GUIDE TO BILLING INDIANA MEDICAID FOR INDIVIDUALIZED EDUCATION PROGRAM HEALTH-RELATED SERVICES PROVIDED BY SCHOOL CORPORATIONS

MEDICAID BILLING GUIDEBOOK

A Guide for Public School Corporations
Indiana Department of Education

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GUIDE TO BILLING INDIANA MEDICAID FOR COVERED SCHOOL-BASED SERVICES AND ACTIVITIES

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PREFACE

HealthEvolutions, under a contract with the Indiana Department of Education, developed this **Guide** as an educational tool to orient school corporations to the Medicaid program in general and to provide an overview of Medicaid claiming requirements for school-based services. The ***Medicaid Billing Tool Kit***, developed as a companion to this Guide, provides detailed information describing school corporation Medicaid provider enrollment, Medicaid-qualified service providers, and Medicaid-covered IEP services, service referral and billing requirements. Copies of the Guide and Tool Kit are available online at IDOE's School-based Medicaid Web page: http://www.doe.in.gov/achievement/individualized-learning/school-based-medicaid.

The topics addressed in this **Guide** are:

1. General information about the Medicaid program
2. General information on Medicaid claiming for covered IEP services and Medicaid-related administrative activities typically performed by school personnel
3. General Medicaid documentation requirements
4. Confidentiality and records retention requirements

GUIDE TO BILLING INDIANA MEDICAID FOR COVERED SCHOOL-BASED SERVICES AND ACTIVITIES

CHAPTER I: INTRODUCTION

The school setting provides a unique opportunity to help students and families identify and access medical assistance benefits and receive covered health care services. The federal government recognizes this unique opportunity and provides specific guidance on furnishing and claiming reimbursement for school-based Medicaid services.

The purpose of this guide to school-based Medicaid claiming in Indiana is:

1. to provide school corporations with a basic understanding of Medicaid coverage for health-related services in a student's Individualized Education Program (referred to as "Medicaid-covered IEP services");
2. to outline Indiana's parameters for billing Medicaid-covered IEP services; and
3. to describe Indiana's school-based Medicaid Administrative Claiming program, which recovers federal funding for some of schools' costs to perform medical service coordination, outreach and referral activities.

This Guide includes general information for Indiana public school corporations, charter schools and state-operated schools interested in claiming federal Medicaid funding for school-based services and activities. As outlined below, applicable statutory, regulatory and legal authority was used in developing this Guide and will govern any future school-based Medicaid claiming program changes.

Coverage and reimbursement policy changes are generally announced by the Indiana Office of Medicaid Policy and Planning (OMPP) through Indiana Health Coverage Program (IHCP) Provider Bulletins. All IHCP bulletins are accessible online at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp; copies of IHCP school-based Medicaid-related bulletins are posted in IDOE's Learning Connection, under the Medicaid in Schools Community Files and Bookmarks Tab.

Legal, Statutory and Regulatory Authority

1. The Social Security Act Title XIX-Grants to States for Medical Assistance programs (42 USC § 1396 et. seq.) commonly referred to as "Medicaid" http://www.ssa.gov/OP_Home/ssact/title19/1900.htm
2. The Code of Federal Regulations, Title 42, Chapter IV, Parts 430 through 498 http://www.ecfr.gov/cgi-bin/text-idx?SID=42e086b60444072e0ea99516782b3dff&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl
3. The Indiana Medicaid State Plan http://www.indianamedicaid.com/ihcp/StatePlan/state_plan.asp
4. Title 12, Article 15 of the Indiana Code http://www.in.gov/legislative/ic/code/title12/ar15/

5. Title 405 of the Indiana Administrative Code, Article 1 and Article 5
   http://www.in.gov/legislative/iac/T04050/A00010.PDF
   http://www.in.gov/legislative/iac/T04050/A00050.PDF
6. Indiana Health Coverage Programs Provider Manual, as amended by Provider Bulletins
   http://provider.indianamedicaid.com/general-provider-services/manuals.aspx
   http://provider.indianamedicaid.com/news,-bulletins,-and-banners/bulletins.aspx
7. Office of Management and Budget ("OMB") Circular A-87
   http://www.whitehouse.gov/omb/circulars_a087_2004

CHAPTER II: DEFINITIONS

The following definitions apply for purposes of this Guide:

1. *Billing Provider* refers to the school corporation that has a provider agreement with Medicaid, provides one or more Medicaid-covered IEP services to an eligible student and bills Medicaid for the Medicaid-covered IEP services it furnishes.
2. *Care Select*, also known as Indiana Care Select, is a Medicaid managed care program for individuals who are Medicaid eligible due to age, blindness or disability. Care Select replaces Medicaid *Select* and will serve many Medicaid members formerly enrolled in the traditional fee-for-service Medicaid delivery system.
3. *Children's Health Insurance Program, "CHIP,"* also known as the State Children's Health Insurance Program, "S-CHIP" and "Hoosier Healthwise Package C," refers to the State's medical assistance program under Title XXI of the Social Security Act for individuals under the age of 19 years.
4. *Current Procedural Terminology © ("CPT")* refers to the uniform codes and descriptions for medical procedures, including coding rules and guidelines, published by the American Medical Association and updated annually.
5. *Early and Periodic Screening, Diagnostic and Treatment ("EPSDT")* refers to the mandatory Medicaid benefit that requires preventive care (including screening and diagnostic services) as well as treatment for children up to age 21 years.
6. *Family Educational Rights and Privacy Act ("FERPA") (20 USC § 1232g; 34 CFR Part 99)* is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when s/he reaches the age of 18 years or attends a school beyond the high school level. See FERPA information at: http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html
7. *Federal Financial Participation ("FFP")* refers to funding contributed by the federal government toward a State's Medicaid program costs. Different rates of FFP are available for different types of medical assistance and administrative expenditures.
8. *Federal Medical Assistance Percentage ("FMAP")* is the percentage of a State Medicaid program's medical assistance expenditures reimbursed by the federal government (often referred to as the "federal share" of the Medicaid reimbursement).
9. *Fee-for-Service, (FFS),* as defined in the Indiana Health Coverage Programs Provider Manual, is a Medicaid service delivery system that reimburses providers on a per-service basis. Under Fee-for-Service reimbursement, Medicaid providers, including school corporations, bill claims directly to Medicaid's claims processing contractor and are reimbursed at the lesser of the Medicaid fee schedule amount or the submitted charge for the service. Indiana Medicaid's fee schedule is accessible online under Quick Links at http://www.indianamedicaid.com.
10. *Free Care* is the term used by the federal Medicaid agency to refer to health care services that are provided without charge to all individuals who receive the care.
11. *Health Insurance Portability and Accountability Act of 1996 ("HIPAA")* is federal legislation that promotes portability of health insurance between jobs and required the U.S. Department of Health and Human Services (DHHS) to issue federal regulations protecting personally identifiable health information. DHHS has issued

HIPAA privacy regulations known as the *Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 160 and § 164*, and other related HIPAA regulations.

12. *Home and Community-Based Waiver Program* refers to an alternative Medicaid program that pays for support services to preclude long term institutionalization of certain qualified individuals. Indiana offers, on a first come first served basis, Medicaid waiver services for individuals with developmental disabilities, certain elderly and disabled individuals, and individuals with traumatic brain injury.
13. *Hoosier Care Connect* is a Medicaid managed care program for individuals who are Medicaid eligible due to age, blindness or disability, replacing *Care Select* in the spring of 2015m and will serve many Medicaid members formerly enrolled in either *Care Select* or *the* traditional fee-for-service Medicaid delivery system.
14. *Hoosier Health Card* is the member identification card for all Indiana Health Coverage Programs. The permanent plastic card is expected to be retained by the member for his or her lifetime and displays the member's name, gender, date of birth and member identification number.
15. *Hoosier Healthwise* refers to Indiana's health care programs for children, pregnant women and low income working families, including those that qualify for assistance under Medicaid and "CHIP," Children's Health Insurance Program.
16. *Hoosier Healthwise benefit package* refers to the quantity and types of Medicaid or CHIP services covered for an individual Hoosier Healthwise member, depending on his or her eligibility status.
17. *Indiana Health Coverage Programs ("IHCP")* refers to all of the medical assistance programs administered by the Indiana Family and Social Services Administration.
18. *Individualized Education Program ("IEP")* is a statement written by a team of professionals, with input from the parent, describing a student's current level of functioning, needed special education and related services, needed transition services, annual goals and benchmarks, and decisions regarding specified issues (as applicable) related to the student's free and appropriate public education or "FAPE." See more on this topic at http://www.ed.gov/parents/needs/speced/iepguide/index.html .
19. *Individuals with Disabilities Education Act ("IDEA"),* first enacted in 1975 as the Education for All handicapped Children Act (Public Law 94-142) and most recently reauthorized in 2004, assures that a free and appropriate education is available to all children with disabilities. IDEA emphasizes special education and related services designed to meet the unique needs of individual students with disabilities; to assure that the rights of children with disabilities and their parents or guardians are protected; to assist states and localities to provide for the education of all children with disabilities; and to assess and assure the effectiveness of efforts to educate children with disabilities.
20. *Medicaid* refers to the State's medical assistance program under Title XIX of the Social Security Act.
21. *Medicaid Managed Care plans* are managed care delivery systems in which the Medicaid agency pays a Managed Care Organization (MCO) a monthly capitation fee for the Medicaid members enrolled in that plan. The MCO is responsible to provide (directly or through referral) the majority of Medicaid-covered services for its members. Certain Medicaid-covered services are not the financial responsibility of the MCO and are referred to as "carved out" services. Health-related IEP services provided by a public school corporation, charter or state-operated school are carved

out of the Medicaid managed care plans and billed directly to the Medicaid claims processing contractor, HP, for payment under the fee-for-service methodology.

22. *Medicaid program delivery system* refers to a comprehensive system of health care providers responsible for rendering Medicaid-covered services to eligible individuals.
23. *Medically reasonable and necessary service* means a 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 service.
24. *Parental Consent to Bill Medicaid* refers to the prior written notice, one-time signed consent and annual notifications required by 34 CFR § 300.154(d)(2)(iv) and 34 CFR § 300.154(d)(2)(v) when access to a student's public benefits or insurance is sought.
25. *Rendering Provider* refers to the licensed, Medicaid-qualified practitioner who is directly performing Medicaid services billed by the "Billing Provider." A Medicaid-enrolled school corporation is both the Billing and the Rendering Provider for IEP services it provides.
26. *Third Party Liability ("Third Party" or "TPL")* refers to a payer (individual, insurer or other program) that is liable to pay all or a part of medical assistance (Medicaid) expenditures made on behalf of a particular individual. Under federal law, Medicaid is the payer of last resort, and in all but a few exceptions, can only make payment after all other liable parties have paid their obligations toward a medical claim.

CHAPTER III: OVERVIEW OF MEDICAID PROGRAM

3.1. REIMBURSEMENT FOR IEP HEALTH-RELATED SERVICES

The Medicaid program is jointly funded by the state and federal governments. In accordance with requirements and options under federal law, each state defines the covered health care services that Medicaid will provide to eligible low-income children, pregnant women, families, elderly and disabled individuals in that state.

