

Medicaid Billing Tool Kit

UPDATE LOG

	TOPIC	SECTION NUMBER	PAGE NUMBER(S) TO BE ADDED	PAGE NUMBER(S) TO BE REMOVED	EFFECTIVE DATE
2012-01-05.1	Title Page	N/A	Title Page (1 pg)	Title Page (1 pg)	01-015-2012
2012-01-05.2	Table of Contents, additions and corrections	N/A	iii-vi (4 pgs)	iii-vi (4 pgs)	01-015-2012
2012-01-05.3	Corrects header and further clarifies General Information	1.1.	1-1-1 & 1-1-2 (2 pgs)	1-1-1 & 1-1-2 (2 pgs)	Technical Amendment
2012-01-05.4	Corrects header; updates/clarifies Tool Kit Use, Format and Updating	1.2. thru 1.4	1-2-1, 1-3-1 and 1-4-1 (3 pgs)	1-2-1, 1-3-1 and 1-4-1 (3 pgs)	Technical Amendment
2012-01-05.5	Updates covered service examples; Clarifies benefit package limitations	2.1.	2-1-1 & 2-1-2 (2 pgs)	2-1-1 & 2-1-2 (2 pgs)	Technical Amendment
2012-01-05.6	Updates related services list from Article 7	2.2.	2-2-2 (1 pg)	2-2-2 (1 pg)	Technical Amendment
2012-01-05.7	Updates Medicaid Provider Enrollment information & Web links	2.3.	2-3-1 & 2-3-2 (2 pgs)	2-3-1 & 2-3-2 (2 pgs)	12-21-2011
2012-01-05.8	Updates info & Web links to identify Medicaid program "excluded parties"	2.3.4.	2-3-4 (1 pg)	2-3-4 (1 pg)	Technical Amendment
2012-01-05.9	Clarifies Medicaid coverage criteria and treatment plan/plan of care.	2.5.3. and 2.5.7.	2-5-2 & 2-5-3 (2 pgs)	2-5-2 & 2-5-3 (2 pgs)	Technical Amendment
2012-01-05.10	<i>Corrects header and page formatting only</i> – NO CONTENT CHANGE	2.5.9. thru 2.5.11.	2-5-4 & 2-5-5 (2 pgs)	2-5-4 & 2-5-5 (2 pgs)	Technical Amendment
2012-01-05.11	Adds reference to relevant section	2.7.2.	2-7-1 & 2-7-2 (2 pgs)	2-7-1 & 2-7-2 (2 pgs)	Technical Amendment
2012-01-05.12	Revises formatting; further clarifies Billing Requirement for referral/order	2.8.	2-8-1 & 2-8-2 (2 pgs)	2-8-1 & 2-8-2 (2 pgs)	Technical Amendment
2012-01-05.13	Adds reference to section clarifying Medicaid referral/order requirement	3.2.	3-2-1 (1 pg)	3-2-1 (1 pg)	Technical Amendment
2012-01-05.14	Clarifies treatment plan/plan of care requirements	3.4.	3-4-1 (1 pg)	3-4-1 (1 pg)	Technical Amendment
2012-01-05.15	Adds reference to section clarifying Medicaid referral/order requirement	4.1.2.	4-1-1 (1 pg)	4-1-1 (1 pg)	Technical Amendment
2012-01-05.16	Clarifies treatment plan/plan of care requirements	4.5.4. & 4.5.5.	4-5-1 & 4-5-2 (2 pgs)	4-5-1 & 4-5-2 (2 pgs)	Technical Amendment
2012-01-05.17	Corrects header and clarifies referral requirement if service needs change	5.1.3.	5-1-1 (1 pg)	5-1-1 (1 pg)	Technical Amendment
2012-01-05.18	Adds reference to relevant section; clarifies relevance to evaluations	5.3.	5-3-1 (1pg)	5-3-1 (1pg)	Technical Amendment
2012-01-05.19	Clarifies treatment plan/plan of care requirements	5.4.	5-4-1 & 5-4-2 (2 pgs)	5-4-1 & 5-4-2 (2 pgs)	Technical Amendment
2012-01-05.20	Clarifies referral requirement if service needs change	6.1.	6-1-1 (1 pg)	6-1-1 (1 pg)	Technical Amendment
2012-01-05.21	Clarifies treatment plan/plan of care requirements	6.5.5.	6-5-1 & 6-5-2 (2 pgs)	6-5-1 & 6-5-2 (2 pgs)	Technical Amendment
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2012-01-05.23	Adds reference to relevant sections.	7.4.2.	7-4-1 (1 pg)	7-4-1 (1 pg)	Technical Amendment
2012-01-05.24	<i>Corrects header and page formatting only</i> – NO CONTENT CHANGE	8.3.	8-3-1 (1 pg)	8-3-1 (1 pg)	Technical Amendment
2012-01-05.25	Clarifies treatment plan/plan of care and physician order requirements	8.4.	8-4-1 (1 pg)	8-4-1 (1 pg)	Technical Amendment
2012-01-05.26	<i>Corrects header and page formatting only</i> – NO CONTENT CHANGE	8.5.	8-5-1 (1 pg)	8-5-1 (1 pg)	Technical Amendment

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2012-01-05.27	Notes privacy safeguard compliance in considerations for trip log format	9.4.2.	9-4-2 (1 pg)	9-4-2 (1 pg)	Technical Amendment
2012-01-05.28	<i>Corrects header and page formatting only – NO CONTENT CHANGE</i>	10.1	10-1-1 thru 10-1-19 (19 pgs)	10-1-1 thru 10-1-19 (19 pgs)	Technical Amendment
2012-01-05.29	Medicaid Provider Enrollment App update per ACA-mandated changes	Appendix A	A1 thru A3 (3 pgs)	A1 thru A5 (5 pgs)	01-01-2012
2012-01-05.30	Updates IHCP Quick Reference and Provider Field Rep Territories	Appendix D	D1 thru D3 (3 pgs)	D1 thru D3 (3 pgs)	12-01-2011
2012-01-05.31	Incorporates Nursing Services in sample referral form template	Appendix F	F3 (1 pg)	F3 (1 pg)	Technical Amendment
2012-01-05.32	Corrects typo on sample Nursing Service Log template	Appendix F	F10 (1 pg)	F10 (1 pg)	Technical Amendment
2012-01-05.33	Updates Medicaid Clearance and Audiometric Form	Appendix H	H1 and H2 (2 pgs)	H1 and H2 (2 pgs)	Technical Amendment
2012-01-05.34	Adds/updates links and information on Medicaid resources	Appendix I	I1 thru I3 (3 pgs)	I1 thru I3 (3 pgs)	Technical Amendment

