Medicaid Medical Billing of Health-related Individualized Education Program Services Provided by Indiana Public School Corporations

MEDICAID BILLING TOOL KIT

Indiana Department of Education

June 20, 2019

Twenty-First Edition

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

MEDICAID BILLING TOOL KIT
FOR HEALTH-RELATED SERVICES IEP SERVICES
TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION
- 1.1. General Information
  - 1.1.1. Introduction
  - 1.1.2. Background
  - 1.1.3. Legal, Statutory and Regulatory Authority
- 1.2. Tool Kit Use and Organization
  - 1.2.1. Purpose and Format
  - 1.2.2. Chapter Organization
  - 1.2.3. Module Organization
  - 1.2.4. Section Organization
  - 1.2.5. Pagination
  - 1.2.6. Tool Kit Publication Date
- 1.3. Tool Kit Updates
  - 1.3.1. Updating Changes
  - 1.3.2. Update Log
  - 1.3.3. Publication Date
  - 1.3.4. Sample Update Log

CHAPTER 2: PURPOSE, BACKGROUND, AND PROGRAM INFORMATION
- 2.1. Purpose and Background
  - 2.1.1. Purpose
  - 2.1.2. Background
  - 2.1.3. Medicaid Billing and Reimbursement for Covered IEP Services Only
  - 2.1.4. Differences among Public Health Insurance Benefit Programs in Indiana
- 2.2. Definitions
- 2.3. Medicaid Service Provider Qualifications
  - 2.3.1. Qualified School Corporation Providers of Medicaid Services
  - 2.3.2. Provider Enrollment Process
  - 2.3.3. Medicaid Provider Enrollment File Update Requirements
  - 2.3.3.a. Medicaid Paperless Communications with All Providers
  - 2.3.4. School Corporation Staff Qualifications
- 2.4. Students Eligible for Medicaid-Covered IEP/IFSP Services
  - 2.4.1. Students Eligible for Medicaid-Covered IEP/IFSP Services
  - 2.4.2. Additional Information on Medicaid Eligibility, Liens and Estate Recovery
- 2.5. General Service Requirements
  - 2.5.1. Introduction
  - 2.5.2. The Federal Free Care Prohibition
  - 2.5.3. Medicaid-Covered IEP Services Include Medically Necessary Evaluations
  - 2.5.4. Service Limitations
  - 2.5.5. Claim Filing Limitations
  - 2.5.6. Medical Necessity
  - 2.5.7. Treatment Plans
  - 2.5.8. Diagnosis Code
  - 2.5.9. Place of Service Code

2.5.10. Procedure Codes and Fees
2.5.11. Modifiers and Explanation of Tables in Appendix E
2.6. Parental/Guardian Authorization
2.6.1. Informing the Parent about IDEA Requirements
2.6.1.a. Initial and Annual Written Medicaid Consent Notification to Parents
2.6.1.b. One-Time Medicaid Consent
2.6.2. Methods for Obtaining Medicaid Consent
2.6.3. Release of Progress Notes to Physician
2.6.4. Access to Private Insurance Benefits
2.7 Audit Requirements
2.7.1. Provider Records
2.7.2. Documentation Timeliness and Security
2.7.3. Timely Documentation
2.7.3.a. Electronic Service Documentation
2.7.4. Records Retention Requirement
2.7.5. Recoupment
2.8. Guidelines for Billing IEP/IFSP Services
2.8.1. General Billing Guidance for Medical Services in a Student's IEP
2.8.2. Things to Consider When Contracting with a Billing Agent

CHAPTER 3: HEARING SERVICES
3.1. Service Definition
3.1.1. Service Definition
3.1.2. Service Limitations
3.2. Provider Qualifications
3.2.1. Qualifications
3.3. Reimbursement Limitations
3.3.1. Limitations
3.4. Plan of Care
3.5. Audit Requirements

CHAPTER 4: THERAPY SERVICES

Module 4.4. Physical Therapy
Section 4.4.1. Physical Therapy Service Description
4.4.1.1. Service Definition
4.4.1.2. Physician Orders
Section 4.4.2. Physical Therapy Provider Qualifications
4.4.2.1. Provider Qualifications for Therapy Services
1.4.2.2. Provider Qualifications for Therapy-Related Services
Section 4.4.3. Physical Therapy Reimbursement Limitations
4.4.3.1 Limitations
Section 4.4.4. Physical Therapy Evaluations
4.4.4.1. Service Definition
4.4.4.2. Service Limitations
4.4.4.3. Required Components
4.4.4.4. Reimbursement

Section 4.4.5. Physical Therapy Plan of Care
4.4.5.1. Plan of Care Requirements/Recommendation for Services
4.4.5.2. Provider Qualifications
4.4.5.3. Plan of Care Components
4.4.5.4. Plan of Care Approval
4.4.5.5. Plan of Care Review
4.4.5.6. Reimbursement
Section 4.4.6. Physical Therapy Sessions
4.4.6.1. Individual Therapy Sessions
4.4.6.2. Group Therapy Sessions
4.4.6.3. Reimbursement Limitations
4.4.6.4. Supervision of Physical Therapy Assistants
Section 4.4.7. Physical Therapy Audit Requirements
4.4.7.1. Student Records
4.4.7.2. Documentation Components

Module 4.5. Speech-Language Pathology
Section 4.5.1. Speech-Language Pathology Service Description
4.5.1.1. Service Definition
4.5.1.2. Service Limitations
4.5.1.3. Orders or Referrals
Section 4.5.2. Speech-Language Pathology Provider Qualifications
4.5.2.1. Provider Qualifications for Therapy and Therapy Support Services
4.5.2.2. Supervision Requirements
Section 4.5.3. Speech-Language Pathology Evaluations
4.1.5.3.1. Service Description
4.5.3.2. Provider Qualifications
4.5.3.3. Diagnostic Testing, Evaluation or Re-evaluation
4.1.5.3.4. Reimbursement Limitations
Section 4.5.4. Speech-Language Pathology Plan of Care
4.5.4.1 Requirement/Recommendation for Services
4.5.4.2. Provider Qualifications
4.5.4.3. Plan of Care Components
4.5.4.4. Plan of Care Approval
4.5.4.5. Plan of Care Review
4.5.4.6. Reimbursement Limitations
Section 4.5.5. Speech-Language Pathology Sessions
4.5.5.1. Service Description
4.5.5.2. Provider Qualifications
4.5.5.3. Individual Sessions
4.5.5.4. Group Sessions
4.5.5.5. Reimbursement Limitations
Section 4.5.6. Speech-Language Pathology Audit Requirements
4.5.6.1. Student Records
4.5.6.2. Documentation Components

Module 4.6. Occupational Therapy
Section 4.6.1. Occupational Therapy Service Description
4.6.1.1. Service Description
4.6.1.2. Service Limitation
4.6.1.3. Physician/Other Medical Professional Orders or Referrals
Section 4.6.2. Occupational Therapy Provider Qualifications
4.6.2.1. Provider Qualifications
Section 4.6.3. Occupational Therapy Reimbursement Limitations
4.6.3.1. Limitations
Section 4.6.4. Occupational Therapy Evaluations
4.6.4.1. Occupational Therapy Evaluations
4.6.4.2. Service Requirements
4.6.4.3. Required Components
4.6.4.4. Reimbursement Limitations
Section 4.6.5. Occupational Therapy Plan of Care
4.6.5.1. Plan of Care Requirement
4.6.5.2. Provider Requirements
4.6.5.3. Plan of Care Components
4.6.5.4. Plan of Care Approval
41.6.5.5. Plan of Care Review
4.6.5.6. Reimbursement Limitations
Section 4.6.6. Occupational Therapy Sessions
4.6.6.1. Service Description
4.6.6.2. Provider Qualifications
4.6.6.3. Occupational Therapy Sessions
4.6.6.4. Service Limitations
Section 4.6.7. Occupational Therapy Audit Requirements
4.6.7.1. Student Records
4.6.7.2. Documentation Components

Module 4.7. Applied Behavior Analysis Therapy
Section 4.7.1. Applied Behavior Analysis Therapy Service Description
4.7.1.1. Service Description
4.7.1.2. Service Limitation
4.76.1.3. Physician/Other Medical Professional Orders or Referrals
Section 4.7.2. Applied Behavior Analysis Therapy Provider Qualifications
4.1.7.2.1. Provider Qualifications
Section 4.7.3. Applied Behavior Analysis Therapy Reimbursement Limitations
4.7.3.1. Limitations
Section 4.7.4. Applied Behavior Analysis Therapy Diagnostic Evaluation
4.7.4.1. Comprehensive Diagnostic Evaluation
Section 4.7.5. Applied Behavior Analysis (ABA) Therapy Individual Treatment Plan
4.7.5.1. Individual Treatment Plan Requirement
4.7.5.2. Provider Qualifications
4.7.5.3. Treatment Plan Components: Initial Course of ABA Therapy
4.7.5.4. Treatment Plan Components: Continued Course of ABA Therapy
4.7.5.5. Reimbursement Limitations

Section 4.7.6. Applied Behavior Analysis Therapy Audit Requirements
4.7.7.1. Student Records
4.7.7.2. Documentation Components

CHAPTER 5: TELEMEDICINE
5.1. Service Definition
5.1.1. Service Description
5.2. Provider Qualifications
5.2.1. Provider Qualifications
5.3. Reimbursement Limitations
5.3.1. Limitations
5.4. Documentation Requirements
5.4.1. Student Records
5.4.2. Telemedicine Documentation Standards

CHAPTER 6: RESERVED

CHAPTER 7: BEHAVIORAL HEALTH SERVICES
7.1. Service Definition
7.1.1. Service Description
7.2. Provider Qualifications
7.2.1. Provider Qualifications for Testing and Treatment Services
7.2.2. Supervision, Plan of Care and Plan of Care Review
7.3. Reimbursement Limitations
7.3.1. Limitations
7.3.2. Diagnostic Interview Examinations
7.3.3. Group Therapy
7.3.4. Hypnosis and Biofeedback-not covered
7.4. Service Requirements
7.4.1. General Service Requirements
7.4.2. Physician/HSPP Orders for Services
7.5. Individual Behavioral Health Services
7.5.1. Individual Behavioral Health Sessions
7.5.2. Service Limitations
7.5.3. Service Reimbursement Limitations
7.6. Group Behavioral Health Services
7.6.1. Group Behavioral Health Sessions
7.6.2. Service Requirements
7.6.3. Service Reimbursement Limitations
7.7. Audit Requirements
7.7.1. Student Records
7.7.2. Diagnosis Code
7.7.3. Documentation Components

CHAPTER 8: NURSING SERVICES
8.1. Service Definition
8.1.1. Service Description
8.1.2. Service Limitations

8.1.3. Physician Order
8.2. Provider Qualifications
8.2.1. Qualifications
8.3. Reimbursement Limitations
8.3.1. Limitations
8.4. Plan of Care
8.4.1. Plan of Care Requirement
8.4.2. Plan of Care Components
8.4.3. Plan of Care Review
8.5. Audit Requirements
8.5.1. Student Records
8.5.2. Documentation Components

CHAPTER 9: SPECIAL EDUCATION TRANSPORTATION SERVICES
9.1. Service Definition
9.1.1. Service Description
9.1.2. Service Limitations
9.2. Provider Qualifications
9.2.1. Qualifications
9.3. Reimbursement Limitations
9.3.1. Limitations
9.4. Audit Requirements
9.4.1. Documentation Components
9.4.2. Trip Log

CHAPTER 10: MONITORING MEDICAID PROGRAM COMPLIANCE
10.1. Audits: External and Internal
10.1.1. Required Documentation
10.1.2. Focusing the Self-Audit Process
10.1.3. Pulling an Internal Audit Sample
10.1.4. What to Expect if Selected for External Audit
10.1.5. Self-Audit Tools: Documentation Checklists and Internal Audit Guidelines:
Hearing
Mental/Behavioral Health
Nursing (R.N.)
Therapies: Physical, Occupational, Speech, Applied Behavior Analysis
Special Education Transportation
10.2. HIPAA and FERPA
10.2.1. HIPAA Electronic Transmissions and Claims Transactions
10.2.2. HIPAA vs FERPA Privacy Protections & Student Health Records
10.3. False Claims Act
10.3.1. Employee Education about False Claims Recovery
10.3.2. Federal and State False Claims Acts
10.3.3. Typical False Claims Act-related Policies

APPENDICES
Appendix A: Indiana Medicaid Provider Enrollment
Appendix B: Medicaid Provider Qualifications Summary

Appendix C: Indiana Laws, Rules & Policy Affecting Medicaid Reimbursement for IEP Services – See Page *C1* for a list of document copies included in Appendix C
Appendix D: Indiana Medicaid Program Contact Information
Appendix E: CMS-1500 Billing Instructions and Billing Code Examples
Appendix F: Sample Consent, Referral and Service Documentation Forms – See Page *F1* for a list of document copies included in Appendix F
Appendix G: Federal Guidance: Medicaid Consent, FERPA, HIPAA AND IDEA
Appendix H: Medical Clearance and Audiometric Test Form
Appendix I: Medicaid Resources

CHAPTER 1: INTRODUCTION TO TOOL KIT

1. 1. GENERAL INFORMATION

1.1.1. Introduction

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

1.1.2. Background

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

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

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

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

3. The Health Insurance Portability and Accountability Act of 1996, "HIPAA," Public Law 104-191 (42 USC § 1320d and federal regulations at 45 CFR § 160, 162 & 164).

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

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

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

7. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, 102 Stat. 683 (July 1, 1988) 42 USC § 1305).

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

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

10. The Family Educational Rights Privacy Act of 1974 "FERPA," Section 438, Public Law 90-247 Title IV, as amended (20 U.S.C. § 1232g and federal regulations at 34 CFR Part 99), otherwise known as the Buckley Amendment.

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

12. Indiana Health Coverage Programs ("IHCP") Provider Reference Modules, as amended by Provider Bulletins. Link to Provider Reference Modules: http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx
    Link to IHCP (Medicaid) Provider Bulletins: http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx.

13. Office of Management and Budget ("OMB") Circular A-87, Cost Principles for State, Local and Indian Tribal Governments. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, produced by the inter-agency Council on Financial Assistance Reform and published in the Dec. 26, 2013 *Federal Register* (to be codified in Title 2 of the Code of Federal Regulations). Beginning December 2014, this final OMB uniform guidance will replace several previous OMB Circulars, including OMB Circular A-87.

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

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

NOTE: This Tool Kit describes covered IEP/IFSP services and requirements for public school corporations to claim Medicaid reimbursement for such services. Medicaid-participating school corporations must continually monitor other authoritative resources, specifically:

a. Applicable state rules and federal regulations governing Medicaid.
b. The Indiana Health Coverage Programs (IHCP) Provider Reference Modules, Monthly Newsletter, bulletins and banner pages. Additional resources are identified in Appendix I of this Tool Kit

1.2. TOOL KIT USE AND FORMAT

1.2.1. Purpose and Format

The purpose of the Tool Kit is to educate Medicaid-enrolled school corporations about the policies and procedures governing Medicaid coverage, billing and reimbursement for IEP health-related services provided to Medicaid-eligible students by Medicaid-qualified service providers. The Tool Kit provides descriptions and instructions on how and when to complete forms and other documentation necessary for Medicaid medical claiming and audit purposes. **Tool Kit information is not applicable to School-based Medicaid Administrative Claiming ("IndianaMAC")**. The most recent updates to this document appear in red font. The format used in this handbook is a consistent way of displaying complex, technical material and is intended to simplify the process for updating such information.

1.2.2. Chapter Organization

Tool Kit Chapters 2 and 10 discuss general billing requirements applicable to all types of Medicaid-covered IEP services; Chapters 3 through 9 address specific requirements for billing each type of Medicaid-covered IEP service. Chapter 4 on Therapy Services is further divided into Modules that discuss billing requirements specific to each type of covered IEP-required therapy service.

1.2.3. Module Organization

In cases involving distinct sub-categories within the type of service discussed in a Chapter, billing requirements specific to each sub-category are addressed in separate Modules. See Chapter 4 on therapies, in which Modules describe requirements for billing Physical, Occupational, Physical, Speech and Applied Behavior Analysis therapies.

1.2.4. Section Organization

Sections within each Tool Kit Chapter are dedicated to a specific topic, such as provider qualifications, service description, reimbursement limitations, documentation, etc. The Section number is included in the page header along with the Chapter number and, if applicable, the Module number.

1.2.5. Pagination

Tool Kit pagination contains the Chapter, Module (if applicable), Section and Page number separated by hyphens. Each section within a chapter begins on page 1. For example, Chapter 2, Section 6 begins with page number 2-6-1; Chapter 2, Section 7 begins with page number 2-7-1.

1.2.6. Tool Kit Publication Date

A date appears on the bottom left corner of each page to indicate the publication date of changes to the content on that page.

