes (proposed and final) are published daily in the *Federal Register* available at http://www.gpoaccess.gov/fr/index.html. Find, review, and submit comments on Federal rules that are open for comment and published in the Federal Register using Regulations.gov.

Other Indiana Medicaid Resources

Information about the Indiana Health Coverage Programs (IHCP), which includes Medicaid and the State Children's Health Insurance Program (CHIP), is available at http://provider.indianamedicaid.com/. The following information is available at this site:

1. The IHCP Provider Manual http://provider.indianamedicaid.com/general-provider-services/manuals.aspx.
2. Forms such as Medical Clearance forms and Electronic Funds Transfer (EFT) account forms, http://provider.indianamedicaid.com/general-provider-services/forms.aspx.
3. Fee schedule http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp.
4. IHCP Provider Communications, http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx .
5. A variety of information related to Provider Services, for example, HIPAA, EFT, Provider Enrollment, description of Explanation of Benefits (EOBs) indicated on the Remittance Advice (RA), how to find your field consultant, can be found by selecting the "Provider Services" drop down menu at the main website above.

Other Federal Medicaid Resources

The Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services, is the federal agency responsible for administration of the Medicaid program. The following is key information accessible via www.cms.hhs.gov:

1. Quarterly Provider Updates to inform the public about regulations and major policies currently under development, completed or cancelled, as well as new/revised manual instructions, http://www.cms.hhs.gov/QuarterlyProviderUpdates/
2. The State Medicaid Manual is the guidance CMS publishes for State Medicaid Agencies, http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927
3. State Medicaid Director Letters (SMDL) contain guidance and clarification on specific topics, such as payment for School-Based Services, http://www.cms.hhs.gov/SMDL/SMD/list.asp
4. Healthcare Common Procedure Coding System (HCPCS) codes (Level I HCPCS consists of CPT-4 procedure codes published by AMA, and Level II is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT-4 codes), http://www.cms.hhs.gov/HCPCSCodesforStateMed/

Procedure Code Sets

Currently, there is no procedure code set specifically designated for use by Indiana Medicaid-participating school corporations. If Indiana Medicaid defines a limited set of procedure codes

that school corporations must use to bill IEP/IFSP services, it will be available online at http://provider.indianamedicaid.com/general-provider-services/billing-and-remittance/code-sets.aspx . School corporations will be notified via IHCP Provider Bulletin and IDOE Tool Kit Updates if such a procedure code set is established.

Code and Diagnosis Manuals

Current Procedural Terminology, American Medical Association (AMA), 2005; *CPT Changes, An Insider's View*, AMA, 2005, and any updates thereto. The CPT is available for purchase through the American Medical Association, by calling 800-621-8335 or www.amapress.com, or may be available at your local library.

Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV), American Psychiatric Association, 1994, and any updates thereto. The DSM-IV is available through the American Psychiatric Association at:

American Psychiatric Publishing, Inc.
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
Phone: 800-368-5777 or 703-907-7322
Fax: 703-907-1091
Email: appi@psych.org
Website: www.appi.org and select on Customer Service

The DSM-IV may also be available at your local library.

International Classification of Diseases, 9th Revision Clinical Modification (ICD-9), American Medical Association, 2005, and any updates thereto. The ICD-9 is available for purchase through the American Medical Association by calling 800-621-8335 or www.amapress.com, or may be available at your local library.

Coding Workshops

School corporations must ensure that their providers are knowledgeable of the CPT codes, their definitions as well as the parameter for each code within their specialty. Coding workshops conducted by Registered Health Information Specialists, Certified Coding Specialists, and Certified Coding Specialist Physicians are beneficial for such purposes.

National Organizations

The National Alliance for Medicaid in Education (NAME), a non-profit organization representing state Medicaid and Education agencies staff responsible for Medicaid Administrative Claiming and/or Direct Billing of Health Related Services in public schools, as well as Local Education Agencies participating in the Medicaid program. For more information visit http://medicaidforeducation.org/.

LEAnet, a coalition of Local Education Agencies dedicated to the protection of school health services from current and pending cuts in Federal Medicaid programs. For more information visit http://www.theleanet.com/.