**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**

January 5, 2012

Tenth Edition

Developed by Health Evolutions, Inc. under contract with the
Indiana Department of Education, Division of Exceptional Learners
in collaboration with the
Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning and
the Indiana State Budget Agency

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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 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 *Medicaid Billing Guidebook: 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 and Tool Kit are intended to help school corporations decide whether to seek Medicaid reimbursement for IEP services, help Medicaid-participating school corporations monitor the work of their medical claims billing agent contractors, and help participating school corporations' staff and contractors 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. The Health Insurance Portability and Accountability Act of 1996, "HIPAA," Public Law 104-191 (42 USC § 1320d and federal regulations at 45 CFR § 160, 162 & 164).
4. Indiana Medicaid State Plan available at www.indianamedicaid.com/ihcp/StatePlan/state_plan.asp.
5. Title 12, Article 15 of the Indiana Code.
6. Title 405 of the Indiana Administrative Code, Articles 1 and 5.
7. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, 102 Stat. 683 (July 1, 1988) 42 USC § 1305).

8. 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.).
9. The Code of Federal Regulations, Title 34, Chapter III, Part 300
10. The Family Educational Rights Privacy Act of 1974 “FERPA,” Section 438, Public Law 90-247 Title IV, as amended (20 U.S.C. § 1232g and federal regulations at 34 CFR Part 99), otherwise known as the Buckley Amendment.
11. Title 511 of the Indiana Administrative Code, Article 7.
12. 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.
13. Office of Management and Budget (“OMB”) Circular A-87, Cost Principles for State, Local and Indian Tribal Governments.
14. Current Procedural Terminology® (CPT) codes and descriptions of the American Medical Association (AMA) and any changes as published by the AMA.
15. 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 **covered IEP services as well as guidance concerning requirements for school corporations to claim Medicaid reimbursement** for such services. **Medicaid-participating** 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 **Indiana Health Coverage Programs (IHCP) Manual, Monthly Newsletter, bulletins and banner pages**. Additional resources are identified in Appendix I of this Tool Kit.

1.3. TOOL KIT UPDATES

1.3.1. Updating Changes

The [Medicaid Billing Tool Kit](#) is updated as needed to incorporate changes that impact school-based Medicaid claiming. The entity responsible for updating the Tool Kit will be determined by the Indiana Department of Education. Updates are coordinated with the Indiana Office of Medicaid Policy and Planning, appear in red font and 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.

Tool Kit updates are posted on the [IDOE School-based Medicaid Web Page](#). The effective dates of policy and program changes are noted in the Update Log.

1.3.2. Update Log

The Tool Kit Update Log accompanies updates and serves as a reference for school corporations to track and accurately incorporate changes into locally maintained 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”). The Tool Kit Update Log also shows the “Effective Date” on which any new or changed policies or 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. School corporations are encouraged to check this date periodically in the online version of the Tool Kit to ensure locally maintained copies are current.

1.4. HOW TO USE THE UPDATE LOG

1.4.1. Introduction

To help ensure that their Medicaid-qualified providers of medical services **and staff or contractors who bill claims** comply with Medicaid program requirements, Medicaid-participating school corporations **are encouraged to** share Tool Kit updates with all who furnish **and submit claims for** Medicaid-covered IEP/IFSP services. *An electronic copy of the latest Medicaid Billing Tool Kit is accessible on the [IDOE School-based Medicaid Web page](http://www.doe.in.gov/exceptional/speced/medicaid.html) at <http://www.doe.in.gov/exceptional/speced/medicaid.html>.*

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, IDOE newsletters and Tool Kit updates to stay current on policy **and procedures that impact school-based Medicaid claiming**. **If you maintain a hard copy of *The Medicaid Billing Tool Kit*, follow these recommendations for keeping it current:**

- **Notice of immediate changes may be communicated via IDOE Learning Connection announcements and bulletins to Directors and may precede your receipt of related Tool Kit updates. Until reflected in a Tool Kit Update, make note of any recent change and file the announcement or bulletin for reference.**
- Upon **notification** of a Tool Kit update, 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 **online Tool Kit, listed under Manuals on the IDOE School-based Medicaid page:**
<http://doe.state.in.us/exceptional/speced/medicaid.html>.

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. **Medicaid-covered IEP services** include: evaluations and re-evaluations; occupational, physical and speech therapy services; audiology services; **nursing services**; behavioral health services; and **IEP specialized transportation**.

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.*

2.1.4. Differences among Public Health Insurance Benefit Programs in Indiana

To minimize the stigma associated with public benefits programs, Indiana uses a generic term, “Hoosier Healthwise,” to refer to most public health coverage benefits available to children. Typically, a child’s family income is a deciding factor in determining health coverage program eligibility. Some children qualify for Medicaid despite family income levels that exceed the program’s federal poverty level-based income standards, and some Medicaid-eligible children may also qualify to receive home and community-based waiver services. Those not eligible for Medicaid may qualify for **C**hildren’s **H**ealth **I**nsurance **P**rogram benefits.

The following table summarizes **Medicaid and “CHIP”** benefit packages available to Hoosier children and the covered services associated with each package. As noted below and in Appendix D of the [Medicaid Billing Guidebook](#), *some IHCP benefit packages limit coverage to a specific number or type of services*. **Children eligible for limited benefit packages are not entitled to the full scope of Medicaid-covered services under the Indiana Medicaid State Plan.**

Claiming reimbursement for IEP services provided to children with limited, or “capped,” public health coverage benefits poses a potential FAPE violation if accessing those benefits results in a cost to the student or student’s family. **Note:** children who qualify for limited benefits typically constitute a very small percentage of a school’s student population, and the district’s billing agent or staff responsible for program eligibility verification can readily identify and filter these out when submitting Medicaid claims for IEP services.

More information about Indiana Health Coverage Programs is available online at <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs.aspx>. Click the links for additional details on each program.

Benefit Package	Coverage
Package A—Standard Plan (Medicaid)	All Medicaid-covered State Plan services for eligible children and families.
Package B—Pregnancy Plan	Coverage limited to pregnancy-related and urge care only for some pregnant females.
Package C—Children’s Health Insurance Program (“CHIP”)	<i>Limited</i> preventive, primary and acute care services for eligible children under 19 years.
Package E—Emergency Services	Emergency services <i>only</i> for children not born in the U.S. (including undocumented aliens).
Package P—Presumptive Eligibility for Pregnant Women	Ambulatory prenatal services <i>only</i> for pregnant women while eligibility is being determined.
<i>CareSelect</i> —Standard Plan (Medicaid) for complex needs	All Medicaid-covered State Plan services for eligible children and adults with complex medical needs.