The federal government's share of Medicaid medical assistance expenditures (Federal Medical Assistance Percentage or "FMAP") varies from state to state and can change as often as quarterly. The chart below shows examples of the typical "share" of total Medicaid IEP service reimbursements* funded by the state and federal governments:

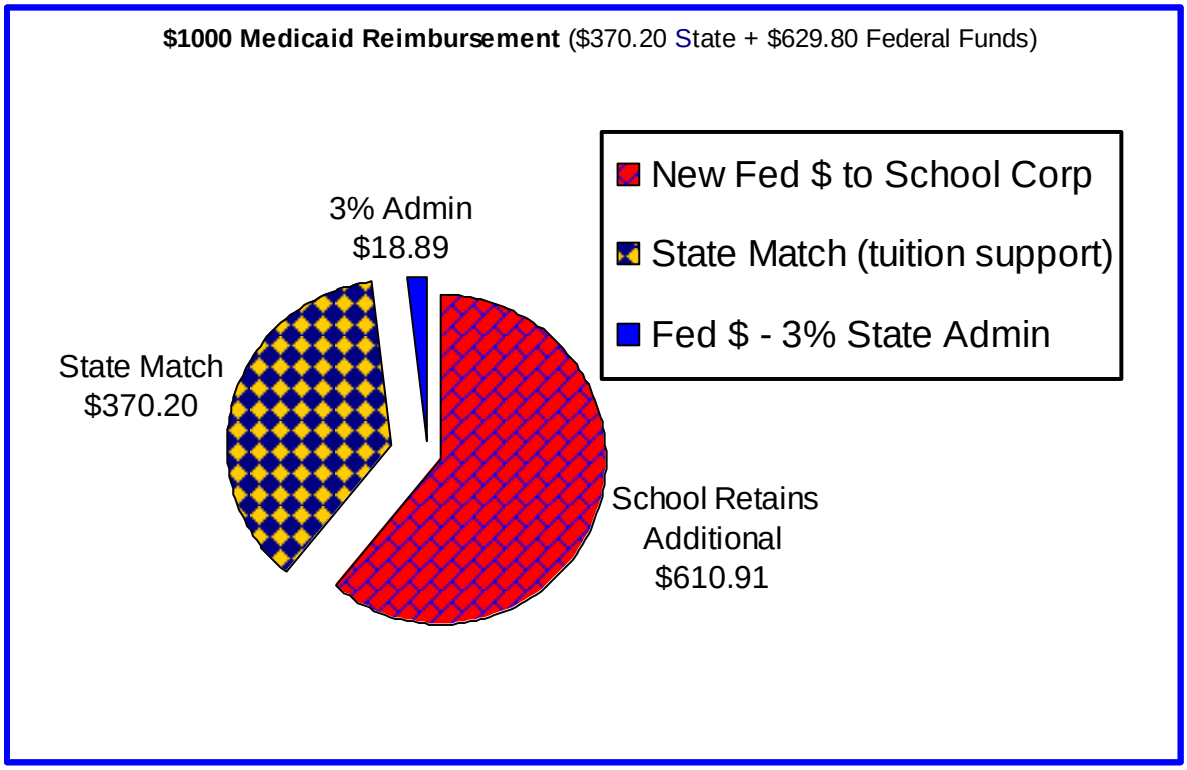
Federal Fiscal Year 2011 (*varied per quarter*) **10/01/10-09/30/11**	**Federal Fiscal Year 2012** **10/01/11-09/30/12**	**Federal Fiscal Year 2013** **10/01/12-09/30/13**	**Federal Fiscal Year 2014** **10/01/13-09/30/14**	**Federal Fiscal Year 2015** **10/01/14-09/30/15**
Fed Share = 76.21-66.52% State Share = 23.79-33.48%	Fed Share = 66.96% State Share = 33.04	Fed Share = 67.16% State Share = 32.84%	Fed Share = 66.92% State Share = 33.08%	Fed Share = 66.52% State Share = 33.48%

In 2003 the Indiana General Assembly passed legislation (see Appendix A), which requires 3 percent of the federal share of each participating school corporation's Medicaid reimbursements to be distributed to the State's General Fund to help defray state costs to administer and oversee school-based Medicaid billing. The remainder is distributed to the Medicaid-participating school corporation, as in the following example (see also the pie chart on the next page):

- The school corporation receives a Medicaid payment of $1,000 for Medicaid-covered IEP services provided to a Medicaid-enrolled student. Using an FMAP or Federal Medical Assistance Percentage of 62.98%:
  - The federal share of the total Medicaid payment amount is $629.80.
  - The state share of the total Medicaid payment amount is $370.20 (received as part of the school corporation's Medicaid reimbursement check, the state share constitutes an "advance" payment of a portion of that school corporation's monthly state tuition support allocation).
- Upon distribution of the school corporation's tuition support funds, DOE withholds $389.09, which represents:
  - $370.20 or the amount of state funds the school corporation received as part of its total monthly Medicaid reimbursement, plus
  - Three percent (3%) of the federal portion of the school corporation's monthly Medicaid reimbursement (in this example, 629.80 X 3% = $18.89), which per IC 12-15-1-16 the State retains to help defray costs for administrative oversight and technical support of school corporations' participation in the Medicaid program.
- **The school corporation's net gain of new unrestricted funds is $610.91.**

* See also Section 3.5 regarding **federal match rates for Medicaid *Administrative* Claiming**.

QUICK TIP: Upon receipt of the $1,000 Medicaid payment, the school corporation restores $389.09 (state share + state administration) to its tuition support account, offsetting the Medicaid adjustment. The remaining $610.91, which is new federal money, can be used as the school corporation sees fit; for example, to support staff development, equipment and services for students with disabilities or school-based health services for all students.



Please refer to Appendix A, Pages A-2 and A-3 for a sample DOE Basic Grant Monthly Distribution Report showing the "Medicaid Adjustment" for the state share and 3% of the federal share of the school corporation's monthly Medicaid reimbursements (highlighted in yellow on the sample form in Appendix A).

For a step-by-step video walk through of the Medicaid Adjustment process, visit the IDOE Video Vault at http://media.doe.in.gov/archive/. Under Finance, click the link to the 3/24/2011 "Medicaid Adjustment" video and follow the on screen prompts to play it. The video link is also available at the Medicaid in Schools Community on The Learning Connection; click "IN DOE video on: Medicaid adjustment for partial "advance" of state tuition allocation" under the Files and Bookmarks Tab. Visit The Learning Connection dashboard for information about using this Web-based educator collaboration tool.

3.2. ROLES AND RESPONSIBILITIES

3.2.1. *Role of the Office of Medicaid Policy and Planning*

The Office of Medicaid Policy and Planning ("OMPP") is the state agency responsible for administration of Indiana's Medicaid program under Title XIX of the Social Security Act and the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. The OMPP administers these and other Indiana Health Coverage Programs (IHCP) with oversight from the Centers for Medicare and Medicaid Services (CMS), which is part of the United States Department of Health and Human Services.

The OMPP contracts with a number of entities to perform various functions related to administration of the State's health coverage programs. These include:

- *Hewlett Packard ("HP")*, the fiscal agent responsible for processing all Indiana Medicaid fee-for-service claims. HP also supports Medicaid provider enrollment, provider relations and customer assistance with billing or payment issues, as well as recipient eligibility verification and third party liability resource verification.

QUICK TIP: *Provider Field Consultants are available to help you.* An HP provider field consultant is assigned to assist Medicaid-enrolled providers within each of several geographic areas of the state. Consultants can visit your office to provide detailed assistance upon request. To identify your area's consultant, visit http://provider.indianamedicaid.com/ click Contact Us under the search box at upper right, then click the Provider Relations Field Consultants link at the left side of the page. See a sample field consultant list at Appendix B.
***IMPORTANT DETAIL*: When calling HP Customer Assistance, be sure to explain that you are calling on behalf of a *School Corporation*.**

- *Hoosier Healthwise and Hoosier Care Connect managed care plans*, which authorize and pay for the majority of services provided to individuals enrolled in risk-based managed care (see Health Care Delivery Systems, Section 3.5.2.). Medicaid-covered IEP services are "carved out" of these risk-based managed care plans; that is, IEP services are not subject to managed care referral and precertification requirements and are paid by HP on a fee-for-service basis.

See Appendix B for a summary of Medicaid contractors and contact information.

3.2.2. *Role of the Division of Family Resources*

The Indiana Family and Social Services Administration (FSSA) Division of Family Resources (DFR), through a network of local County DFR Offices, determines applicants' eligibility for the Medicaid program. For more details visit http://www.in.gov/fssa/dfr/2999.htm.

3.2.3. *Role of the Indiana Department of Education*

1. Medicaid enrollment requirement. Indiana statute requires all school corporations to enroll as Indiana Medicaid service providers. See I.C. § 12-15-1-16. The DOE offers school corporations technical assistance to facilitate their compliance with this requirement.
2. Individuals with Disabilities Education Act. The DOE is the state agency responsible for general oversight of Indiana schools' compliance with the requirements of the Individuals with Disabilities Education Act, 20 USC § 1400 et seq. ("IDEA").
3. Facilitating implementation of Medicaid in schools. In addition to facilitating school corporations' enrollment as Medicaid providers, the DOE serves as a liaison between school corporations and the Medicaid program. In this role, the DOE also:
    - Provides assistance to OMPP with research, budget preparation, financial reporting and account reconciliation, as needed.
    - Cooperates and assists OMPP with financial recoveries that may be necessitated by incorrect billing of Medicaid-covered IEP services.
    - Makes interagency transfers of tuition support funds to contribute the state share of Medicaid reimbursements for IEP services.
    - Initiates policy discussions with OMPP regarding coverage and reimbursement for school-based Medicaid services and activities.
    - Oversees state-level administration of the IndianaMAC program, including policy coordination with state and federal Medicaid agencies as well as general oversight and monitoring of the statewide IndianaMAC vendor and participating LEAs.

3.2.4. *Role of the School Corporation*

1. The public school corporation, state-operated school or charter school is required to enroll as a Medicaid provider [Indiana Code 12-15-1-16]. This includes notifying Medicaid of any change in address, tax ID or other information required to maintain current Medicaid provider enrollment records. See Appendix A for a copy of IC 12-15-1-16 and Appendix C for sample Indiana Medicaid Provider Enrollment forms.
2. As the billing provider for IEP services, the school corporation must ensure that its schools' rendering providers (clinicians and related service providers whose services are billed to Medicaid) meet all of Medicaid's licensure, certification and other criteria to qualify as Medicaid providers

of IEP services that the school corporation bills to Medicaid. All Medicaid providers, including school corporations, must ensure that service providers do not appear on the U.S. Department of Health and Human Services, Office of Inspector General's "List of Excluded Individuals," which is available online at http://www.oig.hhs.gov/fraud/exclusions.asp.

3. The school corporation must safeguard student records in accordance with FERPA and applicable provisions of HIPAA as outlined in Chapter X of this Guide. See also: *Medicaid Billing Tool Kit*, Chapter 10.
4. Prior to accessing the student's Medicaid benefits, the school corporation must (1) give the student/student's parent(s) prior written notice and (2) obtain a one-time written consent to bill Medicaid for health-related services in the student's IEP. After obtaining the one-time (per school corporation) written Medicaid consent, the school corporation must (1) give the student/parent(s) annual written notification of their rights concerning the Medicaid consent and (2) retain a copy of the consent.
5. If audited by the state or federal government or their agents, the Medicaid-participating school corporation must openly disclose all Medicaid records required for audit purposes.
6. The school corporation must provide services that are listed in the student's IEP regardless whether the services are Medicaid-covered and can be billed to Medicaid.
7. The school corporation must ensure that any Medicaid billing errors are corrected as soon as possible.
8. The school corporation must ensure that it bills only for Medicaid-covered IEP services listed in the student's IEP, rendered by a Medicaid-qualified provider and provided on dates of service when the student's Medicaid coverage was in effect.
9. The school corporation must ensure that its billing agent adheres to Indiana Medicaid program requirements for claims submission and coding. To facilitate billing agent adherence to program requirements, the school corporation is encouraged to share with its billing agent copies of Indiana's Medicaid Billing Tool Kit for IEP Services, Indiana Medicaid publications such as manuals, provider bulletins, and newsletters (at www.indianamedicaid.com) and any other relevant information shared by the Indiana Department of Education.
10. The school corporation must retain for seven (7) years service documentation that supports its claims for Medicaid reimbursement and meets the minimum Medicaid requirements. Please refer to Section 9.2.
11. School corporations that hire a Medicaid billing agent are strongly encouraged to enter into a written agreement setting out the agent's roles and responsibilities. See Appendix E to this Guide for some suggestions about interviewing prospective billing agent contractors.
12. The school corporation must continually monitor its billing practices (including those of its contracted billing agent) to ensure consistency with Indiana Medicaid program policies and requirements.