1.3. TOOL KIT UPDATES

1.3.1. Updating Changes

The *Medicaid Billing Tool Kit* is updated as necessary to incorporate changes that impact school-based Medicaid claiming. Updates are coordinated with the Indiana Office of Medicaid Policy and Planning, appear in red font and will be communicated when there is a change in the applicable:

1. Federal law, including statute, regulation or policy

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

3. Provisions of the Indiana Medicaid State Plan

4. Indiana Department of Education (IDOE) and Medicaid program policies. See also: the IDOE School-based Medicaid web page at https://www.doe.in.gov/specialed/school-based-medicaid, and Indiana Health Coverage Programs publications including Provider Reference Modules (formerly the Provider Manual), bulletins, banners and newsletters at https://www.in.gov/medicaid/providers/index.html.

The most recent *Medicaid Billing Tool Kit* and tool kit update logs are available online at https://www.doe.in.gov/specialed/school-based-medicaid. Policy and program change effective dates are noted in the Tool Kit Update Log. The *Medicaid Billing Guidebook* is also available at this site and provides a general overview of Medicaid claiming for school-based services and administrative activities.

1.3.2. Update Log

The Tool Kit Update Log accompanies each update to identify, by topic, the Module Number (if applicable) and Section Number of the updated portion of the Tool Kit. Changes in policy and procedure are displayed in red font on the Update Log with the corresponding effective dates of these changes.

1.3.3. Publication Date

The publication date of each Tool Kit page appears in the bottom left corner of the page. School corporations are encouraged to check this date periodically in the online version of the Tool Kit to ensure that locally maintained copies are current.

1.3.4. Sample Update Log

See a sample *Medicaid Billing Tool Kit* Update Log on the following page.

Medicaid Billing Tool Kit
UPDATE LOG

TOPIC (policy & procedure changes in red)	SECTION NUMBER(S)	PAGE NUMBER(S)	EFFECTIVE DATE
Title Page	N/A	Title Page	2/1/2017
Updates Section 2.3. with details on the 2/13/17 implementation date of Indiana Medicaid's new CoreMMIS system and *Core*MMIS replacement of Web interChange as the means to perform Medicaid Provider Enrollment transactions.	2.3.1. – 2.3.3.a	2-3-1 through 2-3-4	2/13/2017
Updates examples of standardized national procedure codes used for commonly billed IEP-required OT and PT evaluations.	Appendix E, Table 2	*E4*	1/1/2017

February 2017

CHAPTER 2: PURPOSE, BACKGROUND, AND PROGRAM INFORMATION

2.1. PURPOSE AND BACKGROUND

2.1.1. Purpose

This Tool Kit is intended to assist school corporations that participate in the Indiana Medicaid program. It outlines specific Indiana Medicaid program requirements for billing Medicaid-covered IEP or IFSP services. It also educates school corporations about policies and procedures governing school corporation Medicaid provider enrollment (required by IC 12-15-1-16) as well as payment, coverage parameters and limitations and service provider qualifications for Medicaid-covered IEP and IFSP services. In addition, this Tool Kit provides descriptions and instructions for maintaining documentation necessary for Medicaid billing and audit purposes.

This Tool Kit must be used in conjunction with billing instructions and other pertinent information in the Indiana Health Coverage Programs ("IHCP") Provider Reference Modules, provider bulletins, banners and newsletters. The IHCP Provider Reference Modules, which include sample forms and further instructions for Medicaid providers, is accessible online at https://www.in.gov/medicaid/providers/453.htm. Medicaid bulletins, banners and newsletters are also available at this web site.

2.1.2. Background

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

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

2.1.3. Medicaid Billing and Reimbursement for Covered IEP Services Only

The Medicaid program is a state and federally funded medical assistance program. Medicaid-enrolled school corporations may use their Medicaid provider numbers only to bill for Medicaid-covered services in an **IEP** or **IFSP** (***not*** services in a 504 or non-public school student's service plan) and **not** for primary or preventive care furnished by a school-based health center or clinic. **Medicaid-covered IEP services include: occupational, physical, speech and applied behavior analysis therapy, hearing, nursing and behavioral health evaluation and treatment services as well as IEP-required specialized transportation.**

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

2.1.4. Differences among Public Health Insurance Benefit Programs in Indiana

In Indiana "Hoosier Healthwise" is the term used for several public health coverage programs, including Medicaid and the State Children's Health Insurance Program or "CHIP." Typically, a child's family income is a deciding factor in determining program eligibility; but some children with disabilities qualify for Medicaid benefits (including Home and Community-Based Services Waiver services) despite family income levels which exceed limits that apply in other cases.

See details about eligibility for various Indiana Health Coverage Programs (including Hoosier Healthwise, CHIP, Medicaid disability, Medicaid Home and Community-Based Services Waivers, Healthy Indiana Plan ("HIP") and other programs for special populations online at https://www.in.gov/medicaid/members/59.htm.

As noted below, some children are eligible only for ***limited*** Medicaid and CHIP benefits. ***Note***: claiming reimbursement for IEP services provided to children with either private health insurance or limited public health coverage benefits can pose a potential FAPE violation if accessing those benefits results in a cost (such as exhausted benefits) to the student or student's family. Typically, those with limited benefits constitute a small percentage of eligible students, and the school district's billing agent or staff responsible for program eligibility verification can readily identify and exclude them when submitting Medicaid claims for IEP services.

The following table summarizes coverage per Indiana Medicaid and CHIP benefit package. See also the *Medicaid Billing Guidebook* Section 3.4.3. on Eligibility Verification; Section 4.7. on Third Party Liability; and Appendix D.

Benefit Package	Coverage
Package A - Standard Plan **Medicaid**	All Medicaid-covered State Plan services for eligible children, low-income parents and pregnant women.
Package C - Children's Health Insurance Program ("CHIP")	*Limited* preventive, primary and acute care services for eligible children under 19 years.
Package E - Emergency Services	*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 - **Medicaid** for disabled, blind and aged populations	All Medicaid-covered State Plan services for eligible children and adults with complex medical needs.

NOTE: Information in this Medicaid Billing Tool Kit does not necessarily apply to students eligible for the state Children's Health Insurance Program ("CHIP").

2.2. DEFINITIONS

The following definitions apply for purposes of this Tool Kit:

1. Family Educational Rights and Privacy Act ("FERPA") refers to Public Law 90-247, also known as the Buckley Amendment, which provides students ages 18 years or older and their parents with privacy protections and rights regarding student records maintained by federally funded educational agencies or institutions or persons acting for these agencies or institutions.

2. Health Insurance Portability and Accountability Act ("HIPAA") refers to Public Law 104-191 that sets out privacy protections for individually identifiable health information as well as security of information transmitted electronically and privacy safeguards for paper and other non-electronic health records.

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

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

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

6. Medicaid refers to the State's medical assistance program under Title XIX of the Social Security Act. Indiana uses the nickname "Hoosier Healthwise" to identify both the Medicaid program (which provides full health coverage benefits under Hoosier Healthwise "Package A" to children under age 21 years) and the State's Children's Health Insurance Program (a.k.a. "CHIP," which is a separate program created under Title XXI of the Social Security Act that offers only ***limited*** health coverage benefits under Hoosier Healthwise "Package C" to children under 19 years old). **In Indiana, children covered under "Hoosier Healthwise Package A," including those who receive "Hoosier Care Connect" services are eligible for Medicaid.** Children who are covered under other Hoosier Healthwise benefit packages, including Package C (a.k.a. CHIP) are NOT eligible for Medicaid. See Section 2.1.4. of this Tool Kit for further details on benefit packages and coverage.

7. Mid-level practitioner refers to practitioners who may only provide direct service to the student, within their scope of practice, under the direct supervision of a licensed or registered practitioner as required by applicable state licensure or registration laws and regulations.

8. On-site supervision, as used in this Tool Kit and in Medicaid rules, means the supervising practitioner must be in the same building as a "mid-level" practitioner for whom Medicaid requires supervision if providing services billed to Medicaid. Practice acts and practice standards established by the applicable licensing, registering or certifying body may prescribe additional supervision requirements with which the supervising practitioner must comply.

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

10. Special Education-Related Services, not all of which are covered by Medicaid, are defined by Indiana's *Rules for Special Education*, Title 511, Article 7 (511 IAC 7-43-1) and include but are not limited to:
    a. Audiological services.
    b. Counseling services.
    c. Early identification and assessment of disabilities in children.
    d. Interpreting services.
    e. Medical services for the purpose of diagnosis and evaluation.
    f. Occupational therapy.
    g. Orientation and mobility services.
    h. Parent counseling and training.
    i. Physical therapy.
    j. Psychological services.
    k. Recreation, including therapeutic recreation.
    l. Rehabilitation counseling.
    m. School health services.
    n. School nurse services.
    o. School social work services.
    p. Transportation.
    q. Other supportive services.

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

2.3. MEDICAID SERVICE PROVIDER QUALIFICATIONS

2.3.1. Qualified School Corporation Providers of Medicaid Services

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

2.3.2. Provider Enrollment Process

To comply with state law IC 12-15-1-16 (see Section 2.3.1. above) and to be able to bill Medicaid for IEP-required direct medical services such as therapies, nursing and psychologist services, a school corporation must enroll as an Indiana Medicaid provider. Complete enrollment forms and technical assistance with the provider enrollment process are available from the Medicaid agency's contractor, DXC, by contacting Medicaid Provider Enrollment toll free at 800-577-1278, or by clicking "School Corporation" (Type 12, Specialty 120) in the list of Medicaid provider types at this Medicaid agency web site: https://www.in.gov/medicaid/providers/973.htm.

To enroll, each school corporation must also complete a Medicaid provider agreement. Per a federal mandate, the Indiana Medicaid agency is required to collect and safeguard the Social Security Number of the district superintendent or the charter or state-operated school leader, who is considered the "managing employee." Sample pages from the Indiana Medicaid Provider Enrollment Application and Agreement are included in Appendix A, along with a *Federal Register* excerpt regarding mandatory disclosure of the managing employee's identifying information.

Important note: for school corporation Medicaid providers, *disclosure is required of the managing employee only* (i.e., the school district superintendent or charter school leader). *For more information on this federal requirement, see Appendix A and the "**Limited Risk**" screening activities under PROVIDER RISK LEVELS at the following Indiana Medicaid web site: https://www.in.gov/medicaid/providers/589.htm*. See also: Chapter VI, Section 1 of the *Medicaid Billing Guidebook: Guide to Billing Indiana Medicaid for IEP Health-Related Services Provided by School Corporations*, and *School Corporation Medicaid Provider Enrollment Tips & Frequently Asked Questions,* https://www.doe.in.gov/sites/default/files/specialed/school-corp-medicaid-prov-enrollment-tips-faq.pdf.

Revalidation: To remain enrolled as a Medicaid Provider as required by Indiana law, a public school corporation must complete a Provider Enrollment Revalidation every 5 years. See details and instructions online at Indiana Medicaid's web site at https://www.in.gov/medicaid/providers/543.htm.

To maintain their statutorily required Medicaid provider enrollments (see Section 2.3.1. above), all public school corporations, charter schools and state-operated schools must complete the user registration in Indiana Medicaid's *Core*MMIS Provider Portal and **ensure that a designated administrator maintains and safeguard the Portal access security codes (login ID, password, etc.) required to complete Medicaid provider enrollment transactions, including initial provider enrollment, provider enrollment revalidation as required every 5 years, and provider file updates such as address and contact information changes**.

Information and free online training on the *Core*MMIS Provider Portal is available at the Medicaid agency's web site at https://www.in.gov/medicaid/providers/831.htm.

Tips for completing the School Corporation Medicaid Provider Enrollment and related FAQ (Frequently Asked Questions) are available at https://www.doe.in.gov/sites/default/files/specialed/school-corp-medicaid-prov-enrollment-tips-faq.pdf. Medicaid Provider Relations Field Consultants are available for virtual trainings and other workshops. See more details at https://www.in.gov/medicaid/providers/455.htm and https://www.in.gov/medicaid/providers/490.htm.

National Provider Identifier (NPI): To obtain an NPI, a school corporation must apply via the National Plan and Provider Enumerator System (NPPES) web site at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart or complete and submit (to NPPES) the paper form available on the NPPES web site. Once obtained, the school corporation's NPI number can then be included on the Medicaid provider enrollment application.

Taxonomy Code: When obtaining an NPI, the school corporation must enter its federal tax ID number and mailing (street) address and select the following taxonomy code from the choices offered by the online enumerator system:

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

For additional information on Indiana Medicaid's provider enrollment process, visit https://www.in.gov/medicaid/providers/465.htm or contact Indiana Medicaid's contractor at:

DXC Provider Enrollment
P.O. Box 7263
Indianapolis, Indiana 46207-7263
1-800-577-1278

2.3.3. Medicaid Provider Enrollment File Update Requirements

Once enrolled as an Indiana Medicaid-participating provider, the school corporation must keep its Medicaid provider enrollment file up to date. Provider file updates must be performed via the web-based Provider Portal, which requires registration. Provider Portal user instructions and links to registration information are at accessible on Indiana Medicaid's site at https://www.in.gov/medicaid/providers/831.htm. For details on when to update and how to maintain the Medicaid Provider Enrollment file visit https://www.in.gov/medicaid/providers/468.htm. Examples of updates that must be communicated timely to the Indiana Health Coverage Programs (IHCP) Provider Enrollment Unit include any changes in: the name of the school corporation; the name of the person authorized to represent the school corporation *(superintendent/equivalent charter or state school leader)*; the name of the entity filing the corporation's electronic claims; tax ID number(s) required to be on file; and the school corporation's street, mailing and payment address(es). Information on revalidating the Medicaid Provider Enrollment at least every 5 years is available at https://www.in.gov/medicaid/providers/543.htm.

Important Note: Indiana Medicaid stresses the importance of updating provider address information because outdated address(es) can impact receipt of payments, tax documents and program-related correspondence, including audit notices and Provider Enrollment Revalidation deadline notifications. Access user instructions and details at https://www.in.gov/medicaid/providers/545.htm. [Note: *Medicaid allows enrolled providers to designate different addresses for different purposes; see Section 2.3.1. above and further details in the blue text box below.*]

Service Location – identifies where services are performed and claim documentation is kept; this must be a street address and cannot be a post office box.
Pay To – this address is where checks are sent; *note: remittance advice statements explaining Medicaid payment amounts are available only in electronic format via CoreMMIS—see §2.3.3.a.*
Mail To – this address is used for written correspondence, ***including audit notices.***
Legal Name and Home Office – this is your legal address and ***must match*** the address on your district's W-9 form on file with Medicaid Provider Enrollment.

2.3.3.a. Medicaid Paperless Communications with All Medicaid-Enrolled Providers

Indiana Medicaid Provider Remittance Advice (RA) statements (explanations of Medicaid claims activity and reimbursements) are available in electronic format only and can be accessed via Medicaid's *Core*MMIS system (see Section 2.3.2. above). Indiana Health Coverage Programs recommends saving copies of RA statements in PDF format to personal storage devices for future reference.

See *Core*MMIS Provider Portal registration instructions and user information online at https://www.in.gov/medicaid/providers/831.htm. For technical assistance, contact Electronic Solutions Support 8:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday (except holidays) and 8:00 a.m. to 1:00 p.m. Eastern Time Saturday by phone: 800 457 4584 or FAX: 317-488-5185.

In addition to paperless Remittance Advice statements, Indiana Medicaid provider bulletins, banner pages, newsletters and Claim Correction Forms are all paperless. View these paperless provider communications and forms via the IHCP web site. To stay informed of current procedures, policy updates and provider workshop offerings, enroll in the IHCP E-mail Notifications service. Follow the enrollment instructions provided at https://www.in.gov/medicaid/providers/index.html and periodically verify that IHCP has your current e-mail address(es) on file.

2.3.4. School Corporation Staff Qualifications

To bill Medicaid, a school corporation must be enrolled as an Indiana Medicaid provider. In accordance with its signed Medicaid provider agreement, the school corporation must employ or contract with health care practitioners who meet applicable Medicaid provider qualifications* to provide the specific services for which the school corporation bills Medicaid. However, it is ***not*** necessary for school employees and contracted staff who perform IEP services to be individually enrolled as Indiana Medicaid providers, have individual National Provider Identifier (NPI) numbers, or be listed as rendering providers on the school corporation's Medicaid Provider Enrollment.

***Excluded Individuals: In addition to ensuring that employees and contractors who provide Medicaid-reimbursed services meet the Medicaid agency's provider qualification requirements (which may differ from Indiana Department of Education rules and requirements), school corporations must also ensure that their employees and contractors involved in school-based Medicaid claiming are not barred from participation in federally funded programs.** To verify that an employee or contractor is not a Medicaid excluded individual, search or download the Office of Inspector General List of Excluded Individuals and Entities ("LEIE") online at **https://oig.hhs.gov/exclusions/index.asp**, and search the federal System for Award Management (SAM) database at https://www.sam.gov/portal/public/SAM/#1. The Medicaid agency encourages all enrolled providers to include a provision in all their Medicaid-related contracts, including billing agent agreements, stating that the contractor does not employee Excluded Individuals.* *See IHCP Provider Bulletins BT200715 and BT200934 under News, Bulletins and Banners, https://www.in.gov/medicaid/providers/737.htm.*

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

(1) are performing within the scope of practice of their state licensure and certification; and
(2) have not been banned from Medicaid participation; please see the blue text box above concerning searchable databases to identify Excluded parties. These online databases enable users to enter the name of an individual or entity; if a name match is made, the database can verify the match using a Social Security Number or Employer Identification Number.