Information in this Tool Kit does not necessarily apply to services furnished to a student eligible for the Children’s Health Insurance Program (“CHIP”).

who qualify for benefits under “Hoosier Healthwise Package A” and those who qualify for benefits under *CareSelect* are eligible for Medicaid.

Children who qualify for benefits under other Hoosier Healthwise “packages” (including “Package C” aka “CHIP”) are NOT eligible for Medicaid.

7. 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. 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.
8. 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 must meet the qualifications for Medicaid providers of the specific services (s)he is furnishing.
9. 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. Parent counseling and training.
 - i. Physical therapy.
 - j. Psychological services.
 - k. Recreation, including therapeutic 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/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-participating school corporation **has the option to direct its Medicaid reimbursement checks to its special education cooperative by entering the cooperative's name and mailing 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 **apply** online by choosing "School Corporation" from the list of Indiana Medicaid provider types at <http://provider.indianamedicaid.com/become-a-provider/complete-an-ihcp-provider-application.aspx>. To obtain a National Provider Identifier (NPI), school corporations may apply via 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). **Report** the school corporation's National Provider Identifier and taxonomy code (see next two paragraphs) to HP. For NPI reporting instructions, please visit <http://provider.indianamedicaid.com/become-a-provider.aspx> and click on "National Provider Identifier" then click the link to the online **NPI Reporting Tool**.

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 *Medicaid Billing Guidebook: 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 keep its **Medicaid** provider enrollment file up to date. **Updates can be submitted via HP’s Web-based system (“Web interChange”) or on paper forms. Instructions and Web links are provided online at <http://provider.indianamedicaid.com/become-a-provider/update-your-provider-profile.aspx>** 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.]

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 **their employees and contracted staff providing Medicaid-covered IEP services do not appear on the U.S. Department of Health and Human Services Office of Inspector General's "List of Excluded Individuals and Entities (LEIE)" accessible online at <http://www.oig.hhs.gov/fraud/exclusions.asp>. **The federal System for Award Management also offers an online "Excluded Parties List System (EPLS)" search function at <https://www.epls.gov/>. 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 the information in the blue text box **above concerning methods to identify "Excluded Parties"**).

2.5.3. Medicaid Reimbursable Services

Only **medically necessary** services that are **listed in or required to develop** an IEP/IFSP are billable (see Section 2.5.6.). **For example:** An **initial evaluation to assess a student's health-related needs and develop his IEP** may be billed to Medicaid. Similarly, other *medically necessary diagnostic and treatment services in the student's IEP* are billable. Do not bill Medicaid for the evaluation if the student is determined ineligible to receive services under IDEA. **Please note: Medicaid does **not** cover services that are strictly educational in nature.** Examples of services considered strictly educational in nature include: evaluations to identify a specific learning disability (***unless an underlying medical or mental health condition is suspected or must be ruled out as the cause of the learning disability***) and speech therapy continued after a speech-language pathologist determines the student's medical need has been met.

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 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. **See Section 2.5.3. for additional details.** 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—exception: please see Chapter 7 concerning requirement for mental health treatment plan review. The IEP or IFSP may qualify as the treatment plan if it meets Medicaid's criteria (please review 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. For example, if the IEP (or care plan incorporated by reference into 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.

2.7. 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. **Also note place of service if other than on-site/at school (see Tool Kit Section 2.5.9. for details).**
 - 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 where the IEP services were rendered (see Tool Kit Section 2.5.9).
- 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.

2.8. GUIDELINES FOR BILLING IEP/IFSP SERVICES

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

- a. **Authorization for Services:** 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.
- b. **Order or Referral:** In accordance with federal regulations at 42 CFR 440.110, to be covered by Medicaid, **therapy, audiology and nursing** services must be ordered by a physician (M.D. or D.O.) or a licensed practitioner of the healing arts” **as permitted by state law (see details in Tool Kit Chapters 3 through 9 and 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 (for example, “consultation once per semester” is changed to “speech therapy three times per week”). **NOTE:** The frequency of Medicaid billing for a particular service cannot exceed the frequency described in the student's IEP.

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.**

- c. **Parental Consent:** *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). See details in Tool Kit Appendix G.*
- d. **Coding:** When billing Medicaid, school corporations *must use the Current Procedural Terminology © (CPT) code that best describes the Medicaid-covered IEP service provided and any applicable CPT code modifiers (see Appendix E).* School corporations **and their billing agents** must pay particular attention to CPT code descriptions, **noting that some codes are and some are not time-based.**
- e. **Provider Qualifications:** CPT codes are specific to the types and specialties of the practitioners furnishing services within their scope of licensure. *School corporations must ensure they or their billing agents are billing for services for which the rendering provider (furnishing the service): a) has proper licensure/certification, and b) meets the criteria to be a Medicaid-qualified provider. (See also 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.

- f. **Documentation:** Medicaid reimbursements are subject to audit. School corporations must maintain supporting documentation for IEP services claims for seven years from the date the service was provided. See additional details in Tool Kit Chapters 3 through 9 and Section 1 of Chapter 10.

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 “[Medicaid Billing Guidebook](#)” available online at: <http://www.doe.in.gov/exceptional/speced/medicaid.html>.

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?

3.2. PROVIDER QUALIFICATIONS

3.2.1. Qualifications – see also: Section 2.3.4.

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 licensure rules established under Indiana Code 20-28-2-1), 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 from 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 from the American Speech-Language-Hearing Association [<http://www.asha.org/Certification/Aud2011Standards/>].

(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 required for audiological assessment/*evaluation and treatment services*. See also *Tool Kit Section 2.8.1.b*.

3.4. PLAN OF CARE – see also: Section 2.5.7.

In most cases, school corporations prefer that the student’s Individualized Education Program (IEP) serve dual purposes: (1) to describe the health-related services to be provided under the student’s educational program, and (2) to set out the required components of the student’s plan of care (see these components listed below).

A school corporation may also choose to maintain a separate “plan of care” or “treatment plan” (such as an Individualized Healthcare Plan) which meets this Medicaid requirement; however, this separate plan of care must be incorporated by reference into the student’s IEP if the services are to be billed to Medicaid.