3.2.5. *Role of the Billing Agent*

1. The billing agent must comply with the terms of its agreement with the school corporation on billing Medicaid for covered IEP services.
2. The billing agent must maintain billing practices that are consistent with Indiana Medicaid program policies and requirements.
3. The billing agent must notify the school corporation of any billing error(s) as soon as possible following discovery of the error(s) and work with the school corporation to adjust the affected claims.
4. The billing agent must continually review Indiana's Medicaid Billing Tool Kit for IEP Services, Indiana Medicaid policies, rules and publications, including the provider manual, bulletins, banners and newsletters to ensure that its billing practices comply with current, applicable Indiana Medicaid billing requirements.
5. The billing agent must verify the student's Medicaid eligibility on the date of service before billing Medicaid for covered IEP services.

3.3. MEDICAID COVERED SERVICES

While Indiana Medicaid reimbursement is available for a broad range of services, school corporations may bill only for those Medicaid-covered IEP services that are: (1) listed in a Medicaid-eligible student's IEP, (2) provided by the school corporation's Medicaid-qualified provider, and (3) provided in accordance with applicable Medicaid rules in Title 405 of the Indiana Administrative Code, Articles 1 and 5. In general, IEP services for which a school corporation may bill Medicaid are:

Audiologist services
Clinical Social Worker services
Nursing services provided by an R.N.
Occupational therapy
Physical therapy
Psychologist's services
Special Education Transportation services
Speech therapy

QUICK TIP: A school corporation (including a public charter school, turnaround school or state-operated school) may use its Indiana Medicaid school corporation provider number to bill only for covered IEP services. If the service is not in or necessary to develop an eligible student's IEP, the school may not bill it to Medicaid on the school corporation's Medicaid provider number. (Note: initial evaluations required to develop but not necessarily listed in a student's IEP/IFSP, are covered if the student is eligible to receive services under Part B or C of the IDEA and all other applicable Medicaid requirements are met).

3.4 MEDICAID ELIGIBILITY

3.4.1. *General Eligibility Categories Applicable to Students*

Individuals are eligible for Medicaid if they fall into a categorical eligibility group and meet the financial eligibility criteria. Groups that are categorically eligible for Medicaid include: (a) low income children and families, (b) pregnant women, (c) children in foster care or receiving adoption assistance, (d) aged, blind, and disabled individuals.

Not all children in special education fit into one of these Medicaid eligibility categories. In general, children in families with incomes up to 250 percent of the federal poverty level and children with disabling medical conditions qualify for either Medicaid or for the more limited benefits package available through the State Children's Health Insurance Program (CHIP). In Indiana, "Hoosier Healthwise" is an umbrella term for both of these coverage programs for children, families and pregnant women (Medicaid and CHIP). See Appendix D for additional information on where to find general eligibility guidelines and resources to assist students and families who may qualify for assistance.

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3.4.2. *Eligibility Verification Requirements*

The school corporation may bill Medicaid for covered IEP services only for a student who is eligible on the date the service is rendered. Medicaid eligibility is redetermined every six months for children in families receiving cash assistance (i.e., Temporary Assistance for Needy Families or "TANF") and children in families receiving Food Stamps. For all others, eligibility redeterminations are completed annually. Please note that a change in a student's or family's circumstances may cause Medicaid eligibility to change from month to month.

QUICK TIP: Verify eligibility at least monthly. If a claim is denied because a student is no longer eligible, the school corporation or its billing agent may verify the student's eligibility periodically to check for retroactive eligibility. Note that providers have one year from the date of service to bill a claim, and updates to the student's eligibility record may permit the school corporation to bill retroactively for a Medicaid-covered IEP service provided during a retroactively established eligibility period.

3.4.3. *How to Verify Eligibility*

Over time, Medicaid eligibility status can change for a number of reasons. The following options can be used to verify current eligibility of students for dates of service on which a school corporation provided Medicaid-covered IEP services:

1. **Automated Voice Response System (AVR) 1-800-738-6770**. Verify eligibility at no cost using a touch-tone telephone, the member ID or Social Security Number and "from-to" dates of service. There are limitations on the number of inquiries per call (4) as well as a 10-minute time limit per call.[1]

2. **Web interChange**. Verify eligibility using the member ID, Social Security Number, or member name and date of birth. To access Web interchange, obtain a user ID and password by completing the access request form at https://interchange.indianamedicaid.com. Click on "how to obtain an ID," then print, complete and mail the access request form to the address printed on the form. Notice of application approval arrives via e-mail.[2]

3. **270/271 eligibility inquiry and response transaction** – batch or interactive. Trading partners may make eligibility inquiries by exchanging data directly with Indiana Health Coverage Programs (IHCP) via secure File Transfer Protocol (FTP) transactions using an approved software or clearinghouse. See the Electronic Data Interchange (EDI) Communication Guide at http://www.indianamedicaid.com in the EDI Solutions section for a list of approved vendors that provide HIPAA-compliant billing and software services.[3]

According to the Indiana Health Coverage Programs Provider Manual, Chapter 3, Medicaid providers may only access member eligibility information for dates of service that fall within that provider's program enrollment dates. All eligibility verification applications can be used to verify a member's eligibility status for current and prior dates of services following the start date of the school corporation's Medicaid provider enrollment.[4]

Note: Indiana Health Coverage Programs manuals and other resources are available online at http://provider.indianamedicaid.com/general-provider-services/manuals.aspx. See additional provider manual details in the footnotes at the bottom of this page.

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[1] *IHCP Provider Manual*, Chapter 3, Section 5 provides detailed information about how to use AVR.
[2] *IHCP Provider Manual*, Chapter 3, Section 3 describes Web interchange and its functions.
[3] *IHCP Provider Manual*, Chapter 3, Section 4 discusses HIPAA transactions via secure FTP.
[4] *IHCP Provider Manual*, Chapter 3, Section 2 discusses HIPAA-compliant electronic transactions in general.

3.5. MEDICAID BENEFIT PACKAGES AND DELIVERY SYSTEMS

Covered services vary among Hoosier Healthwise benefit packages. Medicaid-enrolled students participate in either traditional fee-for-service or managed care delivery systems. In either case, IEP services provided by school corporations are billed to and paid by Medicaid's contractor, HP, on a fee-for-service basis. This overview is intended to familiarize school corporations with the variety of benefit plans in Indiana, including those that offer only limited coverage.

3.5.1. *Benefit Packages*

The following table summarizes benefit packages and covered services generally available to children in Indiana. As noted below and in Appendix D, *some IHCP benefit packages limit coverage to a specific number or type of services*. Children eligible for limited benefits are NOT Medicaid eligible and are NOT entitled to the full scope of Medicaid-covered services. Claiming reimbursement for IEP services provided to children whose health coverage benefits are limited has the potential to result in a FAPE violation if the school's use of the limited benefit constitutes a cost to the student/student's parent(s). (Note: children who are enrolled in limited benefit packages generally constitute a very small percentage of a school corporation's student population, and the school's billing agent or staff responsible for health coverage eligibility verification can readily identify/filter out these students when submitting Medicaid reimbursement claims for IEP services.) More information about Indiana Health Coverage Programs benefit packages (including Medicaid plans) and service delivery systems (managed care and fee-for-service) is available at http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/hoosier-healthwise.aspx.

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	*Limited* preventive, primary and acute care services for eligible children under 19 years.
Package E—Emergency Services (very limited benefits)	Emergency services *only* for children not born in the U.S. (including undocumented aliens).
Package P—Presumptive Eligibility for Pregnant Women	Ambulatory prenatal services *only* for pregnant women while eligibility is being determined
Hoosier Care Connect (formerly Care Select)—Standard Plan (Medicaid)	All Medicaid-covered State Plan services for eligible children and adults with complex medical needs.

3.5.2. *Health Care Delivery Systems*

The Hoosier Healthwise program has two distinct types of health care delivery systems that impact Medicaid billing for services ***other than those listed in a student's IEP***. These two types of delivery systems are:

- Risk-Based Managed Care (RBMC)
- Traditional Medicaid fee-for-service (FFS)

1. Risk-Based Managed Care (RBMC)

Most Medicaid-enrolled children in Indiana participate in risk-based managed care plans that deliver services covered under the Hoosier Healthwise, *CareSelect* and Hoosier Care Connect programs. Note: as Hoosier Care Connect is implemented the *CareSelect* program will expire; these two programs operate concurrently from April 1 through June 30, 2015. Also note: children who are wards of the State, receiving adoption assistance, foster children and former foster children may voluntarily enroll in the Hoosier Care Connect program.

Under RBMC, the child's managed care plan receives a per capita payment per month for managing and providing the majority of their members' health care services. Typically, Medicaid providers other than school corporations must obtain authorization from and bill these plans for services provided to one of its members. **School corporations are not required to get authorization from or bill managed care plans for IEP services.** For additional information on managed care plans see http://provider.indianamedicaid.com/about-indiana-medicaid/managed-care-entities.aspx and http://www.in.gov/fssa/4913.htm.

QUICK TIP: Managed care billing distinctions are relevant only if the services provided are not in the student's IEP. Regardless of the student's managed care status, covered IEP services are billed by the school corporation directly to Medicaid's fiscal agent, HP, on a fee-for-service basis. *If the service is not in a student's IEP, it may not be billed with the school corporation's Medicaid provider number*. If the school wishes to bill Medicaid for non-IEP services, such as primary care at a school clinic, it must obtain a separate Medicaid provider number for that purpose and comply with all Medicaid managed care and prior authorization requirements.

2. Traditional Medicaid Fee-For-Service Delivery System

Most Medicaid-eligible students obtain services through a managed care delivery system. Students are enrolled in Traditional Medicaid, and all their claims are paid on a fee-for-service basis, if one of the following applies:

a. The student is Medicaid eligible as a current or former foster child.

b. The student is enrolled in a Medicaid home and community-based waiver program. This generally includes children who are disabled, children with autism, traumatic brain injury, or developmental disabilities, or children who meet ICF/MR (Intermediate Care Facility for the Mentally Retarded) level of care criteria. To remain eligible for waiver participation, the total cost of waiver services and other medical services that the student receives cannot exceed the anticipated cost to Medicaid if the student were institutionalized.

3.5.3. *The Role of the Primary Medical Provider*

Another important aspect of Indiana Medicaid's managed care programs is the role of the Primary Medical Provider, or PMP, who directly provides or authorizes the majority of the managed care participant's Medicaid services.

QUICK TIP: Medicaid recognizes the IEP or IFSP as the Medicaid prior authorization for IEP/IFSP services provided by a school corporation's Medicaid-qualified provider, and 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.* Services not authorized in an IEP/IFSP (e.g., primary or well-child care) are subject to all Medicaid Prior Authorization and Managed Care approval/referral requirements.

PMP authorization is not required for IEP services. However, provided that the required release is obtained, communication between the school and the student's PMP is encouraged to promote quality, coordinated care both in and out of the school setting.

Example 1: The student's IEP includes mental health counseling services. The services are provided by the school corporation's Medicaid-qualified provider of mental health services, such as a clinical social worker or psychologist under the supervision of an HSPP ("Health Service Provider in Psychology"). Provided that all documentation requirements are met, the school corporation can use its School Corporation Medicaid Provider Number to bill Medicaid for mental health counseling services provided pursuant to the student's IEP.