***IMPORTANT NOTE: The Indiana Medicaid agency is required to recoup in full any claims involving excluded individuals or businesses.**

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

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

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

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

2. Be at least three but less than 22 years of age (for an IEP service), per Indiana's Special Education rule, 511 IAC 7-33-2(a)(1). For an IFSP service (typically billed by First Steps/Part C agency), or a medically necessary evaluation to develop the IEP of a child transitioning from preschool, the child may be age three years or younger.

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

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

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

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

See Tool Kit Section 2.1.4. for important details about student Medicaid eligibility and coverage.

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

The Indiana Department of Education refers inquiries about the potential estate planning consequences of accepting Medicaid assistance for a special needs child to the Office of Medicaid Policy and Planning. Please see additional details online at http://www.in.gov/fssa/ompp/4874.htm.

2.5. GENERAL SERVICE REQUIREMENTS

2.5.1. Introduction

Medicaid will reimburse school corporations only for services that are identified in an eligible student's IEP/IFSP, furnished by a Medicaid-qualified provider and, when applicable, ordered/referred in writing by a physician/other licensed practitioner of the healing arts acting within the scope of his/her state licensure – see Section 2.8.1. b. Service-specific chapters 3 through 9 of this Tool Kit address Medicaid requirements including but not limited to: provider qualifications; procedure codes; reimbursement limitations; documentation requirements; and plan of care requirements. Chapter 5 discusses availability of Medicaid reimbursement for certain IEP-required services when delivered as a telemedicine service.

Note: school-based health care services that are not authorized in a student's IEP may be billed to Medicaid *only if the school-based clinic or other school-based service provider is enrolled and bills under a different (not the school's) Medicaid Provider ID number*. Medicaid-covered IEP services are face-to-face, health-related services provided to a student or group of students who is/are *eligible to receive services under IDEA*. Covered services must be medically necessary and listed in or required to develop a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Examples of **Medicaid-covered IEP services include**:

1. Speech/language pathology and hearing services
2. Nursing services provided by an R.N.
3. Health-related, including mental health, assessments/evaluations
4. Physical, occupational and applied behavior analysis therapy
5. Psychological testing, evaluation and therapy services
6. IEP-required special transportation services on dates of another covered IEP service

See Appendix E for billing code examples for commonly billed IEP services, including those that Medicaid will cover when furnished as telemedicine services.

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

2.5.2. The Federal Free Care Prohibition

Prior to December 2014, the Centers for Medicare and Medicaid Services ("CMS") interpreted federal law as prohibiting Medicaid payment for services provided free of charge (IEP services were an exception). A 2014 policy change made reimbursement available for covered services regardless whether the provider charges for that service.

2.5.3. Medicaid-Covered IEP Services Include Medically Necessary Evaluations

Only medically necessary services that are listed in or *required to develop* an IEP may be billed to Medicaid (see Section 2.5.6.). In Indiana, these include an initial evaluation if that evaluation is necessary to assess a student's health-related needs and develop his/her IEP (this includes evaluations *necessary to rule out a diagnosis or medical need for therapy, etc*). If an IEP is *not* developed for the student (i.e., the student does not "qualify for Special Ed"), the evaluation is not covered. Medicaid also covers other medically necessary diagnostic and treatment services listed in a student's IEP.

Please note: Medicaid does **not** cover services that are strictly educational in nature. Examples of services considered strictly educational in nature include: evaluations to identify a specific learning disability *(**unless** an underlying medical or mental health condition is suspected or must be ruled out as the cause of the learning disability)* and speech therapy continued after a speech-language pathologist determines the student's medical need has been met.

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

2.5.4. Service Limitations

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

2.5.5. Claim Filing Limitations

With few exceptions, Medicaid will not make a payment on a claim filed more than one hundred eighty (180) days from the date the service is rendered ("date of service" or "DOS"). School corporations are advised to contact the Medicaid fiscal agent promptly to research and resolve claim issues or submit a written inquiry to the fiscal agent's Written Correspondence Unit. The contact information is listed in Appendix D.

School corporations may request a waiver of the 180-day filing limit when submitting a claim with dates of service more than one year prior to the date the claim is submitted. Medicaid may waive the filing limit in certain circumstances after reviewing supporting documentation from the school corporation.

Note also: IHCP Provider Reference Modules: Claim Filing Limitations.

2.5.6. Medical Necessity

Indiana Medicaid's rule at 405 IAC 5-2-17 defines "medically reasonable and necessary service" to mean a covered service that is required for the care or well-being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. See Section 2.5.3. for additional details. Medicaid reimburses school corporations for Medicaid-covered IEP/IFSP services if such services:

1. Are determined to be medically necessary.

2. Do not duplicate another provider's services.

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

4. Are not experimental or investigational.

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

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

2.5.7. Treatment or Care Plan – see Plan of Care discussions in Chapters 3 through 8

A treatment plan or plan of care (see Tool Kit Section 2.8.1.d.) is required for all Medicaid-covered IEP services and must be reviewed every 60 (in some cases 90) days; see Chapter 7 on mental health plan of care review. The IEP may serve as the required treatment plan if it meets Medicaid's criteria (see the Plan of Care sections in each service-specific Chapter of this Tool Kit). The plan of care must *include the amount, frequency, duration and goals of the services to be provided.*

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

2.5.8. Diagnosis Code

Medicaid requires that the applicable diagnosis code, based on the *International Classification of Diseases, 9th Revision Clinical Modification* (ICD-9-CM),* published by the American Medical Association (AMA), and any subsequent revisions thereto, be entered on the CMS-1500 claim form. For behavioral health services, a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (DSM-IV), published by the American Psychiatric Association, and any updates thereto, must be entered on the claim form. A student's diagnosis and corresponding code must be contained in the student's record. ***ICD-10 codes are required beginning October 1, 2015.**

2.5.9. Place of Service Code

On the CMS-1500 (medical) claim, school corporations must enter the Place of Service (POS) code that most appropriately describes where the service was provided, or if by telemedicine. Appropriate POS codes for school corporation services include:

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

For audit purposes, school corporations must maintain appropriate documentation to support the use of the POS code on the claim. Examples of supporting documentation:

1. For POS Code 02, service documentation must show the service was provided via a telecommunication system and attendance records must confirm the location where the child was present when receiving the service.

2. For POS Code 03, attendance records must show that the child was at school when the service was provided.

3. For POS Code 99, attendance and other school activity records (e.g., permission slips for field trips) must show that the child was on a school field trip when the service was provided.

4. For POS Code 12, attendance records must reflect that the child was not on campus but receiving services at his or her home/residential facility.

To avoid unnecessary claim denials when similar services are rendered at multiple service locations on a single date of service, it is acceptable to bill the total units on a single claim line with one POS code. The medical service record must document the specific place of service for each service provided. For example, a school provides 4 units of nursing services at 7:30, 8:30, 9:30 and 10:30 a.m. at school on 9/4/13 and on the same date provides another 3 units of nursing services in the student's home. The school corporation may bill 7 units of service on 1 claim line at POS 03 (school) and document in the student's service record the number of units provided at each different POS.

School corporations generally provide IEP health-related services on the school grounds. In some circumstances, services may be provided in the child's home, another community setting, during a field trip or while the student is transported. Appropriate POS code use and documentation can be helpful in audit situations.

2.5.10. Procedure Codes and Fees

Appendix E of this Tool Kit contains a list of CPT Codes most commonly billed or that may be billed by school corporations when the services are authorized in a student's IEP or IFSP. Current Medicaid reimbursement rates per CPT Code can be viewed online at https://www.in.gov/medicaid/providers/index.html, "Professional Fee Schedule."

2.5.11. Modifiers and Explanation of Tables in Appendix E

In conjunction with CPT procedure codes, school corporations must use appropriate modifiers to denote details about services billed. Appendix E includes examples of procedure code and modifier combinations for commonly billed IEP services. *See also: the Modifiers section in the* IHCP Provider Reference Modules.

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

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

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

Table 4. In addition to the modifiers specified in Tables 1-3, school corporations are required to use the following general modifiers: TM for IEP services, TR for any IEP health-related services provided outside the school district in which the student is enrolled, and TL for IFSP/early intervention services. These modifiers are informational (i.e., they do not affect payment) and must be used to identify IEP and IFSP services billed by school corporations.

Table 5. This table addresses nursing services provided by an R.N. Code 99600 TD TM is used for all IEP nursing services except Diabetes Self-Management Training. Codes

for IEP DSMT services provided by an R.N. are included in the lower half of Table 5. ***Please note: the order of the modifiers is critical for appropriate reimbursement.***

Table 6. This table lists codes and modifiers for common ambulatory and non-ambulatory IEP Special Education transportation services. Reimbursement is available only for transportation services on a day when the student receives another Medicaid-covered IEP service.

Table 7. This table lists codes and modifiers for applied behavior analysis therapy services.

Table 8. This table lists the code and modifiers for IEP services delivered as telemedicine services. Note also: see information on Page 2-5-4 regarding the required Place of Service code for telemedicine.

2.6. PARENTAL/GUARDIAN AUTHORIZATION

2.6.1. Informing the Parent per IDEA Requirements

Effective June 25, 2014, Indiana changed its Medicaid consent rule to align with the 7/1/2013 federal rule change described in 2.6.1.a below. This change permits school corporations to obtain a one-time signed parental consent to release student data as necessary for purposes of billing Medicaid or another public or private insurance after giving the parent ***prior written notice***. In addition to the required prior written notice, the school corporation must provide ***annual*** written notice to all parents/guardians who give "Medicaid consent." Both notices must meet federal requirements (see details below).

2.6.1.a. Initial and Annual Written Medicaid Consent Notification to Parents

Effective July 1, 2013, the U.S. Department of Education made the following change to IDEA Part B regulations at 34 CFR 300.154[d][2][iv], et seq., requiring parental consent to bill Medicaid or other insurance:

(iv) Prior to accessing a child's or parent's public benefits or insurance for the first time, and after providing notification to the child's parents consistent with paragraph (d)(2)(v) of this section, must obtain written, parental consent that—
(A) Meets the requirements of § 99.30 of this title and § 300.622, which consent must specify the personally identifiable information that may be disclosed (e.g., records or information about the services that may be provided to a particular child), the purpose of the disclosure (e.g., billing for services under part 300), and the agency to which the disclosure may be made (e.g., the State's public benefits or insurance program (e.g., Medicaid)); and (B) Specifies that the parent understands and agrees that the public agency may access the parent's or child's public benefits or insurance to pay for services under part 300.
(v) Prior to accessing a child's or parent's public benefits or insurance for the first time, and annually thereafter, must provide written notification, consistent with § 300.503(c), to the child's parents, that includes—
(A) A statement of the parental consent provisions in paragraphs (d)(2)(iv)(A) and (B) of this section;
(B) A statement of the "no cost" provisions in paragraphs (d)(2)(i) through (iii) of this section;
(C) A statement that the parents have the right under 34 CFR part 99 and part 300 to withdraw their consent to disclosure of their child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid) at any time;
and
(D) A statement that the withdrawal of consent or refusal to provide consent under 34 CFR part 99 and part 300 to disclose personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid) does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

Per the federal education regulations cited above, ***prior to obtaining the initial one-time consent*** to disclose a child's personally identifiable information as necessary to bill Medicaid for covered IEP services, **and in *annual* notices thereafter, the school corporation must provide written notification to parents** that includes items (A) through (D) as noted under section (v) of the applicable federal regulation recopied in italics above. See Tool Kit Appendix F for a sample form that combines prior written notice and consent on one form template, as well as sample annual notice language. Sample forms and annual notice language samples, in English and Spanish, are also available at the IDOE web site (see Office of Special Education and School-based Medicaid pages) and in the IndianaIEP system.

2.6.1.b. One-Time Medicaid Consent

Indiana's rule governing the use of public and private insurance proceeds, set out in Title 511 of the Indiana Administrative Code, Article 7, Rule 33, Section 4, was amended effective June 25, 2014, to align with the federal Part B regulation allowing school districts to obtain a one-time consent to disclose a student's records to Medicaid. (*A copy of this rule is included below.*) Effective June 25, 2014, and after giving the required prior written notice (*see Tool Kit Section 2.6.2.a.*) to the parents, or to the student if age 18 or older with no legal guardian, Indiana school districts must obtain a signed, written consent only one time in order to disclose the child's personally identifiable information to the Medicaid agency for purposes of claiming Medicaid reimbursement for services in the child's Individualized Education Program (IEP). Upon obtaining the required written one-time consent, the school district must give written notice annually thereafter (*see also: Tool Kit Section 2.6.2.a., Appendix C, Appendix F and Appendix G*). Prior to 6/25/14, Medicaid consent was required at least annually and when the number, type or frequency of covered services was changed in the student's IEP.

Note: All Medicaid providers, including school corporations must bill available third party insurance prior to billing Medicaid. If the student has third party insurance in addition to Medicaid, the school corporation cannot bill Medicaid for covered IEP or IFSP services *unless* it bills the student's other insurance first. ***See Section 2.1.4. regarding a potential FAPE violation if accessing a student's third party insurance benefits constitutes a cost to the student or parent.*** See also: Tool Kit Section 2.6.4. and *Medicaid Billing Guidebook, Chapter IV, Section 7* on accessing private insurance benefits.

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

Sec. 4. (a) A public agency may use Medicaid or other public benefits or insurance programs in which a student participates to provide or pay for services required under this article, as permitted under the public benefits or insurance program. With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency may not:

(1) require a parent to:

(A) sign up for or enroll in public benefits or insurance programs in order for the student to receive a free appropriate public education; or

(B) incur an out-of-pocket expense, such as the payment of a deductible or copay amount incurred in filing a claim for services provided, but may pay the cost that the parent otherwise would be required to pay; or

(2) use a student's benefits under a public benefits or insurance program if that use would:

(A) decrease available lifetime coverage or any other insured benefit;

(B) result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;

(C) increase premiums or lead to the discontinuation of benefits or insurance; or

(D) risk loss of eligibility for home and community based waivers, based on aggregate health-related expenditures.

(b) A public agency must provide written notice to the parent:

(1) before accessing the student's or the parent's public benefits or public insurance for the first time;

(2) prior to obtaining the one-time written parental consent described in subsection (d) and

(3) annually thereafter.

(c) The written notice described in subsection (b) must:

(1) be provided in language that is understandable to the general public;

(2) be provided in the native language or other mode of communication used by the parent, unless it is clearly not feasible to do so; and

(3) include a statement that:

(A) The public agency must provide written notice and obtain written parental consent prior to accessing the student's or the parent's public benefits or public insurance for the first time.

(B) The parental consent form provided to the parent must specify the:

(i) personally identifiable information that the public agency may disclose;

(ii) purpose of the disclosure;

(iii) agency to which the disclosure may be made; and

(iv) parent understands and agrees that the public agency may access the public benefits or public insurance to pay for services for the student.

(C) The public agency may not:

(i) require parents to sign up or enroll in public benefits or public insurance programs in order for the student to receive a free appropriate public education;

(ii) require parents to incur an out-of-pocket expense such as the payment of a deductible or copay amount incurred in filing a claim for services provided pursuant to this part; and

(iii) use a student's benefits under a public benefits or insurance program if that use would:

(AA) decrease available lifetime coverage or any other insured benefit;

(BB) result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;

(CC) increase the premiums or lead to the discontinuation of benefits or insurance; or

(DD) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

(D) The parent has the right, at any time, to withdraw his or her consent to disclose personally identifiable information to the agency responsible for the administration of the state's public benefits or public insurance program.

(E) The parent's refusal to consent or withdrawal of consent to disclose personally identifiable information to the agency responsible for the administration of the state's public benefits or public insurance program does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.

(d) The written consent form shall:
(1) describe the personally identifiable information that the public agency may disclose;
(2) specify the purpose of the disclosure;
(3) specify the agency to which the disclosure may be made; and
(4) include a statement that the parent understands and agrees that the public agency may access the public benefits or public insurance to pay for services for the student.
(e) The public agency shall obtain the parent's written consent prior to accessing the student's or the parent's public benefits or insurance for the first time.
(f) With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency may access a parent's private insurance proceeds only if the parent provides informed consent as defined by 511 IAC 7-32-17. Each time the public agency proposes to access the parent's private insurance proceeds, it must do the following:
(1) Obtain informed parental consent as defined by 511 IAC 7-32-17.
(2) Inform the parent that refusal to permit the public agency to access the private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.
(g) If a public agency is unable to obtain informed parental consent to access the parent's private insurance, or public benefits or insurance when the parent would incur a cost for a specified service required under this article, the public agency may use its Part B federal funds to pay for the service in order to ensure a free appropriate public education is provided to the student. These funds may also be used to avoid financial cost to a parent who otherwise would consent to the use of private insurance or public benefits or insurance. If the parent would incur a cost, such as a deductible or copay amounts, the public agency may use its Part B funds to pay the cost.
(h) Proceeds from public benefits or insurance or private insurance shall not be considered program income for purposes of 34 CFR 80.25 with respect to the administration of federal grants and cooperative agreements.
(i) If a public agency spends reimbursements from federal funds, such as Medicaid, for services under this article, those funds shall not be considered state or local funds for purposes of maintenance of effort provisions.
(j) Nothing in this article shall be construed to alter the requirements imposed on the state Medicaid agency, or any other agency administering a public benefits or insurance program by federal statute, regulations, or policy under Title XIX or Title XXI of the Social Security Act, or any other public benefits or insurance program.