A new or updated plan of care is required at least annually. Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student’s condition changes or alternative services are ordered (see Tool Kit Section 2.5.7.). Note: A physician’s order is needed at least annually, before initiation of service (see Tool Kit Sections 2.8.1.b. and 3.1.2.). If the student’s medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician’s order is required.

A student’s plan of care along with the physician’s order for the service (see Tool Kit Sections 2.8.1.b. and 3.1.2.) must be retained in the student’s record.

School corporations are encouraged to coordinate 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.

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. – see also: Section 2.3.4.

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. **See also Tool Kit Section 2.8.1.b.**

4.5. PLAN OF CARE – see also: Section 2.5.7.

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 – see also: Section 2.3.4.

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. **See Tool Kit Section 4.5.5. for more discussion.**

A student's plan of care along with the physician's order **for the service (see Tool Kit Sections 2.8.1.b. and 4.1.2.)** must be retained in the student's record.

4.5.5. Plan of Care Review

A **new or updated** plan of care **is required at least** annually. The plan of care must be updated more frequently if the student's condition changes or alternative treatments are recommended. **Note:** A physician's order is needed **at least annually**, before initiation of service (see **Tool Kit Sections 2.8.1.b. and 4.1.2.**). If the student's medical condition requiring the therapy **changes significantly enough to require a substantive change in services**, a **new** physician's order **is required**.

A student's plan of care must be reviewed and updated according to the level of progress. **[Note: Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student's condition changes or alternative services are ordered (see Tool Kit Section 2.5.7.).]** If a determination is made during treatment that additional services are required, these services must be added to the plan of care (**also note physician order/referral requirement discussed in preceding paragraph**). In the event that services are discontinued, the physical therapist must indicate the reason for discontinuing treatment in the student's record.

In most cases, school corporations prefer that the student's Individualized Education Program (IEP) serve dual purposes: (1) to describe the health-related services to be provided under the student's educational program, and (2) to set out the required components of the student's plan of care (see these components listed below). Alternatively, a school corporation may choose to maintain a separate "plan of care" or "treatment plan" (such as an Individualized Healthcare Plan) which meets this Medicaid requirement; however, this separate plan of care must be incorporated by reference into the student's IEP if the services are to be billed to Medicaid.

School corporations are encouraged to coordinate 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.

4.5.6. Reimbursement – see also: Sections 2.5.3. through 2.5.6.

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

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); applicable licensure rules
established under Indiana Code 20-28-2-1; see also 515 IAC
8-1-16 and 515 IAC 4-2-1.

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 – see also: Sections 2.5.3. through 2.5.7.

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. A physician/other Medical Professional order or referral must be obtained upon initiation of service and annually thereafter. **If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician's order is required.**

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. **See also Tool Kit Section 2.8.1.b.**

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 – see also: Section 2.3.4.

To be reimbursed by Medicaid, Speech-Language Pathology *Evaluations* must be performed by a licensed SLP who meets the criteria in Tool Kit Section 5.2.1. Please refer to Section 5.2. of this Tool Kit chapter.

5.3.3. Diagnostic Testing, Evaluation or Re-evaluation

For diagnostic services 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 – see also: Sections 2.5.3. through 2.5.6.

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 – see also: Section 2.5.7.

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 Section 5.4.3. Plan of Care Components. **In most cases, school corporations prefer that the student's Individualized Education Program (IEP) serve dual purposes: (1) to describe the health-related services to be provided under the student's educational program, and (2) to set out the required components of the student's plan of care (see these components listed below). Alternatively, a school corporation may choose to maintain a separate "plan of care" or "treatment plan" (such as an Individualized Healthcare Plan) which meets this Medicaid requirement; however, this separate plan of care must be incorporated by reference into the student's IEP if the services are to be billed to Medicaid.**

5.4.2. Provider Qualifications – see also: Section 2.3.4.

A licensed SLP who meets the criteria in Tool Kit Section 5.2.1. must develop the plan of care for Medicaid-reimbursed speech-language pathology services.

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 serve 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 new or updated plan of care is required at least annually. Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student's condition changes or alternative services are recommended (see Tool Kit Section 2.5.7.). Note: A physician's/other appropriate practitioner's order/referral is needed at least annually, before initiation of service (see Tool Kit Sections 2.8.1.b. and 5.1.3.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new order is required. 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 the plan of care. In the event that services are discontinued, the licensed speech-language pathologist must indicate the reason for discontinuing treatment in the student's record.

A student's plan of care along with the physician's order for the service (see Tool Kit Sections 2.8.1.b. and 5.1.3.) must be retained in the student's record.

School corporations are encouraged to share progress notes and plans of care with the student's physician 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.

5.4.6. Reimbursement Limitations – see also: Sections 2.5.3. through 2.5.7.

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

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 Limitations – see also: Sections 2.5.3. through 2.5.7.

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. **If the student’s medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new order is required.**

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. **See also Tool Kit Section 2.8.1.b.**

6.5. PLAN OF CARE – see also: Section 2.5.7.

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. **Note: A physician's/other appropriate practitioner's order/referral is needed at least annually, before initiation of service (see Tool Kit Sections 2.8.1.b. and 6.1.3.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new order is required.** A student's IEP may suffice as a plan of care if the IEP or IFSP contains the required components described below.

6.5.2. Provider Qualifications – see also: Section 2.3.4.

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 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 new or updated plan of care is required at least annually. Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student's condition changes or alternative services are recommended (see Tool Kit Section 2.5.7.). Note: A physician's order is needed at least annually, before initiation of service (see Tool Kit Section 6.1.3.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician's order is required. 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. In the event that services are discontinued, the registered occupational therapist must indicate the reason for discontinuing treatment in student's record.

School corporations are encouraged to coordinate with the 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.

6.5.6. Reimbursement Limitations – see also: Sections 2.5.3. through 2.5.7.

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

7.2. PROVIDER QUALIFICATIONS

7.2.1. Provider Qualifications for Testing and Treatment – see also Section 2.3.4.

To qualify for Medicaid reimbursement, services must be provided by or under the direction of a licensed physician or a psychologist endorsed as a health service provider in psychology (HSPP). A “Health Service Provider in Psychology” is a licensed psychologist who has training and experience sufficient to establish competence in an applied health service area of psychology (such as clinical, counseling, or school psychology) and who meets the experience requirements of IC 25-33-1-5.1(c). Medicaid-reimbursed psych testing and treatment services may also be provided by other mid-level practitioners under the direct supervision of a physician or HSPP, as outlined below.