Example 2: The student's IEP does NOT include mental health counseling services. If the school's psychologist provides mental health counseling to the student, the school corporation cannot use its School Corporation Medicaid Provider Number to bill Medicaid for the services because they are not included in the student's IEP.

Example 3: The student's IEP contains speech therapy services. The student receives the services at an off-site location [e.g., a special ed cooperative site] from a licensed, ASHA certified speech-language pathologist. The school corporation can use its School Corporation Medicaid Provider Number to bill Medicaid for speech therapy services provided pursuant to the student's IEP.

Example 4: The student's IEP does not contain speech therapy services but the school's or cooperative's licensed, ASHA certified speech-language pathologist provides the services. The school corporation cannot use its School Corporation Medicaid Provider Number to bill Medicaid for the service because it is not in the student's IEP.

3.6. MEDICAID ADMINISTRATIVE CLAIMING, "MAC"

Beginning October 1, 2011, Indiana public school corporations, charter schools and state-operated schools may participate in Indiana's statewide School-based Medicaid Administrative Claiming program, "IndianaMAC," and recover certain costs for *administrative* activities routinely performed by school employees and contracted staff. Districts that choose to participate can claim federal Medicaid reimbursement for part of their state and locally funded costs for MAC-reimbursable administrative (*not direct medical service*) activities. Depending on the activity, 50-75% of eligible staff salary and benefit costs are claimed for the percentage of MAC reimbursable time identified in the statewide time study (see Section 3.6.1.); some of these costs are reduced by the district's Medicaid eligibility rate (generally about the same as the district's free and reduced lunch eligibility rate) and a percentage of related general administrative and district indirect costs are also reimbursed.

3.6.1. *Quarterly Statewide Random Moment Time Study*

To accomplish schools' educational mission, some school personnel spend a portion of their time on administrative activities that improve students' access to health care services and help students/families identify, apply for and access health coverage benefits for which they might qualify. The percentage of time that school staff spend on these types of activities is documented, for all participating districts, through a quarterly statewide random moment time study. Participation requires minimal effort on the part of district employees and contracted staff whose routine job duties include MAC-reimbursable activities. During the school year, these staff are randomly selected to answer 5 questions in a web-based time study tool. Due to the random nature of the selection process, an individual may be sampled once or more in a single calendar quarter or not at all. When selected, school staff typically take about five minutes to complete the 5 time study questions, thereby documenting the individual staff member's activity during a specific moment (60 seconds) of a designated work day. In 2011-12, time study results showed that participating schools in Indiana spent an average of 10.2% of the work day on MAC-reimbursable activities.

3.6.2. *Reimbursable Medicaid Administrative Activities*

In many school districts, certain staff members spend a portion of their time on activities such as conferring with parents or medical professionals about addressing students' unmet health care needs, making or following up on student health care service referrals, arranging for on-site or school-linked health care service delivery, collaborating with community partners to establish health care provider networks for school-age children, helping students/families complete or translate health coverage program application forms, explaining where to apply for health coverage benefits, and arranging for transportation or translation services necessary to access health care. These and other Medicaid-related administrative outreach, referral and coordination activities are eligible for MAC

reimbursement. Funds recovered through IndianaMAC constitute unrestricted federal dollars to participating school districts, charters and state-operated schools.

For more information on IndianaMAC participation, join the IDOE Medicaid in Schools Community on Learning Connection and open the IndianaMAC folder located under the Files and Bookmarks Tab; or, contact the Indiana Department of Education, Office of Special Education, (317) 232-0570.

CHAPTER IV: MEDICAID-COVERED IEP SERVICES FROM THE FEDERAL PERSPECTIVE

This section of the Guide discusses broad federal policies that guide reimbursement for Medicaid-covered IEP services. It also addresses Indiana-specific implementation of federal Medicaid policies and guidance applicable to health-related IEP services.

4.1. FORGING A RELATIONSHIP WITH THE STATE MEDICAID AGENCY

The federal government strongly urges Medicaid-enrolled school corporations to establish a close working relationship with the State Medicaid agency (Indiana Office of Medicaid Policy and Planning or OMPP). In the past, school corporations in Indiana have been reluctant to bill the Medicaid program for IEP services; and when they have billed for services, school corporations relied primarily on their billing agents to provide policy guidance and technical assistance to staff. As Medicaid participation increases, Indiana school corporations are taking significant steps to develop a close working relationship with the DOE and OMPP in order to strengthen their understanding of and compliance with policies and procedures for billing Medicaid-covered IEP services.

4.2. FRAMEWORK FOR MEDICAID-COVERED IEP SERVICE DELIVERY

In general, to claim reimbursement for Medicaid-covered IEP services, the school corporation must ensure the services are:

1. Specifically covered under federal statute or regulations, State Medicaid statute or rules, and included in the State's approved Medicaid State Plan, or
2. Available for patients less than 21 years of age under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Federal Medicaid statute 42 USC § 1396 specifically permits Medicaid payment for medical services provided to students under the IDEA, in accordance with a student's IEP or IFSP ("Individualized Family Service Plan").

4.3. BILLING MEDICAID FOR IEP SERVICES

For a school corporation to use its School Corporation Medicaid Provider Number to bill Medicaid for covered IEP services the following requirements must be met:

1. The student receiving the service must be enrolled in the Medicaid program.
2. The student must qualify for services under the IDEA.
3. The student must have an IEP.
4. The services must be specified in the IEP.
5. The services must be furnished by a practitioner who meets Medicaid-qualified provider criteria as well as applicable State licensure and certification requirements.
6. The school corporation must obtain a signed parental consent to bill Medicaid for covered IEP services provided to the student.*
7. The school corporation must first bill other liable insurers (if any) before billing Medicaid for the services. **Note:** *if billing a student's third party carrier would constitute a FAPE violation (cost the parent/student a copayment, exhaust a benefit limitation, annual or lifetime cap, etc.), the school may not bill the liable public (Medicaid) or private insurance for the IEP service.* ***See also Section 4.7.***

*Please note: Per federal regulations at 34 CFR § 300.154[d][2][iv][A], the U.S. Department of Education requires the Local Education Agency (LEA) to give parent(s), or students who are 18 or older with no legal guardian, prior written notice of intent to bill Medicaid for services in the student's IEP and to obtain a one-time signed consent to bill Medicaid. Annually thereafter, the LEA is required to provide written notice of the student's/parent(s)' rights with regard to the signed consent to bill Medicaid. The *Medicaid Billing Tool Kit* Appendix F offers a sample format for obtaining the one-time Consent to Bill Medicaid for services in an IEP. "Why Are Schools Billing Medicaid?" is a two-sided parent information sheet developed by About Special Kids (A.S.K.). Available in English and Spanish, the parent information sheet and other resources for Medicaid-participating schools are available on IDOE's School-based Medicaid Web page, http://www.doe.state.in.us/exceptional/speced/medicaid.html.

4.4. MEDICAID PROVIDER AGREEMENTS

For a school corporation to bill and receive Medicaid reimbursement for covered IEP-required services, it must complete a Medicaid Provider application and execute a Medicaid provider agreement with the state Medicaid agency. Per federal guidance from the Centers for Medicare and Medicaid Services, *Medicaid and School Health: A Technical Assistance Guide*, published August 1997, school corporations can enroll as providers in the Medicaid program either by qualifying directly to provide covered services or by contracting with independent practitioners to provide the services. Medicaid provider enrollment is discussed in further detail in Section VI of this Guide. See also Section 2.3 of the *Medicaid Billing Tool Kit* available online under "Manuals" at http://www.doe.in.gov/specialed/school-based-medicaid.

4.5. FREEDOM OF CHOICE

Except in cases where it has federal approval to do so, the state Medicaid agency may not restrict a recipient's freedom of choice in obtaining Medicaid-covered services. Medicaid-eligible students may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. See 42 CFR § 431.51.

4.6. REIMBURSEMENT FOR MEDICAID-COVERED IEP SERVICES

For every service covered under the Indiana Medicaid State Plan, there must be a corresponding reimbursement rate methodology. Federal law sets the maximum amount that providers can be paid, and federal policy requires states to adhere to the following Medicaid rate setting principles:

- Payment rates must be sufficient to ensure that recipients have access to high quality care.
- Payment amounts must promote efficiency and economy and be reasonable as defined by the State.
- Payment must be reasonable, allowable and allocable in accordance with applicable federal cost principles. In other words, the amounts paid for services cannot be more than the actual costs of providing the services.

Indiana Medicaid's fee schedule, which lists by procedure code the reimbursement rates for specific services, is available to download free of charge from Medicaid's Web site at: www.indianamedicaid.com. The reimbursement rates on the schedule are applicable for services provided in the school setting and elsewhere. The OMPP may develop separate rates for Medicaid-covered IEP services if such rates better reflect the costs incurred by providers of those services. However, any rates must still comply with the above principles.

4.7. THIRD PARTY LIABILITY (TPL) REQUIREMENTS

Under Medicaid laws and regulations, Medicaid is the payer of last resort, which means that Medicaid can only pay for health care services after the Medicaid member's other health coverage resources have paid their obligation(s) toward the claim. The Medicaid program has mechanisms and policies in place to pursue TPL payments and to identify and recover payments from liable third parties.

4.7.1. *Medicaid Members' TPL Responsibilities*

Medicaid members bear certain responsibilities with respect to TPL:

1. As a condition of eligibility, Medicaid-enrolled individuals ("members") assign to the Medicaid agency all payments from other insurance carriers and other third parties who are legally liable to cover the cost of their health care.
2. Except in cases of undue hardship, every Medicaid member must cooperate with the Medicaid agency to identify and pursue third parties who are liable to pay for services that Medicaid reimbursed on the member's behalf.

4.7.2. *School Corporations' TPL Responsibilities*

As Medicaid providers, school corporations are required to bill a member's third party insurance for Medicaid-covered IEP services *before billing Medicaid*. **Important Note**: billing a student's other insurance carrier *may, in some circumstances,* constitute a FAPE violation; for example, billing a student's private insurance may result in a cost to the parent/student by exhausting a benefit limitation/"cap," or may cause the parent/student to incur a cost in the form of an out-of-pocket deductible or copayment. In the case of a deductible or copayment, the school may avoid a FAPE violation (i.e., cost to the student/parent) by paying the out-of-pocket cost. In circumstances involving an unavoidable cost to the student/parent (such as benefit limit exhaustion), the school may not bill the student's private insurer and therefore may not bill Medicaid for the IEP service.

Medicaid-participating school corporations have the following TPL-related responsibilities:

1. To verify student eligibility and TPL resource (if any) for each date of service using any of Medicaid's Eligibility Verification System (Web InterChange). The systems provide the member's most current TPL information (if any), including insurance carrier, benefit codes, policy numbers and effective dates. Benefit codes include, but are not limited to, Code B-Medical, Code I-Optical, and Code K-Mental Health.
2. To bill the student's third party insurance (if any) prior to billing Medicaid. If it is not clear whether a student's TPL benefit code indicates coverage for a specific IEP service, it is best to bill that resource first to obtain a claim denial or payment.

3. To bill Medicaid only after receiving the third party's denial or partial payment of a claim for an IEP service (see #6 in this section regarding the "90-day rule," if the third party fails to respond regarding the claim).
4. To submit a "blanket denial" if a third party repeatedly denies coverage.

Example: If the third party repeatedly denies payment for a service not covered by the policy or advises that its policy limits have been exhausted, the school corporation can submit with its subsequent claims a copy of the same denial, with a notation stating "Blanket Denial." A blanket denial may be submitted with claims billed up to one year from the original denial date.