Note: Tool Kit Sections 2.1.4., 2.6.4., Chapter 10, Appendix F, Appendix G; also *Medicaid Billing Guidebook* Section 4.7 at https://www.doe.in.gov/specialed/school-based-medicaid.

2.6.2. Methods for Obtaining Medicaid Consent

Consent, as used in Article 7, is defined at 511 IAC 7-32-17 (*see a copy in Appendix C*).

Appendix F includes sample Medicaid consent forms in English and Spanish, which school corporations may adapt for local use. Alternatively, school corporations may incorporate the federally required Medicaid consent language in their local forms.

Appendix F also provides sample language for the **annual written notice required** by 34 CFR 300.154[d][2][v] and 511 IAC 7-33-4(c)(3). This sample language is included in English and Spanish versions of the "SAMPLE Notice of Procedural Safeguards and Parent Rights in Special Education (including Annual Notice for Medicaid Consent) effective July 1, 2013," which is online at http://www.doe.in.gov/specialed/laws-rules-and-interpretations and available in the IndianaIEP system. In its response to comments on the federal Medicaid consent regulation, the U.S. DOE declined to specify when subsequent annual written notifications must be provided to parents; thereby allowing public agencies flexibility to determine the timing of these required annual notifications.

2.6.3. Release of Progress Notes to Physician

School corporations are strongly encouraged to provide the student's Primary Medical Provider (PMP) with progress notes. Such release must be in compliance with the privacy requirements of the Family Educational Rights and Privacy Act (FERPA), 34 Code of Federal Regulations, Part 99 (34 CFR Part 99). In other words, **school corporations must obtain a signed authorization from parents/guardians, or the student if 18 years old with no legal guardian, prior to releasing progress notes to the student's PMP.**

2.6.4. Access to Private Insurance Benefits

All Medicaid providers, including school corporations, must first bill available third party resources, ***if any*** – including private insurance – before billing Medicaid for covered services. However, Medicaid-participating must also comply with (1) the "no cost" provisions of the FAPE guarantee and (2) federal and state requirements to give prior written notice and obtain prior written consent ***"each time"*** the public agency seeks to access a student's or parent's ***private insurance*** benefits [see also 34 CFR 300.154(e) through (f) below, and 511 IAC 7-33-4(f) through (j) above in Tool Kit Section 2.6.1.b.].

34 CFR §300.154 Methods of ensuring services.
… (e) *Children with disabilities who are covered by private insurance.* (1) With regard to services required to provide FAPE to an eligible child under this part, a public agency may access the parents' private insurance proceeds only if the parents provide consent consistent with §300.9.

(2) Each time the public agency proposes to access the parents' private insurance proceeds, the agency must—

(i) Obtain parental consent in accordance with paragraph (e)(1) of this section; and

(ii) Inform the parents that their refusal to permit the public agency to access their private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(f) *Use of Part B funds.* (1) If a public agency is unable to obtain parental consent to use the parents' private insurance, or public benefits or insurance when the parents would incur a cost for a specified service required under this part, to ensure FAPE the public agency may use its Part B funds to pay for the service.

(2) To avoid financial cost to parents who otherwise would consent to use private insurance, or public benefits or insurance if the parents would incur a cost, the public agency may use its Part B funds to pay the cost that the parents otherwise would have to pay to use the parents' benefits or insurance (e.g., the deductible or co-pay amounts).

Important note about third party resources (a.k.a. Third Party Liability or TPL): school corporations or their Medicaid medical billing agents must check for third party resources when verifying the student's Medicaid eligibility. In rare cases, a third party resource (in effect on the date of a previously billed IEP service) may be added retroactively to a student's Medicaid record, and Indiana Medicaid may recover payment from the private insurer if the policy covers that IEP service. Some private insurance policies specifically exclude coverage for IEP/IFSP services, and in such cases, copies of the insurer's denial can accompany all applicable claims for up to one year from the date of the "blanket denial." *See "Blanket Denials," "Billing Procedures," "Subsequent Third Party Liability Payment" and "Third Party Payer Fails to Respond (90-Day Provision)" sections of the IHCP Provider Reference Modules at https://www.in.gov/medicaid/providers/469.htm.*

Note also: in cases where a private insurance resource exists, federal and state Special Education rules permit the public agency to use its Part B funds to pay for the service in order to:
(a) ensure a free appropriate public education is provided to the student,
(b) avoid financial cost to a parent who otherwise would consent to the use of private insurance or public benefits or insurance, and
(c) pay the cost, such as a deductible or copayment, if incurred by the parent when the public agency accesses the available private insurance benefits.
See also: Tool Kit Section 2.6.1. and *Medicaid Billing Guidebook* Chapter IV, Section 7.

2.7. AUDIT REQUIREMENTS

2.7.1. Provider Records

A school corporation must have copies on file of each of its employed and contracted providers' medical licenses, certifications, excluded entity [Section 2.3.4.] and criminal background check results, and other documentation that verifies that each provider meets the Medicaid provider qualifications for the services he or she renders and for which the school corporation bills Medicaid. Such records must be retained for 7 years and made available upon request to federal or state auditors or their representatives.

2.7.2. Documentation

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

The school corporation must maintain the following records:

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

2. Medical or other records, including x-rays or laboratory results that are necessary to fully disclose and document the extent of services provided. Such records must be legible and include, at a minimum, all of the following, including the signature(s) of the service provider and the supervising practitioner if required:
   a. Identity of the student who received the service.
   b. Identity, title and employment records of the provider or the employee who rendered the service.
   c. The date that the service was rendered.
   d. A narrative description of the service rendered. Also note place of service if other than on-site/at school (see Tool Kit Section 2.5.9. for details).
   e. The diagnosis of the medical condition of the student to whom the service was rendered.
   f. Evidence of physician involvement and personal patient evaluation for purposes of documenting acute medical needs, if applicable.
   g. Progress notes about the necessity and effectiveness of treatment.

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

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

a. Location where the IEP services were rendered (see Tool Kit Section 2.5.9.).
b. Documentation of referrals and consultations.
c. Documentation of tests ordered.
d. Documentation of all Medicaid-covered IEP/IFSP services performed and billed.
e. Documentation of medical necessity.

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

Note: Refer to Section 2.7.4. for Medicaid Records Retention Requirements as well as the Audit Requirements section in each service-specific Tool Kit Chapter. See also: (1) Tool Kit Chapter 10, Monitoring Medicaid Program Compliance, for additional information regarding state and federal audits, service-specific documentation checklists and school corporation self-audit guidelines; (2) "Provider Records," "Medical and Financial Record Retention," as well as "Record Review Criteria" under "Provider Utilization Review" in the IHCP Provider Reference Modules available online at *https://www.in.gov/medicaid/providers/469.htm*; and (3) IHCP's free online training on Medicaid Behavioral Health and ABA Documentation Guidelines at http://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_flash.html.

2.7.3. Documentation Timeliness and Security

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

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

2.7.3.a. Electronic Service Documentation

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

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

Password protection should restrict medical records access to authorized personnel only. Each authorized provider should have a unique, confidential password that must be changed at least every 60 days. Authentication is recommended to ensure data integrity. For example, when a provider makes an entry in a medical record, an electronic signature linked to the password is appended onto the medical record with the date and time. This signature creates an electronic fingerprint that is ***unique to the provider*** and verifies when the data was entered or modified. *Important note*: for the electronic documentation to stand alone (without hard copy records signed by the therapist, nurse, etc.) *the electronic record must be entered using the unique, person-specific electronic ID* (password/login or encrypted signature) *of the school employee or contractor who performed the service, developed the plan of care, assessed performance or authored the progress notes*.

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.

School corporations that use the medical service log screens in the statewide electronic IEP (IndianaIEP or IIEP) can choose among a variety of means to save service log data in a format that can be transferred to the district's Medicaid billing agent vendor of choice. The IIEP Standard and Advanced Report options include a Service Log Report that can be generated and saved in a variety of electronic formats then shared with a Medicaid billing agent via password-protected CD, encrypted e-mail or secured access e-mail site. Or, a district may grant its billing agent IIEP access via an administrator role that permits the billing agent to generate, save and extract the district's Service Log report data. See Appendix F, for additional details on IIEP Service Log reports.

2.7.4. Records Retention Requirement

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

2.7.5. Recoupment

Failure to appropriately document services and maintain records may result in recoupment of Medicaid reimbursement. Note Also: See Chapter IX of the *Guidebook* for Records Maintenance requirements.

2.8. GUIDELINES FOR BILLING IEP/IFSP SERVICES

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

a. Authorization for Services: Medicaid recognizes the IEP/IFSP as the prior authorization for Medicaid-covered IEP/IFSP services provided to a Medicaid-eligible student. No other Medicaid prior authorization or Primary Medical Provider (PMP) certification is required for the school corporation to bill Medicaid for the IEP/IFSP services using its Medicaid provider number. For services billed to Medicaid, *the IEP/IFSP must identify the service(s), including the length, frequency, location (if provided off-site), and duration of the service(s). The school corporation may bill only for the identified service(s), as specified in the student's IEP/IFSP.* **NOTE**: Medicaid billing for a service cannot exceed the frequency described in the student's IEP.

b. Order or Referral: To be covered by Medicaid, physical therapy*, nursing and hearing services must be ordered in writing by a physician (M.D. or D.O.); speech and occupational therapy* services require an order/referral from a physician or other "licensed practitioner of the healing arts" as permitted by state law (see the paragraph below on the School Psychology practice act). To be covered by Medicaid, applied behavioral analysis therapy requires a diagnostic evaluation, completed by a qualified provider using a standardized assessment tool approved by the Indiana Office of Medicaid Policy and Planning, which recommends treatment referral for ABA services and includes a projected length of treatment.

   Important note: the ordering, referring or prescribing practitioner must be enrolled with the Indiana Health Coverage Programs (IHCP); see more on Indiana Medicaid enrollment requirements for "Ordering, Prescribing, Referring (OPR)" providers below and online at https://www.in.gov/medicaid/providers/547.htm. See additional details in service-specific Tool Kit Chapters 3 through 9 and sample service referral forms in Appendix F. **NOTE**: written referrals should be obtained at least annually and as necessary to support significant changes in the type of services listed in the IEP (for example, when "consultation once per semester" is changed to "speech therapy three times per week"). Medicaid billing for a service cannot exceed the frequency described in the student's IEP.

   **See the paragraph below regarding a 2/1/2017 expansion of provider types who may write the required referral/order for Medicaid-covered physical and occupational therapy services.*

- Effective July 1, 2006, the scope of practice defined by Indiana's School Psychology practice act, IC 20-28-1-11(see Tool Kit Appendix C) includes: "*referring* a student to (A) a speech-language pathologist **(…)*** licensed under IC 25-35.6 for services for speech, hearing and language disorders; or (B) an occupational therapist licensed under IC 25-23.5 for occupational therapy services; by a school psychologist who is employed by a school corporation and who is defined as a practitioner of the healing arts for the purpose of referrals under 42 CFR 440.110." ****Important note: a physician (MD or DO) must make the referral for IEP hearing services and must be an otolaryngologist if the child is 14 years of age or under*** *(see Tool Kit Sections 3.1.2., 3.2.1. and 3.4.).*

- Effective October 1, 2012, Indiana Health Coverage Programs implemented federally mandated claims edits requiring all Medicaid providers to enter the National Provider Identifier (NPI) of the "Ordering, Prescribing or Referring (OPR) Provider" on claims for services that require an order or referral. Important Note: for Medicaid to pay for a service ordered, prescribed or referred by another provider, the "OPR Provider" must be a Medicaid-enrolled provider. For example, if a student's physician writes the order for an IEP-required PT service, the physician must be Medicaid-enrolled and the physician's NPI must be entered on the school's Medicaid claim for that IEP service. In cases where the school's clinician (employee or contracted staff) makes the referral for an IEP service, the school corporation's NPI must be entered in Field 17b on the claim. See details about Medicaid-enrolled OPR Provider and NPI online lookup tools on the following page and on sample IEP service referral forms in Appendix F. Refer to Appendix C for IHCP bulletins on this topic.

- Effective February 1, 2017, Indiana Medicaid began recognizing additional provider types as authorized to write the required order/referral for Medicaid-covered physical and occupational therapy services. In addition to the provider types noted above and in Tool Kit Chapters 3-9, the following practitioner types may write a referral or order for physical and occupational therapy services effective with dates of service on and after 2/1/2017:
    - For physical therapy services: chiropractor, dentist, nurse practitioner, physician assistant, podiatrist, psychologist (*not school psychologist*)
    - For occupational therapy services: chiropractor, nurse practitioner, optometrist, physician assistant, podiatrist, psychologist - *note: these are in addition to school psychologist with statutory authority per IC 20-28-1-11(B)*

  NOTE: to be eligible for reimbursement, therapy services must be ordered in writing by a provider who is enrolled with Indiana Health Coverage Programs. See additional information about Medicaid provider enrollment requirements for "Ordering, Prescribing, Referring (OPR)" providers below and online at https://www.in.gov/medicaid/providers/547.htm.

INDIANA MEDICAID for Providers

GO

Contact Us | Search Tips | Site Map

About Indiana Medicaid | Become a Provider | General Provider Services | Provider-Specific Information | News, Bulletins, and Banners

Ordering, Prescribing or Referring Providers

IHCP Provider Enrollment Transactions

Affordable Care Act (ACA) Requirements

Complete an IHCP Provider Packet

Ordering, Prescribing or Referring Providers

Participating as an OPR Provider

Update Your Provider Profile

Recertify Provider Enrollment Licenses and Other Certifications

Disenroll from the IHCP

Locations in Need of Providers

National Provider Identifier (NPI)

Provider Home / Become a Provider / Ordering, Prescribing or Referring Providers

ORDERING, PRESCRIBING OR REFERRING PROVIDERS

For Medicaid to reimburse for services or medical supplies that require a practitioner's order, prescription, or referral, the ordering, prescribing, or referring (OPR) provider must be enrolled in Medicaid. OPR providers do not bill IHCP for services rendered but may order, prescribe, or refer services/supplies for IHCP members. Enrolling as an OPR provider is appropriate for practitioners who:

- May occasionally see an individual who is an IHCP member who needs additional services or supplies that will be covered by the Medicaid program
- Do not want to be enrolled as another IHCP provider type
- Do not plan to submit claims to the IHCP for payment of services rendered

PARTICIPATE IN THE IHCP AS AN OPR PROVIDER

Interested practitioners and existing OPR providers should refer to the Participating as an OPR Provider page for detailed information on enrollment and other transactions.

DIRECTORY OF OPR PROVIDERS

IHCP providers who render services or supplies should use the Ordering, Prescribing and Referring (OPR) Provider Search to verify IHCP enrollment of the ordering, prescribing, or referring practitioner, before services or supplies are provided.

QUICK LINKS

Claims Billing

Electronic Data Interchange

FAQs

Fee Schedule

Forms

Manuals

Pharmacy Services

Prior Authorization

Provider Enrollment

Provider Search (non-OPR)

OPR Providers

Preferred Drug List

Presumptive Eligibility

Program Integrity

Provider Education

Verify Member Eligibility

Access Provider Profile

Check Claims Status

For more information and IHCP Ordering, Prescribing, Referring Providers Search Tool, visit https://www.in.gov/medicaid/providers/547.htm. A copy of the Medicaid bulletin on this topic is available in Tool Kit Appendix C. To see if a referring provider has an NPI, visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do and enter the applicable search criteria for the individual practitioner.

c. Medicaid Consent: Parental consent to disclose student data required to access public benefits or private insurance. To bill Medicaid or private insurance for covered IEP services, a school corporation must give prior written notice and obtain signed consent in accordance with the federal Part B regulations at 34 CFR 300.154(d)(2)(iv) and (v); see Tool Kit Section 2.6., Appendix F and Appendix G).

d. Plan of Care: A treatment plan, or plan of care, is required for all Medicaid-covered IEP/IFSP services and in most cases* must be reviewed (assess progress toward goals and appropriateness of services) every sixty (60) days. *See Chapter 7 regarding the 90-day requirement for mental health treatment plan review. The IEP or IFSP may serve as the required treatment plan if it meets Medicaid's criteria (please see Tool Kit Section 2.5.7. and review the Plan of Care sections in each service-specific Chapter of this Tool Kit). The plan of care must include the amount, frequency, duration and goals of the services to be provided.

e. Coding: When billing Medicaid, school corporations *must use the Current Procedural Terminology © (CPT) code that best describes the Medicaid-covered IEP service provided* and any applicable CPT code modifiers (see Appendix E). School corporations and their

billing agents must pay particular attention to CPT code descriptions, noting that some codes are and some are not time-based.

f. Provider Qualifications: CPT codes are specific to the types and specialties of the practitioners furnishing services within their scope of licensure. *School corporations must ensure they or their billing agents are billing for services for which the rendering provider (furnishing the service): a) has proper licensure/certification, and b) meets the criteria to be a Medicaid-qualified provider. (See also Tool Kit Chapters 3 through 9.)*

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

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

2.8.2. Things to Consider When Contracting with a Billing Agent

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

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

CHAPTER 3: HEARING SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-7; 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: IC 25-25.6; 880 IAC 1-1-2.5.