Medicaid Provider Qualifications for Psychological Testing Services

Indiana Medicaid’s July 2010 rule change (excerpt recopied below) lists Medicaid-qualified providers of neuropsychological and psychological testing. [A copy of the entire rule is included in Tool Kit Appendix C, Pages C25-C27.]

“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 A through C(ii) below].

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.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed.

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 A through C(ii) above]”

Medicaid Provider Qualifications for Psychotherapy Services

To qualify for Medicaid reimbursement, 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.
7. 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.

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 licensure rules established under Indiana Code 20-28-2-1. 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, Plan of Care **and Plan of Care Review**

The responsibilities of the physician or HSPP in supervising and directing mid-level practitioners include certifying the diagnosis and supervising the plan of treatment or plan of care (see also: Section 2.5.7.) 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 again 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. **See also Tool Kit Section 7.4.2.**

School corporations **are encouraged to coordinate with** the student’s physician 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.

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. **Note: A physician/HSPP's order is needed at least annually, before initiation of service (see Tool Kit Section 2.8.1.b.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician's order is required.**

Please see Appendix F for a sample Order/Referral Form template that can be adapted for local district use. See also Tool Kit Section 2.8.1.

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 documented medical need.
2. Documentation of IEP nursing services must include the appropriate start and stop times for each patient encounter on the date of service. Documentation of IEP nursing services provided off-site or during a school field trip must note the place of service, and for field trips, must include the beginning and ending dates and times of the field trip. See also Tool Kit Section 2.5.9. regarding Place of Service Codes.
3. When billing all IEP nursing 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 licensed R.N.'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 IEP 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 student's IEP, the school corporation must 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.

Review the IEP Nursing Services-related information contained in the Indiana Medicaid agency provider bulletin #BT201108. A copy of this bulletin is available in Tool Kit Appendix C. This bulletin and other publications intended for Indiana Medicaid service providers are available at the News, Bulletins and Banners Tab, under "Banner Pages" on the [indianamedicaid.com Web site](http://indianamedicaid.com).

8.4. PLAN OF CARE – see also: Section 2.5.7.

8.4.1. Plan of Care Requirement

For Medicaid services ordered by a physician and authorized in the student’s IEP, a Registered Nurse must provide services in accordance with a plan of care developed and maintained specifically for the student. **In most cases, school corporations prefer that the student’s Individualized Education Program (IEP) serve dual purposes: (1) to describe the health-related services to be provided under the student’s educational program, and (2) to set out the required components of the student’s plan of care (see these components listed below). Alternatively, a school corporation may choose to maintain a separate “plan of care” or “treatment plan” (such as an Individualized Healthcare Plan) which meets this Medicaid requirement; however, this separate plan of care must be incorporated by reference into the student’s IEP if the services are to be billed to Medicaid.**

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 new or updated plan of care is required at least annually. Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student’s condition changes or alternative treatments or nursing services are ordered (see Tool Kit Section 2.5.7.). Note: A physician’s order is needed at least annually, before initiation of service. If the student’s medical condition changes significantly enough to require a substantive change in services, a new physician’s order is required. See also Tool Kit Section 2.8.1.b.

School corporations are encouraged to coordinate 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*.

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, **and to observe Special Education students' rights to privacy**, it may simplify the record keeping process to **include all students on the trip log when a vehicle is providing IEP Special Education Transportation** to/from school or to/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 district use.

Note also: Per the IHCP Provider Manual Chapter 8 page 368, mileage is rounded to the nearest whole unit as follows:

“Mileage Units and Rounding

Providers must bill the IHCP for whole units only. For partial mileage units, round to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles.”

Note also: Medicaid reimburses for second and subsequent passengers transported in a single vehicle at half the base rate for the type of transportation provided. See details regarding transportation of multiple passengers and an escort/attendant accompanying the passenger(s) in Medicaid Provider Bulletin BT200505 (Appendix C, Page C11) and IHCP Provider Manual Chapter 8, page 3-169.

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. See also [Medicaid Billing Guidebook](#) Section 9.4.

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 Chapter 7.

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 plan*, 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; 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 and 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 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 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 LAC 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.*

APPENDIX A—MEDICAID PROVIDER AGREEMENT

Access the complete agreement online at <http://provider.indianamedicaid.com/become-a-provider/complete-an-ihcp-provider-application/12---school-corporation.aspx>

		Schedule A
IHCP School Corporation Provider Application and Profile Maintenance Packet		indianamedicaid.com
Provider Information		
<ul style="list-style-type: none"> • Type of Request: This packet is used for multiple purposes; select the purpose that applies: <ul style="list-style-type: none"> ○ New Enrollment – You are enrolling in the IHCP for the first time. ○ New Service Location – You are already enrolled in the IHCP and want to enroll an additional service location. ○ Profile Update – You are already enrolled in the IHCP and you need to change your provider profile information. • A taxonomy code identifies a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or an IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under Reference. The taxonomy requested in field 4 is the taxonomy associated with the NPI in field 2. 		
1. Type of Request:		
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Additional Service Location <input type="checkbox"/> Profile Update		
2. National Provider Identifier (NPI):	3. ZIP + 4:	4. Taxonomy Code:
5. IHCP Provider Number (LPI) and Alpha Suffix: (If currently enrolled)	6. Document Submission Date:	7. Requested Enrollment Effective Date:
Previous IHCP Enrollment Information		
8. Have you ever been enrolled as an IHCP provider?		9. Previous IHCP Provider Numbers (LPIs):
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Service Location Name and Address		
<ul style="list-style-type: none"> • The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained. • The service location name must be the Doing Business As (DBA) name registered with the Secretary of State, except for informal associations such as Sole Proprietorships and General Partnerships. • The service location name must match the DBA name on the W-9. • Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their service location address. • The service location address must be a physical location. A post office box is not a valid service location address. 		
10. Service Location (DBA) Name:		
11. Indiana County (Indiana providers):	12. Telephone:	
13. Service Location Street Address:		
14. City:	15. State:	16. ZIP + 4: (Nine digits required):
17. Is claim documentation kept at this location?		18. Are services provided in Indiana?
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
HP Provider Enrollment Unit P.O. Box 7263 Indianapolis, IN 46207-7263		IHCP School Corporation Provider Application and Profile Maintenance Version 5.0 December 2011
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Legal Name and Home Office Address		
<ul style="list-style-type: none"> The legal name is considered to be the entity maintaining ownership of the named business. The legal name must be the current name on tax, corporation, and other legal documents. The legal name and home office address must match the information currently registered with the Secretary of State, or filed with the County Recorder. If your business name differs from your legal name, a copy of the registration information must be included as an attachment to the application The legal name as well as the home office address and Taxpayer Identification number must match the information on the W-9. The home office address must be a physical location. A post office box is not a valid home office address. If you are using this application packet to update your legal name or home office address, you must include a revised W-9 form as an attachment to the application. 		
19. Legal Name:		
20. Business Name (DBA):		
21. Home Office Street Address:		
22. City:	23. State:	24. ZIP + 4: (Nine digits required)
25. Telephone:		26. Taxpayer Identification Number (TIN):
Mailing Name and Address		
The mailing address is the location where the IHCP sends general correspondence. A post office box is acceptable for a mailing address.		
27. Addressee:		28. Telephone:
29. Mailing Street Address:		
30. City:	31. State:	32. ZIP + 4: (Nine digits required)
Pay To Name and Address		
<ul style="list-style-type: none"> The pay to address is the location where the IHCP sends checks and general claims payment information. If this is a billing agent's address, please provide the name, address, and telephone number of the billing agent. A post office box is acceptable for this address. The pay to name is the name that will appear as the payee on all checks. If the provider is using a billing agent, proof of authorization for the billing agent must be included as an attachment to the application. 		
33. Pay To Name:		
34. Billing Agent Name (if applicable):		35. Pay To Telephone:
36. Pay To Street Address:		
37. City:	38. State:	39. ZIP + 4: (Nine digits required)
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>HP Provider Enrollment Unit P. O. Box 7263 Indianapolis, IN 46207-7263</p> </div> <div style="width: 30%; text-align: right;"> <p>IHCP School Corporation Provider Application and Profile Maintenance Version 5.0 December 2011</p> </div> <div style="width: 30%; text-align: center;"> <p>Page 4 of 25</p> </div> </div>		