5. To refund[5] the Medicaid payment amount within 30 days of receiving payment from any other source for a Medicaid-covered IEP service.
6. To follow Medicaid's "90-day rule" if the school corporation receives no response after billing a third party. The school corporation may bill Medicaid if a third party fails to respond within 90 days, but must include with its claim documentation to substantiate its effort to bill the third party, such as:
    - Copies of the unpaid bills sent to the third party, highlighting the date the claim was submitted to the third party, and with "NO RESPONSE AFTER 90 DAYS" written on the claims or bills.
    - A copy of the school corporation's written notification to the third party documenting the dates of its claims submissions and that no response was received within 90 days of the initial bill/claim.
7. To notify the third party if it made a payment in error. For example, in response to the school corporation's claim, the third party insurer reimbursed the student or student's family rather than the school corporation.
8. To review the school corporation's Remittance Advice ("RA") to understand TPL edits and bill third parties if appropriate.
9. To forward information to Medicaid's TPL Unit if the school corporation receives TPL information that differs from information the school corporation has obtained via Medicaid's Eligibility Verification Systems.[6]

[5] Refer to *IHCP Provider Manual*, Chapter 11, *Paid Claim Adjustment Procedures*.
[6] Refer to *IHCP Provider Manual*, Chapter 5, Section 3 for *TPL Claims Processing Requirements* and Section 4 for *Member TPL Update Procedures*.

4.8. ADDITIONAL POLICY AND BACKGROUND INFORMATION

Various organizations offer online resources and policy information related to Medicaid in schools and coverage for services to children with disabilities:

4.8.1. *National Organizations: Resources Available Online*

National Alliance for Medicaid in Education
http://www.medicaidforeducation.org/

[NOTE: NAME's Web site includes a list of Web links to Individual States' Medicaid, Special Education and Medicaid-in-Schools online resources]

LEAnet, a coalition of Local Education Agencies
http://www.theleanet.org/

American Association of School Administrators
http://www.aasa.org/PolicyAndAdvocacy.aspx

National Association of School Nurses
https://www.nasn.org/portals/0/advocacy/2013_August_Financing_Opportunities_Talking_Points.pdf

National Association of State Directors of Special Education
http://www.nasdse.org/GovernmentRelations/tabid/58/Default.aspx

National Assembly on School-Based Health Care – Handbook for Schools
http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.6552559/k.759D/School_Personnel_Handbook.htm

Congressional Research Service
http://assets.opencrs.com/rpts/RS22397_20080528.pdf

First Focus
http://firstfocus.net/

4.8.2. *Indiana Organizations: Resources Available Online*

INSOURCE
http://www.insource.org/

About Special Kids/A.S.K.
http://www.aboutspecialkids.org/

Indiana School Health Network
http://www.inschoolhealth.org/

CHAPTER V: AUTHORIZATION REQUIREMENTS FOR SERVICES

1.1. WHEN MEDICAID PRIOR AUTHORIZATION OR PMP AUTHORIZATION IS REQUIRED

NO MEDICAID PRIOR AUTHORIZATION OR PMP CERTIFICATION IS REQUIRED FOR SERVICES LISTED IN A STUDENT'S IEP AND BILLED BY A MEDICAID-ENROLLED SCHOOL CORPORATION.

School corporations should answer the following questions before billing Medicaid for a health-related IEP service:

1. *Was the student Medicaid eligible on the date of service?*
2. *Is there a signed parental consent to bill Medicaid?*
3. *If Medicaid requires a referral for the service, is there a referral from an appropriate practitioner?*
4. *Does the rendering provider/clinician (employee or contractor) meet the Medicaid-qualified provider criteria for the type of service provided?*
5. *Does the clinician's service log document provision of the service?*
6. *Is the service authorized in or necessary to develop the student's IEP?*

- If the answer is YES to all of the above, the school can bill Medicaid for the service.
- If the answer to any of these questions is *NO*, the school cannot bill Medicaid for the service.

CHAPTER VI: MEDICAID PROVIDER REQUIREMENTS

Medicaid providers are enrolled by provider type (there are 32 Medicaid provider types) and specialty within provider type. Medicaid-participating school corporations are enrolled under a special provider type (12) reserved for public school corporations, charters or state-operated schools recognized by the Indiana Department of Education.

6.1. PROVIDER QUALIFICATIONS AND ENROLLMENT FOR SCHOOL CORPORATIONS

School corporations can enroll as Medicaid Program service providers by contacting Medicaid's contractor, HP. (Refer to Appendix B for contact information). For more information and technical assistance with Medicaid enrollment, school corporations may contact the IDOE's Office of Special Education.

6.1.1. *Qualifications*

To qualify for provider enrollment as a Medicaid-participating School Corporation:

1. The entity must receive a tuition support payment and be recognized by the Indiana Department of Education as a public school corporation, charter school or state-operated school.
2. The school corporation must complete, sign, date, and submit the original IHCP provider agreement and all other required Medicaid provider enrollment forms. The school corporation must satisfy all elements of the provider agreement, including but not limited to agreeing to provide services to all Medicaid-enrolled students who are eligible for and choose to receive covered IEP services from the school corporation.

6.1.2. *Enrollment*

To receive Medicaid reimbursement, a school corporation must be enrolled as a Medicaid provider. All Medicaid providers are enrolled in accordance with applicable requirements for the provider's designated type and specialty. In Indiana, school corporations, as well as charter schools and state-operated schools, are enrolled under Provider Type 12 - School Corporation, and Specialty 120 - School Corporations. **No other entities, including education collaboratives such as a Special Education Cooperative or Interlocal, may be enrolled under the "school corporation" provider type and specialty.** Medicaid provider enrollment of school corporations is performed by Medicaid's fiscal agent, HP. Technical assistance is available from Indiana Medicaid's contractor, HP, 1-877-707-5750. Contact the IDOE, Office of Special Education for additional resources. See Appendix C for sample excerpts of the Indiana Medicaid Provider Enrollment Application.

When enrolling as an Indiana Medicaid provider, a school corporation must specify as its "billing location" the street address for the school corporation.

However, a school corporation may designate a different "Pay To" address if it prefers to have its Medicaid payments sent to another entity or address. For example, **the school corporation may elect to have its Medicaid reimbursements mailed to a special education cooperative**. Note: a provider enrollment update must be completed to change or add an address to the school corporation's Medicaid provider enrollment file.

QUICK TIP: A Medicaid-enrolled school corporation may only bill Medicaid for Medicaid-covered IEP services that are (1) listed in the IEP of a Medicaid-eligible student, and (2) actually provided to the student, in accordance with Medicaid requirements. Only the school corporation that provided the service may submit a claim to Medicaid.

Once the Medicaid provider enrollment process is completed, the school corporation is assigned a unique Medicaid provider number. Detailed Medicaid provider enrollment requirements can be found in IHCP Provider Manual Chapter 4, accessible at www.indianamedicaid.com/ihcp/ProviderServices. See also *The Medicaid Billing Tool Kit* Section 2.3. The school corporation provider number must be used in both the "rendering provider" and "billing provider" fields on the Medicaid claim form or electronic claim transaction when billing for Medicaid-covered IEP services. Refer to Section 2.3. of *The Medicaid Billing Tool Kit* for information about enrollment and other details regarding Ordering, Prescribing and Referring (OPR) Providers.

6.2. QUALIFICATIONS AND ENROLLMENT FOR SERVICE PROVIDERS IN THE SCHOOL SETTING

While the Medicaid-enrolled school corporation is the "billing provider" for covered IEP services that it bills to Medicaid, the individual who actually performs the Medicaid service is referred to as the "rendering" provider. Individuals who provide services billed to Medicaid must meet specific licensure and credential qualifications.

As the billing provider for Medicaid-covered IEP services, the school corporation is responsible to ensure that its rendering providers (employees and contractors who perform services billed to Medicaid) meet all applicable Medicaid-qualified provider criteria, including licensure, certification and other requirements. See Section 2.3. of the *Medicaid Billing Tool Kit* for more information.

6.2.1. *Qualifications*

The rendering provider must meet Medicaid-qualified provider criteria if the school corporation bills Medicaid for the services s/he performs. *Please note that licensure or certification under state law does not necessarily qualify a practitioner to provide services billed to Medicaid. Refer to Section 2.3. and service specific chapters of the Medicaid Billing Tool Kit or the IHCP Provider Manual for details.* In addition, the rendering provider must provide services only within the scope of his or her licensure and certification and, if applicable, must be supervised as required by applicable professional practice acts. Important Note: *Medicaid may also impose additional requirements for supervision of non-physician practitioners.* Before billing Medicaid for an individual practitioner's services, the school corporation must verify that the individual is not an "Excluded Entity," and barred from participating in federally funded programs. See Section 2.3.4. of the *Medicaid Billing Tool Kit* for details.

6.2.2. *Enrollment*

The rendering provider must be an employee or contractor of the Medicaid-enrolled school corporation (billing provider); however, the individual practitioner (rendering provider) need not be enrolled in the Medicaid program. The Medicaid-enrolled school corporation must ensure that each employee or contractor who furnishes Medicaid-reimbursed IEP services meets all applicable "Medicaid-qualified provider" criteria for his or her discipline.

QUICK TIP: When billing IEP health-related services, the school corporation provider number is used in both the "rendering provider" and "billing provider" fields on the Medicaid claim. See also *Medicaid Billing Tool Kit Section 2.8. regarding Medicaid Ordering, Referring and Prescribing ("OPR") Providers.*

CHAPTER VII: GENERAL MEDICAID BILLING GUIDELINES FOR IEP SERVICES

7.1. GUIDELINES FOR BILLING IEP SERVICES

The following general guidance concerns billing Medicaid for direct services authorized in a student's IEP:

1. The IEP serves as the Medicaid prior authorization for Medicaid-covered IEP services provided to a Medicaid-eligible student. ***The IEP must identify the length, frequency and duration of the services.*** No other Medicaid prior authorization or PMP certification is required for the school corporation to bill Medicaid for IEP services.
2. *After giving prior written notice, the school corporation must obtain a signed consent from the parent(s)* to verify the student's eligibility for Medicaid and to bill Medicaid for covered IEP health-related services provided to the student.
3. When billing Medicaid, school corporations *must use the CPT code that best describes the Medicaid-covered IEP services provided.*
4. School corporations must pay particular attention to *duration limits for each unit of service as defined in the CPT code description*. There is not a default 15-minute unit for every standardized billing code.
5. CPT codes are specific to rendering provider types and specialties. Thus *school corporations must ensure that they are billing for services for which the rendering provider is a Medicaid-qualified provider*. For example, a school corporation cannot bill Medicaid for an occupational therapy service provided by a psychologist.
6. School corporations are enrolled in Indiana's Medicaid program as "billing providers." The school corporation's individual "rendering providers" (e.g., therapists, psychologists, etc.) are not required to enroll in the Medicaid program in order for the school corporation to bill Medicaid for services they provide to Medicaid-eligible students. However, every rendering provider must meet the Medicaid provider qualifications for his/her provider type and specialty. *The school corporation must enter its Medicaid provider number in both the rendering and billing provider fields on the Medicaid claim form or electronic claim transaction.*

7.2. TOOL KIT

Specific billing requirements and instructions, including a sample Medicaid claim form, as well as provider qualifications, service descriptions and billing code examples are included in the *Medicaid Billing Tool Kit* companion to this Guide, available online under "Manuals" at IDOE's School-based Medicaid web page, **http://www.doe.in.gov/specialed/school-based-medicaid**.

CHAPTER VIII: SOLICITATION FOR SERVICES

Solicitation or a fraudulent, misleading, or coercive offer by any provider, including a school corporation, to render a service to a Medicaid member is prohibited. Examples of prohibited solicitation include:

- Door-to-door solicitation
- Mass screenings of large populations, except where such screenings are specifically mandated by law.