3.1. SERVICE DESCRIPTION

3.1.1. Service Definition

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

3.1.2. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

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

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

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

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

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

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

3.2. PROVIDER QUALIFICATIONS

3.2.1. Qualifications – see also: Section 2.3.4.

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

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

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

In addition to meeting all applicable state licensure and practice standards, Medicaid-qualified audiologists must also meet all applicable Medicaid provider qualifications, including criteria in federal regulations at 42 CFR 440.110, recopied below.

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

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

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

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

(A) Have a Certificate of Clinical Competence in Audiology from the American Speech-Language-Hearing Association [http://www.asha.org/certification/].

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

See *Tool Kit* Appendix E for hearing service/speech-language pathology CPT Codes; Appendix F for a sample form to document the physician referral required for assessment and treatment services; and Appendix H for Medicaid's required Medical Clearance and Audiometric Testing form. See also Tool Kit Section 2.8.1.b.

3.3. REIMBURSEMENT LIMITATIONS

3.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6.

The following billing and reimbursement limitations apply to hearing services:

1. In general, hearing services cannot be fragmented and billed separately.

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

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

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

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

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

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

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

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

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

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

School corporations are encouraged to coordinate with the student's physician to facilitate continuity of care. **To share copies of the plan of care or progress notes, school corporations must obtain a signed authorization from parents/guardians prior to release.**

3.5. AUDIT REQUIREMENTS

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

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

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

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

CHAPTER 4: THERAPY SERVICES

MODULE 4.4: PHYSICAL THERAPY

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-8; 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: IC 25-27-1 and 844 IAC 6

4.4.1. SERVICE DESCRIPTION

4.4.1.1. Service Definition

1. Physical therapy

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

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

2. Therapy-related services

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

Note: See Provider Qualifications 4.2.2. – see also: Section 2.3.4.

4.4.1.2. Physician Orders

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

sample form to document the physician referral for Physical Therapy services. See also Tool Kit Section 2.8.1.b., which includes information on a Medicaid "ordering, prescribing, referring provider" policy change that takes effect February 1, 2017.

4.4.2. PROVIDER QUALIFICATIONS

4.4.2.1. Provider Qualifications for Therapy Services – see also: Section 2.3.4.

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

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

4.4.2.2. Provider Qualifications for Therapy-Related Services – see also: Section 2.3.4.

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

Therapy-related services cannot be billed separately to Medicaid.

4.4.3. REIMBURSEMENT LIMITATIONS

4.4.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6.

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

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

2. Assembling and disassembling equipment.

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

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

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

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

7. Performing established clerical procedures.

The therapy-related services listed above <u>cannot</u> be billed separately as they are included in the reimbursement rate for the service modality provided by the licensed physical therapist or physical therapy assistant under the supervision of the licensed physical therapist.

4.4.4. PHYSICAL THERAPY EVALUATIONS

4.4.4.1. Service Definition

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

4.4.4.2. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

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

4.4.4.3. Required Components

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

1. Student's name;

2. Diagnostic testing and assessment; and

3. A written report with needs identified.

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

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

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

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

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

4.4.5.1. Plan of Care Requirements/Recommendation for Services

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

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

4.4.5.2. Provider Qualifications – see also: Section 2.3.4.

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

4.4.5.3. Plan of Care Components

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

1. The student's name.

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

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

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

4.4.5.4. Plan of Care Approval

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

An IEP/IFSP may serve as a plan of care if it meets all the components in this Section. If an IEP/IFSP is used as a plan of care, the date of the IEP/IFSP meeting, as entered on the IEP/IFSP, will suffice as a physical therapist's date for the document. See Tool Kit Section 4.5.5. for more discussion.

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

4.4.5.5. Plan of Care Review

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

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

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

School corporations are encouraged to coordinate with the student's physician to facilitate continuity of care. **To share copies of the plan of care or progress notes, school corporations must obtain a signed authorization from parents/guardians prior to release.**

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

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

4.4.6. PHYSICAL THERAPY SESSIONS

4.4.6.1. Individual Therapy Sessions

1. Service limitations

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

2. Provider qualifications – see also: Section 2.3.4.

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

4.4.6.2. Group Therapy Sessions

1. Service limitations – see also: Sections 2.5.3. through 2.5.7.

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

2. Provider qualifications – see also: Section 2.3.4.

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

4.4.6.3. Reimbursement Limitations – see also: Sections 2.5.3. through 2.5.6.

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

4.4.6.4. Supervision of Physical Therapy Assistants

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

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

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

4.4.7. AUDIT REQUIREMENTS

4.4.7.1. Student Records

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

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

1. A current and valid plan of care.

2. Test results and evaluation reports.

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

4.4.7.2. Documentation Components

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

1. Student's name.

2. Date of service.

3. Type of service.

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

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

6. Description of therapy activity or method used.

7. Student's progress toward established goals.

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

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

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

MODULE 4.5: SPEECH-LANGUAGE PATHOLOGY

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-9 and 42 CFR 440.110
LICENSURE AND PRACTICE STANDARDS: IC 25-35.6, 880 IAC 1-1-2 and 880 IAC 1-2.1 (SLP Support Personnel).

4.5.1. SERVICE DESCRIPTION

4.5.1.1. Service Definition

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

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

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

4.5.1.2. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

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

4.5.1.3. Physician/Other Medical Professional Orders or Referrals

To be covered by Medicaid, speech-language pathology services must be provided pursuant to an order or referral from a physician or other licensed medical practitioner with specific practice act authority to prescribe, order or refer. The school corporation must maintain documentation of such order or referral in the student's records. A physician's/other appropriate medical practitioner's order or referral must be obtained upon initiation of service and annually thereafter. If the student's medical condition requiring therapy changes significantly enough to require a substantive change in services, a new order is required.

Please see the sample referral forms for Speech-Language and Occupational Therapy Services in Appendix F for more information concerning which practitioners of the healing arts have practice act authority to make referrals for speech-language pathology services. See also Tool Kit Section 2.8.1.b.

4.5.2. PROVIDER QUALIFICATIONS

4.5.2.1. Qualifications – see also: Section 2.3.4.

A school corporation can bill Medicaid for IEP speech-language pathology services provided to a Medicaid-eligible student by a speech-language pathologist who (a) is licensed by the Indiana Professional Licensing Agency and (b) is providing services within his/her scope of licensure, ***and*** (c):
1. has a certificate of clinical competence (C's) from the American Speech-Language-Hearing Association (ASHA)[http://www.asha.org/certification/]; or,
2. has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or,
3. has completed the equivalent educational requirements and work experience necessary for the certificate. *(Note number 3 would include those individuals who previously had the certificate but opted not to maintain it.)*

School corporations can also bill Medicaid for treatment services provided by registered speech-language pathology support personnel who are performing within the scope of their individual licensure and supervised by a licensed, ASHA-certified SLP. Please see the following additional information regarding Medicaid-qualified Speech-Language Pathologists and Speech-Language Support Personnel.

See Page 2-5-5 and Appendix E, Table 8 for additional details applicable to billing code/modifier examples and reimbursement rates for Medicaid services provided by a practitioner working under the supervision of a licensed, ASHA-certified SLP.

Medicaid-Qualified Speech-Language Pathologist

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

ASHA's web site at http://www.asha.org/certification/slp_standards/ lists Standards and Implementation Procedures for the Certificate of Clinical Competence ("CCC's"), which are currently in effect. Please visit the ASHA web site periodically to check for recent updates concerning this certification information.

Speech Pathology Support Personnel

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

4.5.2.2. Supervision Requirements

Please carefully review the SLP Support Personnel supervision and documentation requirements set out in 880 IAC 1-2.1 (online at http://www.in.gov/pla/2646.htm). Excerpts of this rule are included at Tool Kit Appendix C.

Minimum supervision requirements for SLP Support Personnel are summarized below. Note: 880 IAC 1-2.1-9 requires the supervisor to assess individual patient (student) needs when deciding the appropriateness of the support personnel service delivery model. Accordingly, the supervisor may determine that increased supervision is required "depending on the:
(A) competency of the SLP support personnel;
(B) needs of the patients or clients served; and
(C) nature of the assigned tasks.
However, the minimum standard must be maintained. Indirect supervision activities may include, but are not limited to, record review, phone conferences, or audio/video tape review."

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

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

As defined in the applicable rule [880 IAC 1-2.1-1], "'"Direct supervision" of support personnel means on-site, in-view observation and guidance by the supervising speech language pathologist while an assigned therapeutic activity is being performed."

4.5.3. SPEECH-LANGUAGE PATHOLOGY EVALUATIONS

4.5.3.1. Service Description

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

4.5.3.2. Provider Qualifications – see also: Section 2.3.4.

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

4.5.3.3. Diagnostic Testing, Evaluation or Re-evaluation

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

1. Student's name;

2. Diagnostic testing and assessment done; and

3. A written report with needs identified.

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

4.5.3.4. Reimbursement Limitations – see also: Sections 2.5.3. through 2.5.6.

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

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

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

4.5.4.1 Requirement/Recommendation for Services

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

4.5.4.2. Provider Qualifications – see also: Section 2.3.4.

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

4.5.4.3. Plan of Care Components

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

1. Student's name;

2. Description of student's medical condition;

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

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

4.5.4.4. Plan of Care Approval

A student's plan of care must be signed, titled and dated by a licensed speech-language pathologist prior to billing Medicaid for services; an IEP/IFSP may serve as a plan of care if it meets all the above components. A student's plan of care must be retained in the student's record and maintained for audit purposes.

4.5.4.5. Plan of Care Review

A new or updated plan of care is required at least annually. Medicaid requires documentation that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student's condition changes or alternative services are recommended (see Tool Kit Section 2.5.7.). Note: A physician's/other appropriate practitioner's order/referral is needed at least annually, before initiation of service (see Tool Kit Sections 2.8.1.b. and 5.1.3.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new order is required. Each plan of care must contain all the plan of care components listed in this Chapter.

A student's plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care. In the event that services are discontinued, the licensed speech-language pathologist must indicate the reason for discontinuing treatment in the student's record.

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

School corporations are encouraged to share progress notes and plans of care with the student's physician to facilitate continuity of care. **Please note: School corporations must obtain a signed authorization from parents/guardians prior to releasing the progress notes or plan of care to the student's physician.**

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

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

4.5.5. SPEECH-LANGUAGE PATHOLOGY SESSIONS

4.5.5.1. Service Description

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

4.5.5.2. Provider Qualifications – see also: Section 2.3.4.

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

4.5.5.3. Individual Sessions

1. Service limitations

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

2. Provider qualifications – see also: Section 2.3.4.

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

4.5.5.4. Group Sessions

1. Service limitations – see also: Sections 2.5.3. through 2.5.7.

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

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

2. Provider qualifications – see also: Section 2.3.4.

   Please refer to Section 5.2. of this Tool Kit chapter and Sections 2.5.3. through 2.5.7.

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

   See *Tool Kit* Appendix E for hearing and speech-language pathology CPT Codes. See also: "Q&A regarding Medicaid Speech Coverage Policy related to the school setting" at the Medicaid in Schools Learning Connection Community's Files & Bookmarks, under Xtra Links for SLPs and Audiologists.

4.5.6. AUDIT REQUIREMENTS

4.5.6.1. Student Records

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

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

1. A current and valid plan of care;

2. Test results and evaluation reports; and

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

4.5.6.2. Documentation Components

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

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

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

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

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

MODULE 4.6: OCCUPATIONAL THERAPY

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

4.6.1. SERVICE DEFINITION

4.6.1.1. Service Description

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

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

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

4.6.1.2. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

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

4.6.1.3. Physician/Other Medical Professional Orders or Referrals

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

Please see the sample referral forms for Speech-Language and Occupational Therapy Services in Appendix F for more information concerning which practitioners of the healing arts have practice act authority to make referrals for OT services. See also Tool Kit Section 2.8.1.b., which includes information on a Medicaid "ordering, prescribing, referring provider" policy change that takes effect February 1, 2017.

4.6.2. PROVIDER QUALIFICATIONS

4.6.2.1. Provider Qualifications – see also: Section 2.3.4.

Occupational therapy must be provided by:

1. A Licensed Occupational Therapist.

2. A Licensed Occupational Therapy Assistant acting within his/her scope of practice, under the supervision of a licensed occupational therapist.

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

4.6.3. REIMBURSEMENT LIMITATIONS

4.6.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6.

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

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

4.6.4. OCCUPATIONAL THERAPY EVALUATIONS

4.6.4.1. Occupational Therapy Evaluation

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

4.6.4.2. Service Requirements – see also: Sections 2.5.3. through 2.5.7.

To be reimbursed by Medicaid, the evaluation must be conducted by a licensed occupational therapist. Medicaid does not reimburse for evaluations performed by a licensed occupational therapy assistant.

4.6.4.3. Required Components

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

1. Student's name.

2. Diagnostic testing and assessment.

3. A written report with needs identified.

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

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

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

Note: See Appendix E of this Tool Kit for the evaluation procedure codes.
.

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

4.6.5.1. Plan of Care Requirement

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

4.6.5.2. Provider Qualifications – see also: Section 2.3.4.

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

4.6.5.3. Plan of Care Components

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

1. Student's name.

2. Description of student's medical condition.

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

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

4.6.5.4. Plan of Care Approval

A student's plan of care must be signed, titled and dated by a licensed occupational therapist prior to billing Medicaid for services. A student's IEP may suffice as a plan of care if it meets all the requirements in this section.

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

4.6.5.5. Plan of Care Review

A new or updated plan of care is required at least annually. Medicaid requires documentation to demonstrate that the current plan of care is reviewed at least once every sixty (60) days or more frequently if the student's condition changes or alternative services are recommended (see Tool Kit Section 2.5.7.). Note: A physician's order is needed at least annually, before initiation of service (see Tool Kit Section 6.1.3.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician's order is required. Each plan of care must contain all the plan of care components listed in this Chapter.

A student's plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to student's plan of care. In the event that services are discontinued, the licensed occupational therapist must indicate the reason for discontinuing treatment in student's record.

School corporations are encouraged to coordinate with the student's physician in order to facilitate continuity of care. **School corporations must obtain a signed authorization from parents/guardians prior to release the progress notes and plan of care to the student's physician.**

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

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

4.6.6. OCCUPATIONAL THERAPY SESSIONS

4.6.6.1. Service Description

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

4.6.6.1. Provider Qualifications – see also: Section 2.3.4.

Medicaid reimburses for occupational therapy sessions provided by a licensed occupational therapist or licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

4.6.6.2. Occupational Therapy Sessions

Medicaid reimburses for individual or group occupational therapy sessions provided by a licensed occupational therapist or licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

4.6.6.3. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

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

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

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

4.6.7. AUDIT REQUIREMENTS

4.6.7.1. Student Records

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

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

1. Current and valid plan of care.

2. Test results and evaluation reports.

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

4.6.7.2. Documentation Components

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

1. Student name.

2. Date of service.

3. Type of service.

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

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

6. Description of therapy activity or method used.

7. Student's progress toward established goals.

8. Signature of service provider, title and date.

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

MODULE 4.7: APPLIED BEHAVIOR ANALYSIS THERAPY

MEDICAID RULES AND REGULATIONS: 405 IAC 5-22-12 and 42 CFR 440.40

4.7.1. SERVICE DEFINITION

4.7.1.1. Service Description

Applied Behavior Analysis (ABA) therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

4.7.1.2. Service Limitations – see also: Sections 2.5.3. through 2.5.7.

Generally, Medicaid-covered ABA therapy is limited to a period not to exceed 40 hours per week. Each course of ABA therapy is limited to a duration not longer than six months. Medicaid does not cover services that focus solely on recreational or educational outcomes. IEP-required ABA therapy services that duplicate services the student receives in another setting are not covered.

Medicaid will only reimburse for one-on-one intervention. Reimbursement is not available for group instruction.

4.7.1.3. Physician/Other Medical Professional Orders or Referrals

Medicaid will cover ABA therapy services only when provided to an individual who (a) is 20 years old or younger, (b) has been diagnosed as having Autism Spectrum Disorder by a qualified provider and (c) has a completed diagnostic evaluation. When completing such an evaluation, a qualified provider shall utilize the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) at the time of the evaluation and include a recommended treatment referral for ABA therapy services. See *Medicaid Billing Tool Kit* Section 4.7.2.1. for qualified provider requirements.