Contact Name	
<ul style="list-style-type: none"> The contact name and email relate to the person who can answer questions about the information provided in this application. Providers will be enrolled to receive email notifications when new information is published to indianamedicaid.com. Provide the email address where these notifications should be sent. Note: Email addresses will be used for IHCP business only and will not be sold or shared for other purposes. 	
40. Contact Name:	41. Telephone:
42. Contact Email Address:	
43. Email Address for Provider Publications:	
Provider Specialty Information	
<p>A taxonomy code identifies a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or an IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under Reference. You may enter up to 15 taxonomies; enter only those that apply to this service location.</p>	
44. Provider Type (two-digit code):	45. Primary Specialty (three-digit code):
12	120
46. Taxonomy Codes associated with this specialty and used for billing:	
HP Provider Enrollment Unit P.O. Box 7263 Indianapolis, IN 46207-7263	IHCP School Corporation Provider Application and Profile Maintenance Version 5.0 December 2011
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APPENDIX D –Indiana Medicaid Program Contact Information

NOTE: Identify yourself as a School Corporation Medicaid Provider when contacting any of the following Indiana Health Coverage Programs help lines and program areas for assistance.



Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization				
ADVANTAGE Health SolutionsSM 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 1-800-738-6770 (317) 692-0819	HP Member Hotline 1-800-457-4584 (317) 713-9627 Opt 1 = Member Services – English Opt 2 = Member Services – Spanish	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 Payment Line 1-866-273-5897 M.E.D. Works Payment Mailing Address P.O. Box 946Indianapolis, IN 46206
HP Electronic Solutions Help Desk INXIXElectronicSolution@hp.com 1-877-877-5182 (317) 488-5160	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 Third Party Liability (TPL) 1-800-457-4510 (317) 488-5045 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 Program Integrity Department P.O. Box 636297 Cincinnati, OH 45263-6297 1-800-457-4515 (317) 347-7598	HP Omni Help Desk 1-800-284-3548 (317) 488-5051	HP Customer Assistance (Providers) 1-800-577-1278 (317) 655-3240 Opt 1 = Member Services Opt 2 = Pharmacy Services Opt 3 = Provider Enrollment Opt 4 = Other Provider Services	IHCP Provider and Member Concern Line (Fraud and Abuse) 1-800-457-4515 (317) 234-7598	
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 INXIXPharmacy@hp.com 1-800-577-1278 (317) 655-3240 Opt 2 = Pharmacy	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 Entities (MCEs)		
Hoosier Healthwise http://www.indianamedicaid.com/ 1-800-889-9949 Care Select http://www.indianamedicaid.com/ 1-866-963-7383 HIP http://www.HIP.in.gov 1-877-438-4479 Pharmacy Customer Assistance 1-800-577-1278 (317) 655-3240 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 St Francis Health Network PA 1-800-291-4140 Fax: 1-800-747-3692 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 1-800-356-1204 (317) 630-2831 Member Services Fax: Fax: 1-877-822-7190 Fax: (317) 829-5530 Medical PA/Management Fax: See Quick Contact Sheet at http://www.mdwise.org/ Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198	Managed Health Services (MHS) http://www.mhsindiana.com/ Claims, Member Services, Family Education Network, Transportation, Language Assistance, Nursewise, Medical PA/Medical Management and Provider Services, 1-877-647-4848 Fax: 1-866-912-4244 Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198 Ombudsman 1-877-647-5326	
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