CHAPTER IX: RECORDS MAINTENANCE

9.1. TYPES OF RECORDS

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

1. A copy of the student's IEP and any addenda that are incorporated into the IEP, such as the student's health plan, behavior plan, nutrition plan, etc. (To be eligible for Medicaid reimbursement the service must be part of the IEP.)
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 information and documentation:
    a. Identity of the student who received the service.
    b. Identity, title and employment records of the provider or the employee who rendered the service.
    c. The date that the service was rendered.
    d. A narrative description of the service rendered.
    e. The diagnosis of the medical condition of the child 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 regarding the necessity and effectiveness of therapy and on-going evaluations to assess progress and redefine goals must be a part of the therapy program. All of the following information and documentation is to be included in the medical record:
    a. Location at which the services were rendered.
    b. Documentation of referrals and consultations.
    c. Documentation of tests ordered.
    d. Documentation of all services performed and billed.
    e. Documentation of medical necessity.

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

9.2. RECORDS RETENTION REQUIREMENTS

Records retention requirements vary depending on the type of records in question, and **Medicaid records retention requirements *differ* from Special Education requirements**. Please note the following retention requirements are applicable to records in support of claims for Medicaid reimbursement for health-related special education services in a student's IEP:

1. State Medicaid rules (405 IAC 1-5-1(b)) require that school corporations maintain records to support claims* for Medicaid services for a period of **seven (7) years** from the date services are provided, or until the resolution of any audit findings or litigation, whichever is latest.
2. Federal and State laws governing retention of Special Education records (34 CFR § 300.624 and 511 IAC 7-38-3) require that certain records be maintained for at least three years after the student exits the program. Additionally, depending on the nature of the records and any pending request for disclosure, some must be retained for up to five (5) years.

QUICK TIP: Given the varying retention requirements, it may be more practical and advisable for school corporations to retain all records related to Medicaid reimbursement for Special Education services for a period of 7 years. *See Chapter IX in this Guide as well as Tool Kit Chapters 2.7. and 10.1.1. for more information concerning records needed to support claims for Medicaid reimbursement for health-related IEP services. Note also: the "Student Records" discussion in each of the service-specific chapters (Audiology, Occupational Therapy, etc.) in the *Medicaid Billing Tool Kit*.

9.3. USE OF ELECTRONIC SIGNATURES

Records must be signed by the provider rendering the service. Electronic signatures may be utilized if the school corporation has an established written policy governing use of such electronic signatures. Such policy must be made available for audit purposes. Use of electronic signature is not mandated.

In the case of electronic service documentation records, Indiana Medicaid's Surveillance and Utilization Review (SUR) reviewers look for the following to ensure validity of electronic medical records:

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

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

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

9.4. WHEN A SCHOOL CORPORATION MAY BE AUDITED

9.4.1. *General Information on Medicaid Auditing Agencies*

Medicaid audits are performed by a variety of federal and state agencies, including Centers for Medicare and Medicaid Services ("CMS"), Government Accountability Office (GAO), U.S. Department of Health and Human Services' Office of the Inspector General (OIG), the Indiana Office of Medicaid Policy and Planning or its Medicaid Surveillance Review ("SUR") unit, State Public Auditors such as the State Board of Accounts, and the State's Attorney General's Medicaid Fraud Control Unit. The purpose of Medicaid audits to ensure that state and federal public funds are spent in accordance with the laws, rules and regulations that govern Medicaid program expenditures. An adverse audit finding may result in demand for repayment of inappropriate Medicaid reimbursements.

9.4.2. *Common Reasons for Audits*

In many cases audits, including Payment Error Rate Measurement (PERM) audits, are initiated based on random selection. Other circumstances include routine review of Medicaid program expenditures which reveals:

- a significant increase or decrease in reimbursements for school-based services, including errors or issues identified in State Medicaid agency payments or federal reporting,
- an exceptional outlier when comparing and ranking similar service providers,
- major legislative or regulatory changes,
- hotline calls or other referrals.

In the case of a Medicaid Surveillance and Utilization Review, rather than demand repayment (which can also occur in a SUR review), audit findings are sometimes used to educate the service provider regarding correction of:

- common claim completion errors,
- inappropriate use of billing codes, or
- misunderstanding of Indiana Medicaid policy and billing requirements.

9.4.3. *Random selection*

All Medicaid-participating providers undergo an audit at some point. However, recognizing that there are more than 30,000 providers enrolled in the program, random selection may not occur often.

9.4.4. *Ranking*

Provider claims are continually reviewed by a variety of agencies to identify exceptions, questionable trends or patterns, etc. Some audit reviews involve comparison and ranking of claims activity for similar providers. A school

corporation's rank, in comparison to other school corporations enrolled in the Medicaid program, may result in that school corporation's selection for an audit.

9.4.5. *Major Legislative or Regulatory Change*

In the event of major changes in federal or state laws, rules and regulations impacting delivery, coverage or reimbursement for school-based services, school corporations, as a provider type, may be selected for review to assess proper implementation of and compliance with such legislative or regulatory changes.

9.4.6. *Referral*

School corporations may also be audited as the result of a referral received by an audit agency. Referrals can come from a number of sources including:

- Individuals enrolled in the Medicaid program (which in the case of students can include their family members).
- Internal reviews or investigations of state and federal agencies.
- Contractors whose responsibilities include Medicaid review or auditing.
- Indiana Medicaid Provider and Enrollee Hotline calls from the general public: 317-347-4527 or 800-457-4515.
- Law enforcement and other state or local agencies.

Additional information regarding the Medicaid auditing process in general, and what school corporations can expect when they are selected for audit, is discussed in the companion to this Guide, *Medicaid Billing Tool Kit*, Chapter 10.

CHAPTER X. HIPAA AND FERPA: CONFIDENTIALITY AND RECORDS DISCLOSURE

THIS SECTION IS NOT INTENDED AS LEGAL ADVICE TO SCHOOL CORPORATIONS REGARDING HIPAA OR FERPA COMPLIANCE. IT DISCUSSES GENERAL REQUIREMENTS AS THEY PERTAIN TO STUDENT RECORDS RETAINED FOR MEDICAID BILLING AND DOCUMENTATION PURPOSES. SCHOOL CORPORATIONS ARE ENCOURAGED TO CONSULT THEIR LEGAL ADVISORS TO ENSURE COMPLIANCE WITH THESE LAWS AND REGULATIONS.

10.1. APPLICABILITY OF HIPAA AND FERPA

The goals of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") include but are not limited to improving portability and continuity of individual and group health insurance, simplifying administrative systems in health insurance, and establishing common national standards for electronic transmission of health information. Under the authority of HIPAA, the U.S. Department of Health and Human Services promulgated regulations to protect the confidentiality of health information. These regulations, the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"), provide broad exemption for health records that are part of educational records and therefore protected under the Family Educational Rights and Privacy Act (FERPA).

FERPA is the federal law that protects the privacy of student education records and applies to all schools that receive funding from the U.S. Department of Education. It provides rights to parents of minors that transfer to the children when they reach the age of 18. This section of the Guide discusses FERPA requirements as they apply to medical records.

It is important for Medicaid-participating schools to understand how HIPAA and FERPA apply to student records. "Educational Records" are protected by FERPA, and records that are protected under FERPA are exempt from HIPAA requirements. However, HIPAA safeguards apply to student records transmitted electronically for Medicaid eligibility verification or claim transaction purposes. (See also: *Medicaid Billing Tool Kit,* Chapter 10, Section 2, and Page 6 of the *Joint Guidance on the Application of the* **Family Educational Rights and Privacy Act (FERPA)** *And the* **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** *To Student Health Records* .) School corporations are encouraged to clarify with their legal advisors which records, under which circumstances, are and are not subject to FERPA and HIPAA protections.

QUICK TIP: In general, HIPAA applies to a health care provider's medical records regarding patient treatment or records related to employees' health care benefits. FERPA applies to student records, including medical records held by the school. Additional information is available online from the U.S. DOE: http://www2.ed.gov/policy/gen/guid/ptac/pdf/idea-ferpa.pdf.

10.2. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

10.2.1. *HIPAA terms defined*

Protected Health Information (PHI) refers to health information that is transmitted or maintained in any form or media (e.g., paper, oral, or electronic) that identifies the individual or that has sufficient information that can be used to identify the individual (such as name, date of birth, social security number, sex, race, etc.). Note that sometimes the combination of certain information on the record can be used to identify an individual about whom the record refers. The HIPAA Privacy Rule specifically excludes "educational records" covered by FERPA from the definition of PHI. See 45 CFR § 164.501.

Covered entity means a health plan, health care provider or health care clearing house. See 45 CFR § 164.103.

Health plan means any individual or group that provides or pays for the cost of medical care, including employer sponsored group health plans, health insurance issuers, health maintenance organizations (HMOs), Medicare and Medicaid. See 45 CFR § 164.103.

Health care provider means a provider of medical or health services, and an individual or organization that furnishes, bills or is paid for health care in their normal course of business, including hospitals, health clinics, physicians, and nurses.

10.2.2. *General Rule*

A covered entity cannot use or disclose Protected Health Information, except as provided under the HIPAA Privacy Rule.

10.3. FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

10.3.1. *Education Records*

"Education records" under IDEA fall under the protection of FERPA. "Education records," sometimes referred to as "school records," are defined by rule as records directly related to a student and maintained by a public agency or by a party acting for the public agency, including:

- Test protocols that contain personally identifiable information regarding the student and the student's IEP, and
- Video clips, audio clips, scanned images, and other electronically recorded or produced items, such as information generated as part of an alternative assessment of student proficiency.

More specifically, educational records include a variety of items, for example, date of birth, date of enrollment, bus route, immunization history, achievement test scores and grades, attendance records, awards, degrees achieved, student medical records created by a school nurse or other health care provider, and special education plans and evaluations. The term does not include the records of instructional, supervisory, administrative, or ancillary personnel that remain in the sole possession of the maker of the record and are not accessible to or revealed to any other person.[7]

Based on this definition, a student's records related to health-related IEP services, including assessments and therapies, are subject to FERPA protections. IDEA provides additional safeguards, as well.

10.3.2. *Student/Parent Rights and School Responsibilities under FERPA*

1. Rights of parents and students

Under FERPA, parents of minor students and students 18 years and older have the right to:

a. Inspect and review the student's education records maintained by the school corporation. School corporations are not required to provide copies of records unless it is impossible for parents or eligible students to review the records or where the adjudication of rights is implicated. School corporations may charge a fee for copies, subject to certain limitations.
b. Request that a school corporation correct records which they believe to be inaccurate or misleading. If the school corporation decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school corporation still decides

[7] 511 IAC 7-32-31

not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.

2. Responsibilities of School Corporations

Generally, school corporations must have written permission from the parent or eligible student to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under any of the following conditions:

a. School corporation officials with a legitimate educational interest.
b. Other school corporations to which a student is transferring.
c. Specified officials for audit or evaluation purposes.
d. Appropriate parties in connection with financial aid to a student.
e. Organizations conducting certain studies for or on behalf of the school corporation.
f. Accrediting organizations.
g. To comply with a judicial order or lawfully issued subpoena.
h. To appropriate officials in cases of health and safety emergencies.
i. To state and local authorities, within a juvenile justice system, pursuant to specific State law.

School corporations may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, school corporations must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school corporation not disclose directory information about them. School corporations must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school corporation.

CHAPTER XI: SCHOOL CORPORATION SELF-ASSESSMENT TOOL

Across the country, audits of Medicaid claims for school-based services typically identify the following common errors in one or more claims for IEP-required services submitted by Medicaid-participating schools.

1) Missing Documentation, including daily progress notes, a copy of the applicable IEP, parent consent form, medical authorization (referral, order, prescription) dated prior to date of service, attendance records for date of service, and transportation log for date of service.
2) Claims for services on dates when the student or service provider were not present.
3) Claims for non-medical activities.
4) Claims for services not authorized in the student's IEP.
5) Claims for services furnished by a non-licensed or otherwise unqualified provider.
6) Transportation claims billed for round trip services on a date when the student was transported only one way.
7) Claims for transportation services on a date when the student did not receive another Medicaid-covered IEP service on the same day.