The school corporation must maintain documentation in the student's record of this evaluation including the recommended treatment referral for ABA therapy services. Supporting documentation for and copies of updated treatment plans must also be maintained in accordance with Medicaid requirements if medical necessity requires continuation of ABA services beyond the initial course of ABA therapy. See full details in Indiana Medicaid's ABA therapy services coverage rule and provider bulletin, which are included in Appendix C. *Important note*: for services furnished pursuant to a student's Individualized Education Program, the IEP is the prior authorization for services provided in accordance with Medicaid's ABA therapy rule coverage criteria, and no other prior authorization is required.

4.7.2. PROVIDER QUALIFICATIONS

4.7.2.1. Provider Qualifications – see also: Section 2.3.4.

Initial Diagnosis and Diagnostic Evaluation

When making the initial diagnosis of Autism Spectrum Disorder (ASD) and completing the diagnostic evaluation, the qualified provider shall utilize the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) at the time of the evaluation and include a recommended treatment referral for ABA therapy services. A Medicaid-qualified provider includes any of the following:

- Licensed physician
- Licensed health service provider in psychology (HSPP)
- Licensed pediatrician
- Licensed psychiatrist
- Other behavioral health specialist with training and experience in the diagnosis and treatment of ASD.

Applied Behavior Analysis (ABA) Therapy

To be covered by Medicaid, ABA therapy services must be delivered by one of the following provider types:

- Health Service Provider in Psychology (HSPP)
- Licensed or board-certified behavior analyst, including bachelor-level (BCaBA)*****, master-level (BCBA), and doctoral-level (BCBA-D) behavior analysts
- Credentialed Registered Behavior Technician (RBT)* - N*ote: services performed by a credentialed RBT are reimbursed at seventy-five percent (75%) of the Medicaid rate on file.*

**** To be covered by Medicaid, IEP-required services rendered by a BCaBA or a credentialed RBT must be performed under the direct supervision of a BCBA, BCBA-D or HSPP.***

Providers must meet all applicable state and federal requirements governing licensure and practice standards as well as Medicaid provider qualifications 405 IAC 1 and 405 IAC 5.

4.7.3. REIMBURSEMENT LIMITATIONS

4.7.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6. and Appendix C for a copy of Medicaid's ABA therapy rule at 405 IAC 5-22-12

For the Initial Course of Applied Behavior Analysis (ABA) Therapy

Subject to the benefit limitations set out in 405 IAC 5-22-12, Medicaid coverage is available for an initial course of ABA therapy not to exceed six months only when rendered by a qualified provider and all the following criteria are met:

➢ The student is (a) 20 years of age or younger, (b) has been diagnosed as having Autism Spectrum Disorder by a qualified provider, and (c) has a completed diagnostic evaluation.

➢ A qualified provider develops a treatment plan for the student. Per Medicaid's rule at 405 IAC 5-22-12, treatment plans shall be focused on addressing specific behavioral issues and community integration. All treatment plans shall include a projected length of therapy. See Medicaid Billing Tool Kit Section 4.7.5.1. regarding treatment plan requirements.

➢ The goals of the intervention are appropriate for the individual's age and impairment.

➢ Documentation is provided that describes an individual treatment plan developed by a qualified provider and includes all the following:

- ☐ The identified behavioral, psychological, family, and medical concerns
- ☐ Measurable short-term, intermediate and long-term goals that are based on standardized assessments relative to age-expected norms and that address the behaviors and impairments for which the intervention is to be applied. Note: The goals should include baseline measurements, progress to date, and an anticipated time line for achievement, based on both the initial assessment and subsequent interim assessments over the duration of the intervention.
- ☐ Plans for parent/ guardian training and school transition
- ☐ Documentation that ABA services will be delivered by an appropriate provider who is licensed or certified as a behavior analyst or is a credentialed RBT. See Section 4.7.2. for Medicaid-covered ABA therapy service provider qualifications.

For a Continued Course of Applied Behavior Analysis (ABA) Therapy

Subject to the benefit limitations set out in 405 IAC 5-22-12, Medicaid coverage is available for continuation of IEP-required ABA therapy beyond the initial course. Each course of ABA therapy not to exceed a duration of six months is covered only when rendered by a qualified provider and if all the following criteria are met:

➢ The student has met the criteria for an initial course of ABA.

➢ The individual treatment plan is updated, as required. See *Medicaid Billing Tool Kit* Section 4.7.5.1. regarding treatment plan requirements.

➢ Developmental testing, to establish a baseline in the areas of social skills, communications skills, language skills, and adaptive functioning, was conducted no later than two months after the initial course of ABA treatment began.

➢ The individual treatment plan (see Section 4.7.5.1.) includes age- and impairment-appropriate goals and measures of progress in social skills, communication skills, language skills, and adaptive functioning.

➢ For each goal in the individual treatment plan, the following is documented:

- ☐ Progress to date
- ☐ Anticipated time line for achievement of each goal based on both the initial assessment and subsequent interim assessments over the duration of the intervention

➢ Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning is documented.

For All Applied Behavior Analysis (ABA) Therapy

Medicaid coverage for ABA therapy services is available only for a period not to exceed 40 hours per week. ABA therapy services **extending beyond forty (40) hours per week of direct therapy** must be medically necessary. Each course of ABA therapy is limited to a duration not longer than six months.

Medicaid coverage is <u>not available</u> for ABA therapy services that:
(1) Focus solely on recreational outcomes.
(2) Focus solely on educational outcomes.
(3) Are duplicative, such as services rendered under an individualized educational program (IEP) that address the same behavioral goals using the same techniques as the treatment plan.

Reimbursement is not available for services that do not meet Medicaid's medical necessity criteria. See *Medicaid Billing Tool Kit* Sections 2.5.6. and 2.5.3. for additional details regarding medical necessity.

Medicaid will only reimburse for one-on-one intervention. Reimbursement is not available for group instruction.

4.7.4. Applied Behavior Analysis Therapy Diagnostic Evaluation

4.7.4.1. Completed Diagnostic Evaluation

A completed diagnostic evaluation performed by a qualified provider is required for covered IEP-required applied behavior analysis (ABA) therapy services. See *Medicaid Billing Tool Kit* Section 4.7.2.1. for qualified provider requirements. See discussion about additional requirements for covered IEP-required applied behavior analysis (ABA) therapy services in *Medicaid Billing Tool Kit* Section 4.7.4.3. and in Medicaid's ABA therapy rule and provider bulletin in Appendix C.

When making the initial diagnosis of Autism Spectrum Disorder (ASD) and completing the diagnostic evaluation, the qualified provider shall utilize the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) at the time of the evaluation and include a recommended treatment referral for ABA therapy services.

4.7.5. INDIVIDUAL TREATMENT PLAN – see also: Section 2.5.7.

4.7.5.1. Individual Treatment Plan Requirement

Treatment plans must include measures and progress specific to language skills, communication skills, social skills, and adaptive functioning. Treatment plans shall be focused on addressing specific behavioral issues and community integration. All treatment plans shall include a projected length of therapy and be supported by documentation as described in Section 4.7.3.1. Individual treatment plans shall be based on criteria such as the individual's:

(1) needs;
(2) age;
(3) school attendance, **including any homeschooling;** and
(4) other daily activities as documented in the treatment plan that are not otherwise excluded from Medicaid coverage.

4.7.5.2. Provider Qualifications

The required individual treatment plan must be developed by a licensed or certified behavior analyst. See Section 4.7.2.1.

4.7.5.3. Treatment Plan Components: Initial Course of ABA Therapy

For the initial course of ABA therapy, the individual treatment plan developed by a licensed or certified behavior analyst must include all the following:

- The identified behavioral, psychological, family, and medical concerns
- Measurable short-term, intermediate, and long-term goals that are based on standardized assessments relative to age-expected norms and that address the behaviors and impairments for which the intervention is to be applied. Note: The goals should include baseline measurements, progress to date, and an anticipated time line for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention
- Plans for parent/guardian training and school transition
- Documentation that ABA services will be delivered by an appropriate provider. See Section 4.7.2. for Medicaid-covered ABA therapy service provider qualifications.

4.7.5.4. Treatment Plan Components: Continued Course of ABA Therapy

For each continued course of ABA therapy, the individual treatment plan developed by a licensed or certified behavior analyst must include age- and impairment-

appropriate goals and measures of progress in social skills, communication skills, language skills, and adaptive functioning.

4.7.5.5. Reimbursement Limitations

Medicaid does not reimburse separately for developing or reviewing a student's individual treatment plan.

4.7.6. AUDIT REQUIREMENTS

4.7.6.1. Student Records

School corporations must maintain documentation of Medicaid services provided to each Medicaid-enrolled student. Services billed to Medicaid must be referenced in the Medicaid-eligible student's IEP or IFSP. Each Medicaid-eligible student's records must meet the general documentation requirements specified in Chapter 2, Section 7 of this Tool Kit and include, but are not limited to, the following:

1. A current and valid treatment plan that meets applicable requirements described in Section 4.7.3. and 4.7.5.;

2. Test results and evaluation reports; and

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

4.7.6.2. Documentation Components

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

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

***** All documentation must be signed, titled and dated by the provider of service at the time services are rendered. Late entries must be noted accordingly. **Documentation of required supervision (signature of supervising provider, title and date) must also be maintained, if applicable.** Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation requirements above.

Note: Indiana Health Coverage Programs offers free online training on Medicaid Behavioral Health and ABA Documentation Guidelines at http://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_flash.html

CHAPTER 5: TELEMEDICINE SERVICES

MEDICAID RULES AND REGULATIONS: 405 IAC 5-2-28; 12-15-5-11; IC 12-15-21-2; IC 12-15-21-3; IC 25-1-9.5-6; 42 CFR 440.60(a); 42 CFR 440.80

5.1. SERVICE DEFINITION

5.1.1. Service Description

The definition of Telemedicine is set forth in IC 25-1-9.5-6 as follows:

Sec. 6. (a) As used in this chapter, "telemedicine" means the delivery of health care services using electronic communications and information technology, including:

(1) secure videoconferencing;
(2) interactive audio-using store and forward technology; or
(3) remote patient monitoring technology;

between a provider in one (1) location and a patient in another location.

(b) The term does not include the use of the following:

(1) Audio-only communication.
(2) A telephone call.
(3) Electronic mail.
(4) An instant messaging conversation.
(5) Facsimile.
(6) Internet questionnaire.
(7) Telephone consultation.
(8) Internet consultation.

The Indiana Health Coverage Programs Provider Reference Module and bulletins on Telemedicine Services include the following additional information and service description details:

Telemedicine services are defined as the use of videoconferencing equipment to allow a medical provider to render a service to a patient at a distant location. Medicaid covers telemedicine services, including medical exams and certain other services normally covered by Medicaid, within the parameters specified in Indiana Administrative Code 405 IAC 5-38. Note: Medicaid-covered services delivered as telemedicine services are subject to the same coverage limitations and restrictions as they would be if not delivered by telemedicine.

Note: Telemedicine is <u>not</u> the use of the following:

- Telephone transmitter for transtelephonic monitoring
- Telephone or any other means of communication for consultation from one provider to another

In any telemedicine encounter, services may be rendered in an inpatient, outpatient, or office setting, and there will be the following:

(1) A distance site.
(2) An originating site.
(3) An attendant to connect the patient to the provider at the distance site.

(4) A computer or television monitor to allow the patient to have:
(A) real-time;
(B) interactive; and
(C) face-to-face;
communication with the distance site provider via IATV technology.

See *Medicaid Billing Tool Kit* Section 5.2.1. regarding services for which Medicaid will *not* reimburse when delivered as a telemedicine service.

See further coverage criteria, limitations and restrictions that are applicable per type of service in each of the service-specific chapters of this Tool Kit and in the applicable Medicaid rules for those types of service. Copies of Medicaid rules are included in Appendix C; please check "Article 5. Medicaid Services" at the following web site for the most current versions of each: http://www.in.gov/legislative/iac/iac_title?iact=405).

5.2. PROVIDER QUALIFICATIONS

5.2.1. Provider Qualifications

The types of IEP-required services that Medicaid covers when delivered as a telemedicine service (all but those listed below) are subject to the same provider qualifications as when the service is delivered in person (i.e., as when the service is not delivered as a telemedicine service). See Section 2: Provider Qualifications in each of the service-specific chapters of this Tool Kit for the licensure and credentialing criteria required to be a Medicaid-qualified provider of that service type.

Medicaid reimbursement for telemedicine services is not available for the following provider types and services (bold font added for emphasis, see below):
(A) Ambulatory surgical centers.
(B) Outpatient surgical services.
(C) Home health agencies or services.
(D) Radiological services.
(E) Laboratory services.
(F) Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
(G) Anesthesia services or nurse anesthetist services.
(H) **Audiological services**.
(I) Chiropractic services.
(J) Care coordination services with the member not present.
(K) Durable medical equipment (DME) and home medical equipment (HME) providers.
(L) Optical or optometric services.
(M) Podiatric services.
(N) **Physical therapy services**.
(O) **Transportation services**.
(P) Services provided under a Medicaid home and community-based waiver.
(Q) Provider to provider consultations.

5.3 REIMBURSEMENT LIMITATIONS

5.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6.

For purposes of Medicaid's coverage and reimbursement of telemedicine services, the following definitions apply:

- "Distant site" means a site at which a provider is located while providing health care services through telemedicine.
- "Interactive television" or "IATV" means the videoconferencing equipment at the distant and originating site that allows real time, face-to-face consultation.
- "Originating site" means any site at which a patient is located at the time health care services through telemedicine are provided to the individual.

Limitations on Medicaid reimbursement for telemedicine services include the following conditions:

The student receiving the IEP-required service delivered via telemedicine must:

- be physically present at the originating site; and
- participate in the visit.

The practitioner who will be evaluating or treating the patient from the distant site must determine if it is medically necessary for a medical professional to be at the originating site. Separate reimbursement for a provider at the originating site is payable only if that provider's presence is medically necessary*****. Adequate documentation must be maintained in the medical record to support the need for the provider's presence at the originating site during the visit. Such documentation is subject to postpayment review. If a health care provider's presence at the originating site is medically necessary, billing of the appropriate evaluation and management code is permitted.

See Provider Bulletin #201807 in Appendix C for additional limitations regarding prescription of opioids via telemedicine.

*****Note: **School corporations billing Medicaid for telemedicine services must have written protocols for circumstances when the patient/student requires a hands-on visit with the consulting provider.**

Note also: Store and forward technology is not reimbursable by Medicaid. "Store and forward" means the transmission of a patient's medical information from an originating site to the provider at a distant site without the patient being present for subsequent review by a health care provider at the distant site. Medicaid's restrictions on reimbursement for store and forward technology does not disallow the permissible use of store and forward technology to facilitate provision of Medicaid reimbursable services.

5.4 AUDIT REQUIREMENTS

5.4.1. Student Records

School corporations are required to maintain a record for each Medicaid-eligible student that includes documentation of Medicaid reimbursable IEP services delivered as telemedicine services. IEP-required evaluation and treatment services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or IFSP. It is not necessary for the IEP to specify whether the service will be delivered as a telemedicine service or not.

Each Medicaid-eligible student's records must include the general documentation requirements specified in Chapter 2, Section 7 of this Tool Kit and in the service-specific chapter applicable for the type of IEP service provided (for example, Chapter 8 discusses IEP-required Nursing Services). Additionally, see Chapter 10 for service-specific checklists of the types of documentation typically requested for program review and audit purposes.

5.4.2. Telemedicine Documentation Standards

Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate that the services were rendered via telemedicine and must clearly identify the location of the hub and spoke sites.

Note: School corporations billing Medicaid for IEP-required telemedicine services must have written protocols for circumstances when the patient/student requires a hands-on visit with the consulting provider.

See also: *Medicaid Billing Tool Kit* Page 2-5-4 and Provider Bulletin #201807 in Appendix C concerning the Place of Service ("POS") code to be entered on fee-for-service Medicaid claims for telemedicine services.

All other Medicaid documentation guidelines apply for services rendered via telemedicine, such as chart notes and start and stop times. Documentation must be available for postpayment review for up to seven (7) years from the date of service.

CHAPTER 6: RESERVED

This page is intentionally left blank.

CHAPTER 7: BEHAVIORAL HEALTH SERVICES

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

7.1. SERVICE DEFINITION

7.1.1. Service Description

1. Psychological/Psychiatric Services

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

2. Behavioral Health Services

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

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

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

7.2. PROVIDER QUALIFICATIONS

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

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

Medicaid Provider Qualifications for Psychological Testing Services

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

"*Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:*
(A) A physician.
(B) An HSPP.
(C) A practitioner listed … [in A through C(ii) below].
The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a master's degree in a mental health field and one (1) of the following:
(i) A certified specialist in psychometry (CSP).
(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

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

The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed … [in A through C(ii) above]"

Medicaid Provider Qualifications for Psychotherapy Services

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

1. A licensed psychologist.

2. A licensed independent practice school psychologist. (See Appendix C.)

3. A licensed clinical social worker.

4. A licensed marital and family therapist.

5. A licensed mental health counselor.

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

7. An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

Providers must meet all applicable state and federal laws governing licensure and practice standards as well as Medicaid provider qualifications in 405 IAC 1 and 405 IAC 5. Click "legislative" branch at www.in.gov for current versions of state laws and rules. See also: Appendix C of this Tool Kit.