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Paper Claim Filing			
HP Claim Attachment Cover Sheets (Electronic Claims) P.O. Box 7259 Indianapolis, IN 46207-7259	HP Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	HP Medical Crossover Claims, including 590 and Waiver P.O. Box 7267 Indianapolis, IN 46207-7267	
HP Dental Claims P.O. Box 7268 Indianapolis, IN 46207-7268	HP Institutional Crossover/UB-04 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims P.O. Box 7271 Indianapolis, IN 46207-7271	HP CMS-1500 Claims, single and attachment claims including 590 and Waiver P.O. Box 7269 Indianapolis, IN 46207-7269	
Care Select – Care Management Organizations (CMOs)			
ADVANTAGE Health SolutionsSM http://www.advantageplan.com/ Member Services 1-800-784-3981 Provider Services 1-866-504-6708 Medical PA P.O. Box 80068 Indianapolis, IN 46280 1-800-784-3981 Fax: 1-800-689-2759 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 1-800-356-1204 (317) 630-2831 Member Services Fax 1-877-822-7188 Medical PA P.O. Box 44214 Indianapolis, IN 46244-0214 1-800-356-1204 (317) 630-2831 Fax: 1-877-822-7186 Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198	Pharmacy See Pharmacy Services Contact Information on page one.	HP Claims Providers 1-800-577-1278 (317) 655-3240 Opt 1 = Member Services Opt 2 = Pharmacy Services Opt 3 = Provider Enrollment Opt 4 = Other Provider Services Members 1-800-457-4584 (317) 713-9627 Opt 1 = Member Services – English Opt 2 = Member Services – Spanish
Healthy Indiana Plan (HIP) Organizations		HIP – Enhanced Services Plan (ESP) Organizations	
MDwise http://www.mdwise.org Member Services and Provider Services 1-800-356-1204 (317) 630-2831 Fax: 1-877-822-7192 Fax: (317) 822-7192 Medical and Behavioral Health Claims Paper Claims: MDwise HIP Claims P.O. Box 78310 Indianapolis, IN 46278 Electronic Claims: WebMD/Emdeon Institutional Payer ID 12K81 Professional Payer ID 5X172 McKesson/Relay Health Institutional Payer ID 4976 Professional Payer ID 4481 Medical PA /Management Fax: See Quick Contact Sheet at http://www.mdwise.org/ Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198	Anthem http://www.anthem.com Member Services 1-800-553-2019 Provider Inquiry P.O. Box 37010 Louisville, KY 40233-7180 1-800-345-4344 Medical PA 1-866-398-1922 Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198	Managed Health Services (MHS) http://www.mhsindiana.com/ Claims, Member Services, Family Education Network, Transportation, Language Assistance, Nursewise, Medical PA/Medical Management and Provider Services, 1-877-647-4848 Fax: 1-866-912-4244 Pharmacy PA 1-866-879-0106 Fax: 1-866-780-2198 Ombudsman 1-877-647-5326	ACS – Non-Pharmacy P.O. Box 33077 Indianapolis, IN 46203-0077 1-866-674-1461 (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 (317) 655-3240
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: 1-877-392-6894	Anthem – HIP P.O. Box 6144 Indianapolis, IN 46206-6144 1-866-902-1690 – Option 3 Fax: 1-866-387-2959	Anthem – HHW P.O. Box 6144 Indianapolis, IN 46206-6144 1-866-902-1690 – Option 3 Fax: 1-866-387-2959	Managed Health Services (MHS) – HIP 1099 N. Meridian Street, Suite 400 Indianapolis, Indiana 46204-4287 1-877-647-4848 Fax: 1-866-753-7240
Managed Health Services (MHS) – HHW 1099 N. Meridian Street, Suite 400 Indianapolis, Indiana 46204-4287 1-877-647-4848 Fax: 1-866-753-7240	MDwise – Care Select P.O. Box 44214 Indianapolis, IN 46244-0214 1-800-356-1204 (317) 630-2831 Fax: 1-877-822-7188 Fax: (317) 822-7519	MDwise – HIP P.O. Box 44236 Indianapolis, IN 46244-0236 1-800-356-1204 (317) 630-2831 Fax: 1-877-822-7192 Fax: (317) 822-7192	MDwise – HHW P.O. Box 441423 Indianapolis, IN 46244-1423 1-800-356-1204 (317) 630-2831 Fax: 1-877-822-7190 Fax: (317) 829-5530

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The latest IHCP Quick Reference is typically accessible by clicking the Newsletters link at [Indiana Medicaid’s Web site](http://provider.indianamedicaid.com/) (<http://provider.indianamedicaid.com/>) then scrolling to the last page of the most recent Provider Newsletter. The Quick Reference link is typically included under “For More Information” on the final page of each monthly provider newsletter.

Indiana Medicaid Provider Field Consultants by Territory



Changes in Provider Relations consultants are effective December 1

Effective December 1, 2011, please note the following changes (some temporary) in Indiana Health Coverage Programs (IHCP) Provider Relations consultants:

- Northeastern Indiana and Sturgis, MI – Tawanna Danzie temporarily replaces Rhonda Rupel; telephone: (317) 488-5080.
- Southwestern Indiana and Owensboro and Louisville, KY – Judy Green temporarily replaces Ken Guth; telephone: (317) 488-5153
- Out-of-state providers, as well as Hamilton/Oxford, OH – Donnette Reese replaces Jenny Atkins; telephone: (317) 488-5049

- Marion County, CMS-1500 (claim specific) – Pam Byrd; telephone: (317) 488-5186
- Marion County – UB-04 and dental (claim specific) – Shantel Silnes; telephone: (317) 488-5309

Current Provider Relations consultants territory assignments

Territory	Consultant	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke; also Chicago and Watseka, IL
2	Tawanna Danzie	(317) 488-5080	Allen, DeKalb, Elkhart, Fulton, Kosciusko, LaGrange, Marshall, Noble, St. Joseph, Steuben, Whitley; also Sturgis, Michigan
3	Relia Manns	(317) 488-5363	Benton, Boone, Carroll, Cass, Clinton, Fountain, Grant, Hamilton, Howard, Madison, Miami, Montgomery, Tippecanoe, Tipton, Wabash, Warren, White
4	Daryl Davidson	(317) 488-5388	Adams, Blackford, Dearborn, Decatur, Delaware, Fayette, Franklin, Hancock, Henry, Huntington, Jay, Ohio, Randolph, Ripley, Rush, Shelby, Union, Wayne, Wells; also Cincinnati and Harrison, OH
5	Pam Byrd	(317) 488-5186	Marion County – CMS-1500 (claim specific)
5	Shantel Silnes	(317) 488-5309	Marion County – UB-04 and dental (claim specific)
6	Virginia Hudson	(317) 488-5148	Bartholomew, Brown, Clay, Greene, Hendricks, Jackson, Jennings, Johnson, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo; also Danville, IL
7	Judy Green (temporary)	(317) 488-5153	Clark, Crawford, Daviess, Dubois, Floyd, Gibson, Harrison, Jefferson, Knox, Martin, Orange, Perry, Pike, Posey, Scott, Spencer, Switzerland, Vanderburgh, Warrick, Washington; also Owensboro and Louisville, KY
8	Donnette Reese	(317) 488-5049	All out-of-state providers except those in the cities listed below; also Hamilton and Oxford, OH

As of December 1, 2011

For updated Provider Field Consultant contact information, click the Newsletters link at Indiana Medicaid’s Web site, <http://provider.indianamedicaid.com/>. A link to the current list of Indiana Medicaid Provider Relations Field Consultants is typically included under “For More Information” on the final page of each monthly provider newsletter.