The remainder of this section offers school corporations suggestions about assessing their ongoing compliance with Medicaid requirement in three areas:

11.1. PROVIDER ENROLLMENT AND QUALIFICATIONS

School corporations must ensure that their Medicaid provider enrollment information is current. Any changes, such as a change of chief administrator, location, address where payment is to be sent, etc. must be updated as soon as possible. As school corporations can only bill for Medicaid-covered IEP services provided by Medicaid qualified providers, they must have systems in place to ensure that all school practitioners (whose services are billed to Medicaid) comply with Medicaid provider qualification requirements.

11.2. SERVICE DELIVERY

Under IDEA, school corporations must ensure that students receive all services in the IEP, whether or not such services are/may be billed to Medicaid. Additionally, school corporations must have systems in place to ensure that only services that are authorized in the IEP are billed to Medicaid using the school corporation's Medicaid provider number.

11.3. ONGOING MONITORING

The school corporation's responsibility extends beyond ensuring that students receive services identified in the IEP. In order to assure the integrity of their Medicaid-covered IEP services, school corporations must have systems in place to monitor service delivery, claims billed and payments received, and to make necessary adjustments and corrections to billings and payments School corporations must also establish systems to ensure that billing is supported by proper documentation.

ENROLLMENT & QUALIFICATIONS	SERVICE DELIVERY, BILLNG & CODING	MONITORING
A. School Enrollment ❑ Address/location current (Medicaid provider ID#) ❑ "Pay to" address current ❑ Review and sign provider agreement **B. Rendering Provider Enrollment** ❑ Enrollment in Medicaid (Medicaid provider ID #) ❑ Credentials (licensure or certification) current & on file ❑ Evidence of school's relationship with rendering provider (employee, contractor, etc.) **C. Compliance with practice standards** ❑ Hold rendering providers responsible for compliance with practice standards & put in place a reporting mechanism to appropriate licensure entity.	**A. Ensure the following through professional services and requiring ongoing training on coding practice** ❑ Service code reflects service rendered ❑ Pay particular attention to time-sensitive codes ❑ Attention to rounding-off of time spent on services ❑ Use of established HIPAA compliant codes **B. School—Billing Agent relationship** ❑ Specifically outline responsibilities & roles of school and billing agent in contract. ❑ Develop reporting & monitoring requirements to ensure cooperative relationship in ongoing monitoring of billing. For example: ➢ Eligibility verification ➢ Review of claim denials ➢ Billing/payment schedule ➢ Handling of TPL	**A. Claims** ❑ Review Medicaid Remittance Advice ❑ Ensure that payment received reflects claim for service (amount, service, rendering provider, child receiving service) ❑ Update TPL information **B. Documentation** ❑ **Who?** ➢ Identity of child to whom service is rendered (e.g., RID, SSN, DOB) ➢ Identity of provider of service (name and credentials) ❑ **What?** ➢ Diagnosis relevant to treatment ➢ Relevant IEP for service date ➢ Service provided (amount, duration and scope) ➢ Physician, HSPP or School Psychologist referral ❑ **When?** ➢ Date of service ➢ Time spent on service ➢ Attendance record of child matches date of service ➢ School bus record of transport to/from service ❑ **Where?** ➢ Location of service ➢ School bus record of transport to/from service ❑ **Disclosure and confidentiality** ➢ Does school have appropriate signed consent documents in place? ➢ Has school notified students and parents of rights? ➢ Are notices regarding confidentiality and disclosure posted/publicized?

APPENDIX A

INDIANA CODE SECTION ON SCHOOL-BASED MEDICAID CLAIMING

IC 12-15-1-16 School corporation or school corporation's provider; enrollment in Medicaid program; sharing reimbursable costs

Sec. 16. (a) Each:

(1) school corporation; or

(2) school corporation's employed, licensed, or qualified provider;

must enroll in a program to use federal funds under the Medicaid program (IC 12-15-1 et seq.) with the intent to share the costs of services that are reimbursable under the Medicaid program and that are provided to eligible children by the school corporation. However, a school corporation or a school corporation's employed, licensed, or qualified provider is not required to file any claims or participate in the program developed under this section.

(b) The office of Medicaid policy and planning and the department of education may develop policies and adopt rules to administer the program developed under this section.

(c) Three percent (3%) of the federal reimbursement for paid claims that are submitted by the school corporation under the program required under this section must be:

(1) distributed to the state general fund for administration of the program; and

(2) used for consulting to encourage participation in the program.

The remainder of the federal reimbursement for services provided under this section must be distributed to the school corporation. The state shall retain the nonfederal share of the reimbursement for Medicaid services provided under this section.

(d) The office of Medicaid policy and planning, with the approval of the budget agency and after consultation with the department of education, shall establish procedures for the timely distribution of federal reimbursement due to the school corporations. The distribution procedures may provide for offsetting reductions to distributions of state tuition support or other state funds to school corporations in the amount of the nonfederal reimbursements required to be retained by the state under subsection (c).

As added by P.L.80-1994, SEC.1. Amended by P.L.224-2003, SEC.64.

SAMPLE DOE REPORT SHOWING MEDICAID ADJUSTMENT

(see highlighted areas on Page *A3*)

[redacted] DOESA541 - Indiana Department of Education - Division of School Finance - July 15, 2011

2011 BASIC GRANT MONTHLY DISTRIBUTION

Payment Date	Tuition Support	Honors Grant	Special Education Grant	Vocational Education Grant	Prime Time Grant	Restoration Grant	Small Schools Grant	Total Basic Grant	Total Payment
1/14/2011	$906,874.42	$2,700.00	$79,739.17	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,080,724.43	$1,026,765.53
2/15/2011	$906,874.42	$2,700.00	$76,091.67	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,076.93	$1,022,986.30
3/15/2011	$906,874.42	$2,700.00	$76,091.67	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,076.93	$1,023,232.20
4/15/2011	$906,874.41	$2,700.00	$76,091.66	$10,456.25	$18,531.16	$62,423.41	$0.00	$1,077,076.89	$1,021,463.29
5/16/2011	$906,874.42	$2,700.00	$76,091.67	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,076.93	$1,023,234.32
6/15/2011	$906,874.41	$2,700.00	$76,091.66	$10,456.25	$18,531.16	$62,423.41	$0.00	$1,077,076.89	$1,023,099.35
7/15/2011	$906,874.42	$2,700.00	$76,699.58	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,684.84	$1,023,281.59
8/15/2011	$906,874.42	$2,700.00	$76,699.58	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,684.84	$1,023,977.73
9/15/2011	$906,874.42	$2,700.00	$76,699.59	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,684.85	$1,023,977.74
10/14/2011	$906,874.41	$2,700.00	$76,699.58	$10,456.25	$18,531.16	$62,423.41	$0.00	$1,077,684.81	$1,023,977.70
11/15/2011	$906,874.42	$2,700.00	$76,699.59	$10,456.25	$18,531.17	$62,423.42	$0.00	$1,077,684.85	$1,023,977.74
12/15/2011	$906,874.41	$2,700.00	$76,699.58	$10,456.25	$18,531.16	$62,423.41	$0.00	$1,077,684.81	$1,023,977.68
Total	$10,882,493.00	$32,400.00	$920,395.00	$125,475.00	$222,374.00	$749,081.00	$0.00	$12,932,218.00	$12,283,951.17

	-- Plus Adjustments --				-- Minus Adjustments --					
Payment Date	Previous Year	Appropriation/ Spending Authority Reimbursement	Other	Total Plus Adjustments	Veterans Memorial	Common School	Previous Year	Appropriation / Spending Authority Reductions	Other	Total Minus Adjustments
1/14/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $52,987.31	$971.59	$53,958.90
2/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $53,705.82	$384.81	$54,090.63
3/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $53,707.30	$137.43	$53,844.73
4/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $53,707.30	$1,906.30	$55,613.60
5/16/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $53,707.30	$135.31	$53,842.61
6/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	* $53,707.11	$270.43	$53,977.54
7/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.11	$696.14	$54,403.25
8/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.11	$0.00	$53,707.11
9/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.11	$0.00	$53,707.11
10/14/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.11	$0.00	$53,707.11
11/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.11	$0.00	$53,707.11
12/15/2011	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	# $53,707.13	$0.00	$53,707.13
Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$643,764.82	$4,502.01	$648,266.83

PAYMENTS	JAN-JUN	JUL-DEC	TOTALS
TOTAL BASIC GRANT	$6,466,109.00	$6,466,109.00	$12,932,218.00
PREVIOUS YEAR +	$0.00	$0.00	$0.00
OTHER + ADJUSTMENTS	$0.00	$0.00	$0.00
TOTAL + ADJUSTMENTS	$0.00	$0.00	$0.00
VETERANS MEMORIAL	$0.00	$0.00	$0.00
COMMON SCHOOL	$0.00	$0.00	$0.00
PREVIOUS YEAR -	$0.00	$0.00	$0.00
OTHER - ADJUSTMENTS	$3,805.87	$696.14	$4,502.01
TOTAL - ADJUSTMENTS	$325,328.01	$322,938.82	$648,266.83
TOTAL PAYMENTS	$6,140,780.99	$6,143,170.18	$12,283,951.17

CALCULATION OF STATE SUPPORT PER RESIDENT ADM	
A. RESIDENT ADM FALL 2010	1,855.37
B. TUITION SUPPORT	$10,882,493.00
C. TUITION SUPPORT PER ADM	$5,865.40
D. PRIME TIME GRANT	$222,374.00
E. PRIME TIME PER K-3 ADM	$444.75

*** Reflects Actual Reduction**

 # Reflects Estimated Reduction

	-- Other Plus Adjustments --	-- Other Minus Adjustments --		
Payment Date	**Medicaid Plus**	**Medicaid Minus**	**Repayment of Advance**	**Desegregation Minus**
1/14/2011	$0.00	$971.59	$0.00	$0.00
2/15/2011	$0.00	$384.81	$0.00	$0.00
3/15/2011	$0.00	$137.43	$0.00	$0.00
4/15/2011	$0.00	$1,906.30	$0.00	$0.00
5/16/2011	$0.00	$135.31	$0.00	$0.00
6/15/2011	$0.00	$270.43	$0.00	$0.00
7/15/2011	$0.00	$696.14	$0.00	$0.00

APPENDIX B

Visit Indiana Medicaid's Web site (http://provider.indianamedicaid.com/) for updates. Choose "About Indiana Medicaid" and click the IHCP Quick Reference Guide under "Contact Us."