7.2.2. Supervision, Plan of Care and Plan of Care Review

The responsibilities of the physician or HSPP in supervising and directing mid-level practitioners include certifying the diagnosis and supervising the plan of treatment or plan of care (see also: Section 2.5.7.) as follows:

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

2. At least every ninety (90) days after the intake process, the physician or HSPP must again see the student or review the student's medical information and certify medical necessity on the basis of medical information provided by the mid-level practitioner. The review must be documented in writing. See also Tool Kit Section 7.4.2.

School corporations are encouraged to coordinate with the student's physician to facilitate continuity of care. **School corporations must obtain a signed authorization from parents/guardians prior to releasing the progress notes and plan of care to the student's physician.**

7.3. REIMBURSEMENT LIMITATIONS

7.3.1. Limitations – see also: Sections 2.5.3. through 2.5.6.

7.3.2. Diagnostic Interview Examinations

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

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

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

Please note: Medicaid reimbursement for specific procedure codes varies based on the licensure and credentials of the individual performing the service. See Table 1, Page *E3* in Appendix E for specific examples of billing codes and modifiers; some may be billed only for services performed by a physician or Health Service Provider in Psychology (HSPP) and others may be billed for services provided by Medicaid-qualified "mid-level" practitioners under the supervision of a physician or HSPP.

To be eligible for Medicaid reimbursement, testing pursuant to a student's IEP must evaluate the student's health-related educational needs. Psychological or neuropsychological testing to evaluate a strictly educational need, for example testing to identify a suspected Learning Disability, is not considered medical in nature and therefore cannot be billed to Medicaid.

7.3.3. Group therapy

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

7.3.4. Hypnosis and Biofeedback

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

7.4 SERVICE REQUIREMENTS

7.4.1. General Service Requirements

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

7.4.2. Physician/HSPP Involvement and Sign Off

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

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

The physician or HSPP must sign and date the documentation within the required time frames before claims for behavioral services rendered by qualified mid-level practitioners can be billed to Medicaid. Note: A physician/HSPP's order is needed at least annually, before initiation of service (see Tool Kit Section 2.8.1.b.). If the student's medical condition requiring the therapy changes significantly enough to require a substantive change in services, a new physician's order is required.

Please see Appendix F for a sample form template that can be adapted for local district use to document physician/HSPP sign off for evaluation and treatment services provided by a qualified "mid-level practitioner" as defined in Medicaid's rule at 405 IAC 5-20-8 (copy in Tool Kit Appendix C). See also Tool Kit Section 2.8.1.

7.5. INDIVIDUAL BEHAVIORAL HEALTH SERVICES

7.5.1. Individual Behavioral Health Sessions

Individual behavioral health sessions as defined in this Chapter may be billed to Medicaid when a school corporation's Medicaid-qualified provider renders an individualized service to one Medicaid-eligible student.

7.5.2. Service Limitations

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

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

7.5.3. Service Reimbursement Limitations

The Common Procedural Terminology © or "CPT" procedure codes used to bill Medicaid services specify the basis for reimbursement of each service. Some billing codes are paid based on the amount of time spent with the patient and others are paid one rate per service per day.

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

7.6. GROUP BEHAVIORAL HEALTH SERVICES

7.6.1. Group Behavioral Health Sessions

Group behavioral health services as defined in this Chapter may be billed to Medicaid when a school corporation's Medicaid-qualified provider renders service(s) to a group of students. Note: Services are billed only for IEP-required services provided to students in the group who are Medicaid-enrolled.

7.6.2. Service Requirements

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

The group size is defined as a minimum of two (2) students. *It is not a requirement for all students in the group session to be Medicaid-enrolled.*

7.6.3. Service Reimbursement Limitations

The Common Procedural Terminology © or "CPT" procedure codes used to bill Medicaid services specify the basis for reimbursement of each service. Some billing codes are paid based on the amount of time spent with the patient and others are paid one rate per service per day.

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

7.7 AUDIT REQUIREMENTS

7.7.1. Student Records

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

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

1. Test and assessment results.

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

7.7.2 Diagnosis Code

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

7.7.3. Documentation Components

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

1. Student's name.

2. Date of service.

3. Description of therapy or counseling session.

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

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

6. Signature of service provider, title and date.

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

Note: Indiana Health Coverage Programs offers a free online training on Behavioral Health and ABA Documentation Guidelines and best practices at http://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_flash.html

CHAPTER 8: NURSING SERVICES

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

8.1. SERVICE DEFINITION

8.1.1. Service Description

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

To be covered by Medicaid, IEP nursing services must be performed by a licensed Registered Nurse (R.N.). See Provider Qualifications, 8.2.1.

8.1.2. Service Limitations

Medicaid reimbursement for IEP nursing services is limited to services provided by a licensed Registered Nurse (R.N.) who is employed or contracted with a Medicaid-participating school corporation. Services must be medically necessary, provided pursuant to a Medicaid-enrolled student's IEP and provided in a school setting, including a field trip location and on a school bus or other school-owned vehicle as required by the IEP. For additional details see the Indiana Medicaid agency's policy bulletin on IEP Nursing and Transportation Services, BT201108 as well as Medicaid's rule and annotated billing guidelines for Diabetes Self Management Training (DSMT) services at Appendix C of this Tool Kit.

8.1.3. Physician Order

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

8.2. PROVIDER QUALIFICATIONS

8.2.1. Qualifications – see also: Section 2.3.4.

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

Registered Nurses providing IEP Nursing Services must meet all applicable state and federal laws governing licensure and practice standards as well as Medicaid provider qualifications set out in 405 IAC 5-22-2.

8.3. REIMBURSEMENT LIMITATIONS

8.3.1. Limitations

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

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

2. Documentation of IEP nursing services must include the appropriate start and stop times for each patient encounter on the date of service. Documentation of IEP nursing services provided off-site or during a school field trip must note the place of service, and for field trips, must include the beginning and ending dates and times of the field trip. See also Tool Kit Section 2.5.9. regarding Place of Service Codes.

3. When billing all IEP nursing services except for diabetes self-care management training (DSMT), school corporations must use the Current Procedural Terminology (CPT) ® code 99600 TD TM, which is an all inclusive code for services performed in accordance with the licensed R.N.'s scope of practice, including but not limited to oral or rectal medication administration and nebulizer treatment administration. See Tool Kit Appendix F for examples of IEP nursing services that may be billed to Medicaid. See Appendix C for copies of Indiana Medicaid's DSMT coverage rule and annotated Medicaid Provider Reference Modules excerpt regarding DSMT billing guidelines.

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

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

Review the IEP Nursing Services-related information contained in the Indiana Medicaid agency provider bulletin #BT201108. A copy of this bulletin is available in Tool Kit Appendix C. This and other publications intended for Indiana Medicaid service providers are available online by clicking Bulletins or Banners at https://www.in.gov/medicaid/providers/index.html.

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

8.4.1. Plan of Care Requirement

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

8.4.2. Plan of Care Components

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

1. The student's name.

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

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

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

8.4.3. Plan of Care Review

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

School corporations are encouraged to coordinate with the student's physician to facilitate continuity of care. **To share copies of the plan of care or progress notes, school corporations must obtain a signed authorization from parents/guardians prior to release.**

8.5. AUDIT REQUIREMENTS

8.5.1. Student Records

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

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

1. A current and valid plan of care.

2. Test results and evaluation reports.

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

8.5.2. Documentation Components

Documentation of each nursing service must include the following information:

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

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

3. Description and duration of procedures performed.

4. Progress notes.

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

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

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

CHAPTER 9: SPECIAL EDUCATION TRANSPORTATION SERVICES

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

9.1. SERVICE DEFINITION

9.1.1. Service Description

Indiana Medicaid-covered Special Education Transportation Services are IEP- required services provided by a school corporation which involve a trip (1) between home and school, or (2) between school or home and an off-site Medicaid service provider, on a day when the student receives another Medicaid-covered IEP/IFSP service. Medicaid-reimbursed Special Education Transportation must be furnished by the school corporation's employee or contractor. To qualify for reimbursement, special education transportation services must meet a health-related, including behavioral, need that is documented in the student's IEP.* Additional payment is available for an attendant, subject to the limitations in 405 IAC 5-30-8(1) and (2), provided the student's IEP includes the need for an attendant and all other Medicaid requirements are met.

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

9.1.2. Service Limitations

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

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

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

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

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

9.2. PROVIDER QUALIFICATIONS

9.2.1. Qualifications – see also: Section 2.3.4.

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

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

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

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

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

9.3. REIMBURSEMENT LIMITATIONS

9.3.1. Limitations

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

Reimbursement for special education transportation services is subject to the requirements set forth in 405 IAC 5-30-1, the Medicaid provider agreement, and guidelines set forth in Indiana Health Coverage Programs (IHCP) provider reference modules, banner messages, and provider bulletins (see applicable sections of *BT200505*, http://provider.indianamedicaid.com/ihcp/Bulletins/BT200505.pdf). School corporations must follow all Transportation billing guidelines set out in BT200505, ***except*** *those noted in BT 201108, which are specific to IEP Transportation Services provided by Medicaid-participating school corporations* (see the IEP Transportation Services-related sections of BT201108, recopied at Appendix C). Trips must be billed according to the level of service rendered and not according to the vehicle type. Medicaid defines a trip as transporting the Medicaid member from the initial point of pick-up to the drop-off point at the final destination. The Medicaid-enrolled student being transported must be present in the vehicle for the service to be reimbursed. All Medicaid transportation providers are expected to transport individuals using the shortest, most efficient routes. All IEP transportation services provided to the same individual on the same date of service must be billed on one claim.

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

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

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

9.4. AUDIT REQUIREMENTS

9.4.1. Documentation Components

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

1. Student's name.

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

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

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

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

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

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

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

9. The driver's printed name and signature.

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

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

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

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

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

9.4.2. Trip Log

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

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

Note: See Tool Kit Appendix F for sample trip log forms to adapt for local district use.

Note also: Per the IHCP Provider Reference Modules, mileage is rounded to the nearest whole unit as follows:
"***Mileage Units and Rounding***
Providers must bill the IHCP for whole units only. For partial mileage units, round to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles."

Note also: Medicaid reimburses for second and subsequent passengers transported in a single vehicle at half the base rate for the type of transportation provided. See details regarding transportation of multiple passengers and an escort/attendant accompanying the passenger(s) in Medicaid Provider Bulletin BT200505 (Appendix C) and IHCP Provider Reference Modules.

CHAPTER 10: MONITORING MEDICAID PROGRAM COMPLIANCE

10.1. AUDITS: EXTERNAL AND INTERNAL

To guard against fraud and verify proper use of public funds, various entities audit Medicaid program expenditures. These include federal agencies within the U.S. Department of Health and Human Services, such as the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) or their contractors (e.g., "MIC" Medicaid Integrity Contractors), as well as state agencies, including the State Board of Accounts, the State Inspector General, and the state Medicaid agency (Office of Medicaid Policy and Planning, "OMPP") or its contractors. See also *Medicaid Billing Guidebook* Section 9.4.

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

Via desk reviews and on-site audits, Indiana Medicaid's Surveillance and Utilization Review (SUR) contractor monitors compliance with billing requirements, provides education to correct any improper coding or billing practices, and recovers any identified Medicaid overpayments. Outlined below are the basic elements that are reviewed when SUR conducts an audit. Indiana Medicaid and the Department of Education recommend using this basic information to develop or strengthen a self-audit process. Self-auditing is one way to reduce the risk of adverse findings and repayments/interest penalties in the event that your school corporation is selected for a state or federal audit.

See also: Provider and Member Utilization Review under IHCP Provider Reference Modules https://www.in.gov/medicaid/providers/810.htm and free, online Program Integrity Provider Education Training at https://www.in.gov/medicaid/providers/832.htm.

10.1.1. Required Documentation

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

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

See the service-specific self-audit tools at the end of this chapter.

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

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

10.1.2. Focusing the Self-Audit Process

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

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

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

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

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

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

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

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

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

See the service-specific self-audit tools at the end of this chapter.

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

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

10.1.3. Pulling an Internal Audit Sample

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

10.1.4. What to Expect if Selected for External Audit

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

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

The following narrative shares some insights gained from the Medicaid audit experience of a large urban Indiana school corporation.

Lessons Learned from a Medicaid Audit

Larry Bass, Director, Evansville-Vanderburgh Special Education

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

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

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

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

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

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

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

Pages 10-1-5 through 10-1-22 contain samples of service-specific documentation checklists and internal audit guidelines that can be adapted for use in self-auditing and internal program compliance monitoring by Medicaid-participating school corporations.

Medicaid Documentation Checklist for IEP Hearing Services

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

Medical necessity and service authorization:

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

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

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

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

Direct medical service provision to a Special Education student:

□ Student's name and date of birth.

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

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

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

□ File copy of service providers' signature and initials.

Financial/accounting records:

□ Copies of claims submitted to Medicaid.**

□ Copies of Medicaid Remittance Advice statements.**

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Documentation Checklist for
IEP Behavioral/Mental Health Services

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

Medical necessity and service authorization:

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

Direct medical service provision to a Special Education student:

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

Note: Indiana Health Coverage Programs offers a free online training on Behavioral Health and ABA Documentation Guidelines and best practices at
http://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_flash.html

Financial/accounting records:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical necessity and service authorization:

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

Direct medical service provision to a Special Education student:

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

Financial/accounting records:

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Documentation Checklist for
IEP Occupational Therapy Services

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

Medical necessity and service authorization:

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

Direct medical service provision to a Special Education student:

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

Financial/accounting records:

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Documentation Checklist for
IEP Physical Therapy Services

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

Medical necessity and service authorization:

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

Direct medical service provision to a Special Education student:

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

Financial/accounting records:

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Documentation Checklist for IEP Speech Therapy Services

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

Medical necessity and service authorization:

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

Direct medical service provision to a Special Education student:

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

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

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

Financial/accounting records:

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Documentation Checklist for
IEP Applied Behavior Analysis (ABA) Therapy Services

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

Medical necessity and service authorization:

□ A copy of the comprehensive diagnostic evaluation* performed by a qualified provider, which must include the required recommended treatment referral for ABA therapy specifying the projected length of treatment *(*see Chapter 4, Section 1.7.1.3. on referrals and 1.7.4. on evaluations).*
□ A copy of the signed parental consent for Medicaid billing.
□ Copies of all IEPs valid during each school year in which Medicaid services were provided/billed. NOTE: evals/reevals that meet Medicaid requirements *(see Chapter 4, Section 1.7.4.)*, as well as frequency, duration & scope of all treatment services must be documented/authorized in the IEP(s) or in an IHP incorporated into an IEP by reference.
□ Evidence of medical assessment by a qualified direct service provider, progress notes, treatment plans that meet applicable requirements *(see Chapter 4, Section 1.7.5.)*, original signed and dated service logs (must include date and time of service, duration of service in minutes, service description & outcome/response/progress, signature and title/credentials of service provider & supervisor's signature for service providers requiring direct supervision by a qualified provider); *if applicable, maintain a key to explain abbreviations/codes used by individual practitioners in required documentation*

Direct medical service provision to a Special Education student:

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

- *Health Service Provider in Psychology (HSPP)*
- *Licensed or board-certified behavior analyst, including bachelor-level (BCaBA)*, master-level (BCBA), and doctoral-level (BCBA-D) behavior analysts*
- *a credentialed registered behavior technician*

* *See Chapter 4, Section 1.7.2. for provider qualifications for initial diagnosis and diagnostic evaluation*

□ File copy of service providers' signatures and initials.

Note: Indiana Health Coverage Programs offers a free online training on Behavioral Health and ABA Documentation Guidelines and best practices at
http://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_flash.html

Financial/accounting records:

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

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

Internal Audit Guidelines
Medicaid-reimbursed **Applied Behavior Analysis (ABA) Therapy** Services

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

2) If the procedure code billed was based on time spent providing service to the student, is the billed time verified in the student records? If not, is there additional documentation (e.g., service logs or provider notes) available to verify the time spent? If service was provided by a BCaBA or credentialed RBT, was it billed with the correct modifier(s), and required supervision documented? *Educate staff on supporting documentation for timed procedure codes and mid-level practitioners' service provision.*

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

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

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

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

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

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

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

Medicaid Documentation for
Medicaid-reimbursed Telemedicine Services

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

For services that Medicaid reimburses as telemedicine services, all other Medicaid documentation guidelines apply for each type of IEP service rendered via telemedicine. These include chart notes, start and stop times, written referrals, etc. For more information see Page 2-5-4 of the *Medicaid Billing Tool Kit*, the applicable Medicaid rules per service type (copies in Appendix C and information on how to view the most current rule version online), the applicable service-specific chapters of the *Medicaid Billing Tool Kit*, and the service specific self-audit documentation checklists in this chapter (10) of the *Medicaid Billing Tool Kit*.