Nursing Service/Physical Therapy Referral

To be completed by licensed physician.

Student Name: _____ **Date of Birth:** _____

Parent's: _____

Address: _____

Diagnosis:

Physical Therapy: Evaluation
 Treatment Services: _____

Other: _____

Nursing Service: Assessment
 Treatment Services: _____

Other: _____

Precautions: _____

Additional Comments:

Authorized Signature: _____

Print Name & Title: _____

Date: _____

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												
Date of Service (DOS)	Start Time	Stop Time	Total Service Time (minutes)	Assessment		catheterization	respiratory care	splz feeding	hlth supp syst othr	meds admn	DSMT	Nurse's Notes & Initials
				develop / revise IHP	v physical / mental status							

Nurse's Signature, Credentials _____ Date _____ Nurse's Signature, Credentials _____ Date _____

APPENDIX H
Medical Clearance and Audiometric Test Form
Continued on Page H2

IHCP MEDICAL CLEARANCE AND AUDIOMETRIC TEST

Instructions: The Medical Clearance and Audiometric Test Form must be used for all hearing aid fittings under the Indiana Health Coverage Programs. This form must be completed and carry the proper signature where indicated, before requests will be considered for prior authorization.

PART I Member History		
Member's Name	RID Number	Age
If Institution, Admission Date	Previous Institution	
If unable to independently maintain the member's hearing aid, are there resources available to assist in maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:		
Medical Diagnosis	Hearing Diagnosis	
Has this member worn a hearing aid previously? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, purchase dates	IHCP Purchased?
If member previously owns/wears amplification, give the model and status of the instrument and settings.		
PART II Medical Clearance (to be completed by physician)		
<i>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 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:</i>		
1. Is there any evidence of infection or drainage from either ear?	Yes	No
2. Is there any significant headache, vertigo, 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 eardrum?	Yes	No
6. Perforation of the eardrum?	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:		
<input type="checkbox"/> I recommend the patient to be fitted for a hearing aid. <input type="checkbox"/> I recommend the patient be referred for future medical evaluation.	Signature of Physician	Date

Medical Clearance and Audiometric Test Form
Continued from Page H1

PART III Audiological Assessment (to be completed by audiologist or otolaryngologist)								
Member's Name						Age	RID Number	
<i>RE ANSI 1969</i>								
Frequency	500	1000	2000	3000	4000	Speech	Right	Left
Left-Air						SRT		
Left-Bone						Word Recognition (WRS)	/50 dbHL	/50 dbHL
Right-Air						Word Recognition (WRS)	/MCL	/MCL
Right-Bone								
Validity of Test Results: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor						Special Tests:		
Hearing Aid recommended for: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Binaural <input type="checkbox"/> Hearing Aid not recommended								
Recommendation information:								
Signature (Testing conducted by Audiologist or Otolaryngologist)							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.

PART IV Hearing Aid Evaluation (to be completed by audiologist or hearing aid dealer)					
Ear	Left Aided	Right Aided	Unaided Left	Unaided Right	Binaurally Aided
Make/Model					
SRT					
MCL					
PB Quiet					
PB Noise(+5 S/N)					
PB Level					
Special Conditions:					
Signature (Evaluation conducted by Audiologist or Hearing Aid Dealer)					Date
PART V Hearing Aid Contract (to be completed by audiologist or hearing aid dealer)					
<p><i>Should there be complaints from a member, and/or other responsible persons directly interested in the member, 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 IHCP. 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.</i></p> <p><i>There is to be no solicitation of IHCP patients, for the purpose of fitting hearing aids. As a general policy, there are to be no replacement hearing aid fittings for IHCP patients where the hearing aid in use is less than five years old.</i></p> <p><i>"I have read the regulations and standards adopted and approved by the IHCP for the fitting and dispensing of hearing aids for IHCP cases and I have followed the procedures provided therein."</i></p>					
Audiologist/Hearing Aid Dealer's Signature			Indiana License/Registration No.		Date

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 Vetoes of 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. Changes to the Medicaid Covered Services Rule are published in the *Indiana Register* <http://www.in.gov/legislative/register/irtoc.htm> on the first day of the month. Click the links to daily, weekly or monthly collections for a list of publication contents to identify Notices of Intent to Adopt a Rule, Notices of Public Hearings, Proposed, Emergency and Final Rules as well as Non-Rule Policy Documents published by Indiana’s Legislative Services Agency. This site also offers a User’s Guide link with background information.

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

specific section by topic, for example: Section 440.110—Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders.

2. **Proposed and Final federal regulation** changes are published daily in the *Federal Register* <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>. Find, review, and submit **public comments about Federal rules online at** www.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 <http://provider.indianamedicaid.com>.

Other Federal Medicaid Resources

In 2011, the U.S. Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS), which oversees state administration of the Medicaid program, launched a new Web site: <http://medicaid.gov/>. The new site offers Medicaid and CHIP data by state, federal policy guidance, a “What’s New” section, and quick links to program initiatives such as Insure Kids Now <http://www.insurekidsnow.gov/>. Additionally, the following key information is 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 instruction <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 on specific topics such as payment for School-Based Services <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html?filterBy=SMD%23dynamic-list>
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) https://www.cms.gov/MedHCPCSGenInfo/02_HCPCSCODINGPROCESS.asp#TopOfPage

Procedure Code Sets

If, in the future, Indiana Medicaid designates a school corporation provider “code set,” it will be available online at <http://provider.indianamedicaid.com/general-provider-services/billing-and-remittance/code-sets.aspx>. If such a procedure code set is ever established, Indiana school corporations will be notified via IHCP Provider Bulletin, Tool Kit Update and IDOE Learning Connection announcements.

Code and Diagnosis Manuals

Current Procedural Terminology and *CPT Changes, An Insider’s View*, and any updates thereto. The latest CPT code book and related publications may be purchased from the American Medical Association, 800-621-8335 or www.amapress.com, or may be available at a public library.

Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV), American Psychiatric Association, 1994, and any updates thereto. The DSM-IV may be available at a public library and can be purchased 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

International Classification of Diseases, 10th Revision Clinical Modification (ICD-10-CM), American Medical Association, 2005, and any updates thereto. The ICD-10 handbook is available for purchase through the American Medical Association, 800-621-8335 or www.amapress.com, or may be available at a public library.

Coding Workshops

School corporation staff providing health-related IEP services are encouraged to become familiar with the CPT codes, definitions and parameters relevant to their specialties. 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/>.