IHCP Quick Reference Guide

Nonpharmacy Contact Information

HP Provider Assistance
1-800-577-1278

Prior Authorization – Medical FFS
ADVANTAGE Health Solutions℠
ATTN: Prior Authorization Dept.
P.O. Box 40789
Indianapolis, IN 46240
1-800-269-5720
Fax: 1-800-689-2759

IHCP Member Hotline
1-800-457-4584

Premium Collection Services
Package C Payment Line
1-866-404-7113

Package C Payment 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 Address
M.E.D.Works
P.O. Box 946
Indianapolis, IN 46206

HP Electronic Solutions Help Desk (Web InterChange Technical Assistance)
INXIXElectronicSolution@hp.com
1-877-877-5182

HP Forms Requests
P.O. Box 7263
Indianapolis, IN 46207-7263

Provider Inquiries Administrative Review Requests
HP Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

HP Third Party Liability (TPL)
P. O. Box 7262
Indianapolis, IN 46207-7262
1-800-457-4510
Fax: (317) 488-5217

HP Casualty
INXIXTPLCasualty@hp.com

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

Fraud and Abuse Reporting
IHCP Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297
Program Integrity@fssa.in.gov

IHCP Provider and Member Concern Line
1-800-457-4515
(317) 234-7598

Long-Term Care Rate-setting Long-Term Care Audits
Myers and Stauffer (M&S)
9265 Counselors Row, Suite 200
Indianapolis, IN 46240
Help desk: 1-800-591-1183
Fax: (317) 571-8481
msic.com

Nonpharmacy FFS Claim Filing

Web InterChange Electronic Claims
Web InterChange

HP Claim Attachments (Electronic Claims)
P.O. Box 7259
Indianapolis, IN 46207-7259

HP Adjustment Forms (No Refund Checks)
P.O. Box 7265
Indianapolis, IN 46207-7265

HP *CMS-1500* 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 Claims (Crossover/*UB-04* Inpatient Hospital, Home Health, Outpatient, and Long-Term Care)
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

HP Refunds
P.O. Box 2303, Dept. 130
Indianapolis, IN 46206-2303

Uncashed IHCP Check Returns
HP Finance Department
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

Indiana Medicaid Provider Field Consultants by Territory

Territory Number	Consultant Name	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Fulton, Jasper, Lake, LaPorte, Marshall, Newton, Porter, Pulaski, Starke, St. Joseph
2	Shari Galbreath	(317) 488-5080	Adams, Allen, Blackford, Dekalb, Elkhart, Huntington, Jay, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley
3	Open (voice mailbox monitored daily)	(317) 488-5363	Benton, Boone, Carroll, Cass, Clinton, Delaware, Fountain, Grant, Hamilton, Howard, Madison, Miami, Montgomery, Tippecanoe, Tipton, Warren, White
4	Tami Foster	(317) 488-5309	Bartholomew, Dearborn, Decatur, Fayette, Franklin, Hancock, Henry, Jackson, Jefferson, Jennings, Ohio, Randolph, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne
5	Virginia Hudson	(317) 488-5186	Marion
6	Patti Mager	(317) 488-5148	Brown, Clay, Daviess, Greene, Hendricks, Johnson, Knox, Lawrence, Martin, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
7	Ken Guth	(317) 488-5153	Clark, Crawford, Dubois, Floyd, Gibson, Harrison, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick

Indiana Medicaid Provider Relations Field Consultant Supervisor

Name	Title	Telephone
Maureen Hoffmeyer	Provider Relations Supervisor	(317) 488-5073

Visit Indiana Medicaid's Web site (http://provider.indianamedicaid.com/) for updates. Click "Contact Us" at the top right of the landing page, then click Provider Relations Field Consultants in the links at the left hand side.

APPENDIX C

SCHOOL CORPORATION MEDICAID PROVIDER AGREEMENT

Pages *C2* through *C4* display copies of the first few pages of the Indiana Medicaid Provider Application for School Corporations. A complete copy with all addenda and attachments is available online at:

http://provider.indianamedicaid.com/become-a-provider/complete-an-ihcp-provider-packet/12-%E2%80%93-school-corporation.aspx

Included in the last several pages of the School Corporation Medicaid Provider Application is a separate "Delegated Administrator" addendum, which allows a school corporation to grant authority to a specific individual or entity (e.g., a billing agent contractor) to update Indiana Medicaid provider file records on its behalf for purposes of Medicaid provider enrollment, provider profile maintenance or claims submission.

| Overview

IHCP School Corporation Provider Enrollment and Profile Maintenance Packet | indianamedicaid.com

Who Uses This Packet

You should use this packet if you are a provider type 12 – School Corporation.

General Instructions

- This enrollment and maintenance packet can be used for the following tasks:
  - **Enrolling in the Indiana Health Coverage Programs (IHCP) for the first time** – Complete all fields in each section unless a section is optional and does not apply to you.
  - **Adding a new service location** – Complete all fields in each section unless a section is optional and does not apply to you.
  - **Revalidating your current enrollment in the IHCP** – Complete all fields in each section unless a section is optional and does not apply to you.
  - **Making updates to information about your business**, also known as your Provider Profile – Do not complete the entire packet; complete and submit only the pages of the packet and the supporting documentation that apply to the update. Only the following sections are required when using the packet to update your profile:
    - Schedule A – Type of Request
    - Schedule A – Provider Information
    - Schedule A – Contact Information
    - IHCP Provider Signature Authorization Addendum
    - Any section where the information has changed; if the information in a section has not changed, leave the section blank. For example, if the mailing address has changed but the pay-to address has not, complete the mailing address section and leave the pay-to address blank.

  NOTE: The most common Provider Profile updates can most easily be made online through Web interChange or by using profile maintenance forms. See the Update Your Provider Profile page at indianamedicaid.com for more details.
- Read the instructions in each section of the packet carefully.
- Required addenda are included with this packet and must be submitted with the packet.
- Where sections of the packet request supporting documentation (such as a copy of a certification), the required documentation must be included as an attachment to the packet.
- If the packet needs correcting or is missing required documentation, the HP Provider Enrollment Unit will contact you by telephone, email, fax, or mail. This contact is intended to communicate what needs to be corrected, completed, and submitted before the IHCP can process your enrollment transaction.
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer screen. This information can then be saved to a file and printed for mailing. Using these interactive features facilitates both the packet's completion and review processes.

Next Steps

1. After completing this packet, including all applicable addenda, and collecting the necessary supporting documentation, perform a quality check using the following checklist. The quality check helps ensure your packet can be processed and does not have to be returned for corrections.

Provider Use Only	Quality Checklist
☐	If you are updating your Provider Profile, do not complete the entire packet; double-check that only the following sections have been completed: ☐ Schedule A – Type of Request ☐ Schedule A – Provider information ☐ Schedule A – Contact Information ☐ IHCP Provider Signature Authorization Addendum ☐ Any section where the information has changed; if the information in a section has not changed, leave the section blank. Submit only the pages of the packet and the supporting documentation that apply to the update.
☐	If you are enrolling for the first time, adding a service location, or revalidating your enrollment, double-check that all sections of this packet have been completed and signed.
☐	Double-check that the Service Location name, or DBA name, in the **Service Location Name and Address** section of Schedule A matches the business name on the **Federal W-9 form.**
☐	Double-check that the name and address in the **Legal Name and Home Office Address** section of Schedule A matches the information on the **Federal W-9 form.**
☐	Double-check that the **Provider Agreement** has been signed by an authorized official listed on Schedule C. (The Provider Agreement must not be signed by a delegated administrator.)
☐	Double-check that the required addenda, as applicable, are completed and included with the packet. ☐ Affordable Care Act Application Fee Addendum (all) ☐ Affordable Care Act Provider Screening Addendum (as applicable) ☐ Delegated Administrator Addendum/Maintenance Form (as applicable) ☐ Electronic Funds Transfer Addendum/Maintenance Form (as applicable) ☐ Federal W-9 Form (all) ☐ Signature Authorization Addendum (all) ☐ Provider Agreement (all)
☐	If you are required to remit an application fee to the IHCP, include the electronic payment confirmation number on the Affordable Care Act Application Fee Addendum.
☐	Double-check that all required supporting documentation, including copies of applicable professional and operating licenses, is included as an attachment to the packet. Required documentation is listed on the *IHCP Provider Type and Specialty Matrix* at indianamedicaid.com.
☐	If your filed business name (DBA) differs from your legal or personal name, include a copy of registration documentation from the Secretary of State or County Recorder's office as an attachment to the packet.
☐	If you are submitting the **IHCP Electronic Funds Transfer Addendum/Maintenance Fee**, include a voided check OR a signed letter from your bank that lists the account holder's name, Taxpayer Identification Number (TIN), and the appropriate account and routing numbers as an attachment to the packet.

2. Print the completed packet. It is important to return all pages in the packet, in the correct page number order, with all required documents.
3. Make a copy of the packet for your records.
4. Mail the packet, including all required addenda and supporting documentation, to the following address:

   HP Provider Enrollment
   P.O. Box 7263
   Indianapolis, IN 46207-7263

| Schedule A

IHCP School Corporation Provider Enrollment and Profile Maintenance Packet | indianamedicaid.com

Type of Request

1.Type of Request:

This packet is used for multiple purposes; select the purpose that applies:

- ☐ **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.
- ☐ **Revalidate Enrollment** – You received a letter indicating you must revalidate your IHCP enrollment.
- ☐ **Profile Update** – You are already enrolled in the IHCP and you need to change your provider profile information.

Provider 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 References. The taxonomy requested in field 4 is the taxonomy associated with the NPI in field 2.

2. National Provider Identifier (NPI):	3. ZIP + 4: **(Nine digits required)**	4. Taxonomy Code:

5a. Are you currently enrolled as an IHCP provider? ☐ Yes ☐ No	5b. If Yes, what is your Legacy Provider Identifier (LPI):
6a. Were you previously enrolled as an IHCP provider? ☐ Yes ☐ No	6b. If Yes, what was your previous LPI:

Contact Information

- The contact name and email relate to the person who can answer questions about the information provided in this packet.
- 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.
- Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

7. Contact Name:	8. Telephone:

9. Contact Email Address:

10. Email Address for Provider Publications:

APPENDIX D

Income Eligibility for Indiana Health Coverage Programs for Children

Visit http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx to learn more about general income eligibility guidelines for Hoosier Healthwise (Indiana's Medicaid and Children's Health Insurance Program) for children and youth. Also available at this site: general eligibility guidelines for Medicaid waiver programs for individuals of any age with complex medical conditions and intellectual disabilities.

Additional resources and information are available online at:

Video on how to access health coverage in Indiana: http://fssaprivacy.articulate-online.com/p/2210308525/DocumentViewRouter.ashx?Cust=22103&DocumentID=e5c06745-7246-4f63-b9a5-96db50f043ad&Popped=True&v=1&&InitialPage=player.html

Online Eligibility Screening Tool for **Indiana** Health Coverage Programs and Other Benefits: https://www.ifcem.com/CitizenPortal/application.do

Online Information, Resources and Tools to help individuals access health coverage and services in U.S.: https://www.healthcare.gov/

APPENDIX E

THINGS TO CONSIDER WHEN PROCURING A MEDICAID BILLING AGENT

Suggested questions to ask prospective billing agent contractors:

1. What is the extent of the Medicaid billing agent's knowledge of special education and school practices?
2. What is the extent of the agent's general knowledge of the Medicaid program; of applicable federal and *Indiana's* state laws, rules and regulations; and of school-based Medicaid IEP services, in particular?
3. How long has the agent been in business in Indiana? In other states?
4. Ask for references, and contact them.
5. Where/how will the agent keep claims documentation and individually identifiable student data?
6. (Assuming PC or web-based tracking), can the agent's automated system be set up to maintain service documentation for all students, or will it just maintain service records for Medicaid members?
7. What kind of feedback will the agent provide to the school corporation on the adequacy of the documentation prepared by the school corporation's service providers?
8. What kind and frequency of standardized reports will the agent provide to the school corporation?
9. What kind of feedback will the agent provide to the school corporation on reasons for claims denials?
10. What, if any, self-auditing or compliance monitoring does the billing agent perform, and will the findings be shared with the school corporation?
11. What are the agent's expectations of the school corporation: for example, what data will it require from the school corporation, and how often? Will school personnel choose among coding and time increment options from a menu when entering data into the agent's system, or will school personnel enter only the service and time descriptions for the agent to translate into billing codes and units/time increments, as appropriate?
12. How will the agent charge for its services, based on Medicaid reimbursements, number of paid claims transactions, other fee structure? Are fees all-inclusive?

Suggestions to consider when drafting a contract or Request for Proposals (RFP):

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?

APPENDIX F

CMS GUIDANCE ON MEDICAID REIMBURSEMENT FOR SCHOOL-BASED SERVICES AND ACTIVITIES

To check for updated federal guidance on claiming Medicaid reimbursement for school-based services and administrative activities, visit the Centers for Medicare and Medicaid Services Web site, www.cms.gov, and enter School Health in the "CMS Search" field.

June 19, 1998

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

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

Prior Authorization No Longer Required for Special Education Services

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

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

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

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

Additional Information

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