In addition to all other service-specific documentation:

- Documentation must be maintained at the hub and spoke locations to substantiate the services provided.

- Documentation must indicate that the services were rendered via telemedicine and must clearly identify the location of the hub and spoke sites.

Important note: **School corporations billing Medicaid for IEP-required telemedicine services must have written protocols for circumstances when the patient/student requires a hands-on visit with the consulting provider.**

Also note: in additional to all other applicable CPT code modifiers, claims for IEP services delivered as telemedicine services must include the telemedicine Place of Service ("POS") code. See *Medicaid Billing Tool Kit* Page 2-5-4 as well as the relevant IHCP Provider Bulletin (#201807) in Appendix C.

Medicaid Documentation Checklist for
IEP-required Special Education Transportation Services

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

Medical necessity and service authorization:

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

Special Education Transportation service provision to a Special Education student:

□ Student's name and date of birth.
□ *Student's Medicaid ID number was added to trip log after the log was turned in by driver*.
□ Copy of date-of-service-specific transportation documentation/trip log.
□ Attendance records for student and providers of school-based transportation and other Medicaid- covered IEP services.
□ Copy of service providers' license(s)/certification(s) at time of service provision: *Medicaid-reimbursed Special Education transportation services must be rendered by the school corporation's employee or contractor who meets the standards for driver personnel. In addition to holding a commercial driver's license, school bus drivers must comply with State safety experience, education, and certification requirements, per IC 20-27-8-10 and 20-27-8-15. School corporations must comply with State statutory requirements at IC 9-25 with regard to public liability and property damage insurance covering the operation of school bus equipment. Vehicles used for Medicaid transportation services must comply with the applicable school bus standards outlined in 575 IAC Rules 1 and 5, including Rule 5.5 applicable to vehicles ordered for purchase and initially placed in service on or after July 1, 1990.*
□ File copy of transportation service providers' signature and initials.

Financial/accounting records:

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

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

Internal Audit Guidelines
Medicaid-reimbursed Special Education **Transportation** Services

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

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

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

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

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

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

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

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

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

10.2. HIPAA AND FERPA

10.2.1. HIPAA Electronic Transmissions and Claims Transactions

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

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

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

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

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

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909001.html

10.2.2. HIPAA versus FERPA Privacy Protections and Student Health Records

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

improperly. Similarly, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health care providers to safeguard individually identifiable "Protected Health Information." Both federal laws are clearly intended to protect individuals' private health records from improper disclosure. As indicated in Section 9.2.1. above, Medicaid-participating public schools must comply with the HIPAA security rule when engaging in *electronic* health care transactions (for example, electronic data transactions to submit claims or verify eligibility/coverage), however, FERPA, not HIPAA, privacy requirements apply to non-electronically transmitted student education records, including Special Education records, for purposes of disclosing individually identifiable information. *(See also: Tool Kit Appendix G.)*

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

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

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

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

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

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

10.3. FALSE CLAIMS ACT

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

10.3.1. Employee Education about False Claims Recovery

Section 6032 of the Deficit Reduction Act (DRA) of 2005 established section 1902(a)(68) of the Social Security Act, which relates to "Employee Education About False Claims Recovery." Beginning January 1, 2007, a governmental component providing health care items and services for which Medicaid payments are made (e.g., a school corporation) qualifies as an "entity" and must comply with the requirements of section 1902(a)(68) **if its annual Medicaid payments total at least $5,000,000 in any given federal fiscal year** (October 1 through September 30). Please refer to the Indiana Health Coverage Programs (IHCP) provider bulletin #BT200729 on this topic, as well as item #43 in the School Corporation Medicaid Provider Agreement https://www.in.gov/medicaid/files/ihcp%20school%20corporation%20provider%20enrollment%20and%20maintenance%20form.pdf.

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

10.3.2. Federal and State False Claims Acts

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

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

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

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

Indiana enacted a **State Medicaid False Claims and Whistleblower Protection statute** [IC 5-11-5.7], which applies only to claims, requests, demands, statements, records, acts, and omissions made or submitted in relation to the Medicaid program. This statute is separate from the more general State False Claims and Whistleblower Protection Act [IC 5-11-5.5]. Indiana's Medicaid False Claims and Whistleblower Protection statute (see Appendix C) includes definitions, penalties and protections similar to those in the federal False Claims Act. To view a copy of this state statute online, go to http://www.in.gov/legislative/ic/code/title5/ar11/ch5.7.pdf.

For more information on False Claims and Whistleblower Protections visit the Indiana Attorney General's web site at http://www.in.gov/attorneygeneral/2807.htm. To report Medicaid Fraud committed by a Medicaid provider, complete the online form at https://indianaattorneygeneral.secure.force.com/MedicaidFraudComplaints/.

10.3.3. Typical False Claims Act-related Policies

As stated in Section 9.3.1. above, school corporations that receive $5,000,000 in total annual Medicaid reimbursements are obligated, under Section 6032 of the Deficit Reduction Act (DRA) of 2005, to establish and disseminate to all employees, contractors and agents (who are involved in providing, monitoring, coding or billing health care

services) written policies concerning detecting and preventing waste, fraud and abuse. The $5,000,000 threshold is determined by the total state and federal share of Medicaid reimbursement amounts paid to your school corporation in a federal fiscal year (October 1 through September 30). These written policies may be in paper or electronic form, and they must be (1) readily available to all employees, contractors and agents to whom you are obligated to disseminate such policies, and (2) included in any existing employee handbook (you need not create an employee handbook if one does not exist).

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

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

improvements in internal procedures and safeguards, and/or referral to federal and state agencies or law enforcement officials;

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

APPENDIX A
INDIANA MEDICAID PROVIDER ENROLLMENT

Medicaid Provider APPLICATION/AGREEMENT FORM Excerpt

Access the entire form and completion instructions online at
http://provider.indianamedicaid.com/become-a-provider/complete-an-ihcp-provider-packet/12---school-corporation.aspx

| 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.
☐ **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:	

Medicaid Provider APPLICATION/AGREEMENT FORM Excerpt

| Provider Agreement

IHCP Provider Agreement | indianamedicaid.com

This agreement must be completed, signed, and returned to Hewlett Packard Enterprise for processing.

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

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the Indiana Health Coverage Programs, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify FSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To provide covered services and/or supplies for which federal financial participation is available for Indiana Health Coverage Program members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Indiana Health Coverage Program members including at a minimum:
   a. members' name, address, and social and economic circumstances;
   b. medical services provided to members;
   c. members' medical data, including diagnosis and past history of disease or disability;
   d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   e. any information received in connection with the identification of legally liable third party resources.
7. To release information about Indiana Health Coverage Program members only to the FSSA or its agent and only when in connection with:
   a. providing services for members; and
   b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Indiana Health Coverage Program covered services.
8. To maintain a written contract with all subcontractors, which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
9. To notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30-days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
10. To submit claims, using only the billing number assigned to it by FSSA or its fiscal agent, for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Indiana Health Coverage Program covered services rendered pursuant to this Agreement.
11. To abide by the *Indiana Health Coverage Programs Provider Manual*, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon publication to the official state Medicaid website.

Federal Register Excerpt Regarding the Managing Employee SSN Requirement

5906 Federal Register / Vol. 76, No. 22 / Wednesday, February 2, 2011 / Rules and Regulations

as a way to minimize the administrative burden of enrolling additional providers, State Medicaid agencies may implement a streamlined enrollment process for those providers who only order or refer, that is who do not bill for services, similar to the CMS–855–O process in the Medicare program. *Comment:* A commenter questioned whether a provider that has enrolled as a participating provider to comply with § 455.410(b) must submit fee-for-service claims to the Medicaid agency, or is the provider's status as an enrolled provider sufficient for compliance. *Response:* Under § 455.410(b), a physician or other professional need not submit fee-for-service claims to the State Medicaid agency to remain enrolled as a Medicaid provider. *Comment:* With respect to § 455.440, one State asked whether the provider's NPI must be on each and every claim or whether it is sufficient for the provider's NPI to be on file with the State Medicaid agency, and whether the prescribing provider's NPI would be required on pharmacy claims. *Response:* Under § 455.440, "all claims for payment for items and services that were ordered or referred" must contain the NPI. This is based upon the statutory requirement in section 1902(kk)(7)(B) of the Act that States require the NPI "of any ordering and referring physician or other professional to be specified on any claim for payment that is based upon an order or referral of the physician or other professional." Therefore, the provider's NPI must be on every claim, including pharmacy claims; it is not sufficient for the provider's NPI to be on file. g. Other State Screening—Medicaid and CHIP Section 1902(kk)(8) of the Act establishes that States are not limited in their abilities to engage in provider screening beyond those required by the Secretary. Accordingly, in § 455.452, we proposed that States may utilize additional screening methods, in accordance with their approved State plan. As stated previously, pursuant to section 2107(e)(1) of the Act and specified in our regulations in Part 457, all provisions that apply to Medicaid under sections 1902(a)(77) and 1902(kk) of the Act apply to CHIP. Because we proposed a new regulation under which all provider screening requirements that apply to Medicaid providers will apply to providers that participate in CHIP, this requirement for other State screening under § 455.452 applies in CHIP.

h. Final Screening Provisions— Medicaid and CHIP We are adopting the Medicaid and CHIP provider screening requirements as proposed with the following modifications: • We clarified § 455.104(b)(1) regarding the elements of corporate addresses. • We clarified § 455.104(b)(2) with regard to whom the spouse, parent, child, or sibling is related. • We clarified § 455.104(b)(4) to require managing employees to provide SSNs and DOBs. • We clarified § 455.104(c)(1), and § 455.104(c)(1)(i) and (ii) to include submission of disclosures from disclosing entities as well as providers. • We clarified § 455.104(c)(1)(iii) to require submission of disclosures upon the request of the Medicaid agency during the revalidation of enrollment process.• We are adopting § 455.450 with modifications, having clarified that the State agency must screen applications both in re-enrollment and re-validation of enrollment in the introductory paragraph; deleted the reference to publicly traded companies in § 455.450(a); deleted reference to persons with controlling interests, agents and managing employees who are required to provide fingerprints in § 455.450(d); and clarified the basis for adjusting a screening level related to moratoria § 455.450(e)(2). • At § 455.414 we clarified that States must revalidate the enrollment information of all providers at least every 5 years. • We are adopting § 455.416 with modifications clarifying terminations of persons with 5 percent of more direct or indirect ownership interests in the provider; and deleting reference to persons with controlling interests, agents and managing employees under bases for termination for failure to provide fingerprints.• We clarified § 455.434 to require criminal background checks from providers or persons with a five percent or more direct or indirect ownership interest in the provider who meet the State Medicaid agency's criteria as a high risk to the Medicaid program; and to require fingerprints from providers and person with a five percent or more direct or indirect ownership interest in the provider, upon the State Medicaid agency's or CMS' request. • We are not finalizing the proposed provision that States deactivate the enrollment of any provider that has not billed for 12 months. • And finally, we are not finalizing the proposed requirement at § 438.6(c)(5)(vi) that required all ordering and referring Medicaid Managed Care network providers to be enrolled as participating providers based on commenters' concerns regarding access to services for beneficiaries. 5. Solicitation of Additional Comments Regarding the Implementation of the Fingerprinting Requirements While this final rule with comment period is effective on the date indicated herein, we strongly believe that certain issues warrant further discussion. Accordingly, we will continue to seek comment limited to our implementation of the fingerprinting provisions contained in § 424.518 and § 455.434 of this rule. Specifically, we seek comment on methods that we can use to ensure the privacy and confidentiality of the records that will be generated pursuant to adopting the criminal history records check provisions specified herein. As described, we will adopt all protocols issued by the FBI. However, we are interested in any other privacy concerns that interested parties may have in addition to thoughts on how best to address these concerns. In addition, we seek comment on the means by which we can measure the effectiveness of our adoption of criminal history records checks. That is, we are seeking comments on tangible, measureable methods we should use to demonstrate the effectiveness of these provisions. In addition, we seek comment on whether we should adopt additional technology to identify providers and suppliers that are enrolling in the program. In the proposed rule, we solicited specific comments on this topic. However, we are interested in receiving additional input from providers, suppliers, and other interested parties in light of the provisions set forth in this final rule with comment period. As noted, we are only seeking comment on the limited areas previously described. We will accept public comment for 60 days following publication of this final rule with comment period. To reiterate, we are finalizing the requirement that providers and suppliers will be subject to criminal history records checks in the event they are considered within the "high" level of risk as described in this rule. Providers and suppliers, and all other commenters, are encouraged to submit comments within the 60-day window to assist us in best implementing the requirements that we are finalizing surrounding this

APPENDIX B
MEDICAID COVERED IEP HEALTH RELATED SERVICES PROVIDER QUALIFICATIONS SUMMARY

Medicaid will reimburse for the services if provided by *school corporation employees or contracted staff* who meet the qualifications specified in the table below. In addition, school corporations must comply with applicable state licensure, certification or registration laws and rules as well as applicable federal Medicaid regulations requiring a written order from a physician or other appropriate practitioner of the healing arts.

State licensure or registration refers to licensure or registration by the state's Professional Licensing Agency or Department of Education, as appropriate/applicable. A school corporation can bill for Medicaid-covered IEP/IFSP health-related services provided to a Medicaid-eligible student by a practitioner who is appropriately licensed, registered and/or certified to practice in the State, meets all applicable Medicaid provider requirements and is providing services within his/her scope of practice.

Covered Service	Provider Qualifications	Legal Authority
Hearing	- Licensed audiologist who has ASHA certification or is completing/has completed 350 hours supervised clinical experience and has performed at least 9 months of full-time supervised audiology services after obtaining a master's or doctoral degree in audiology or related field and has successfully completed an approved national examination in audiology. - Licensed otolaryngologist. - A person registered for his clinical fellowship year under the direct supervision of a licensed, ASHA certified audiologist. - A registered hearing aid specialist (hearing aid evaluation only)	42 CFR 440.110 IC 25-35.6 405 IAC 5-22-7(a)
Physical Therapy	- Licensed physical therapist - Certified physical therapist assistant under the direct supervision of a licensed physical therapist.	42 CFR 440.110 IC 25-27 405 IAC 5-22-8 844 IAC 6
Speech-Language Pathology	- Licensed speech-language pathologist who (1) has ASHA certification or (2) has completed the academic program and is acquiring supervised work experience to qualify for ASHA certification or (3) has completed equivalent educational requirements and work experience necessary for ASHA certification. - Registered speech-language pathology support personnel may also provide services subject to 880 IAC 1-2.1 under the supervision of a certified, licensed speech-language pathologist.	42 CFR 440.110 IC 25-35.6 405 IAC 5-22-9 880 IAC 1-1-2 880 IAC 1-2.1
Occupational Therapy	- Licensed therapist. - Licensed therapy assistant under the supervision of the licensed therapist.	42 CFR 440.110 405 IAC 5-22-11 844 IAC 10
Applied Behavior Analysis (ABA) Therapy	- Licensed or board-certified behavior analyst, including: o bachelor-level behavior analyst (BCaBA) under the direct supervision of a BCBA, BCBA-D or HSPP o master-level behavior analyst (BCBA) o doctoral-level behavior analyst (BCBA-D) o credentialed registered behavior technician (RBT) under the direct supervision of a BCBA, BCBA-D or HSPP See also: *Chapter 4, Module 4.7, Section 4.7.2. for details on Medicaid-qualified provider criteria.*	42 CFR 440.40 405 IAC 5-22-12

Covered Service	Provider Qualifications	Legal Authority
Behavioral Health	- Licensed physician (M.D. or D.O.). - Health Service Provider in Psychology (HSPP). The following practitioners under the direction of a licensed physician or HSPP: - Licensed psychologist. - Licensed independent practice school psychologist. - Licensed clinical social worker. - Licensed marital and family therapist. - Licensed mental health counselor. - A person holding a master's degree in social work, marital and family therapy, or mental health counseling.	405 IAC 5-20-1 405 IAC 5-20-8(2) IC 20-28-12 IC 25-33-1-5.1 515 IAC 2-1
Nursing	- Licensed Registered Nurse	42 CFR 440.110 IC 25-23-1-1.1 IC 25-23-1-11 405 IAC 5-22-2 848 IAC 2-1-2 848 IAC 2-2-1 through 2-2-3
IEP Specialized Transportation	- In addition to holding a commercial driver's license, school bus drivers must comply with State safety experience, education, and certification requirements for drivers per IC 20-27-8. - School corporations must comply with statutory requirements at IC 9-25-4 with regard to public liability and property damage insurance covering the operation of school bus equipment. - Vehicles used for Medicaid transportation services must comply with applicable school bus standards outlined in 575 IAC Rules 1 and 5, including Rule 5.5 applicable to vehicles ordered for purchase and initially placed in service on or after July 1, 1990.	IC 20-27-8 405 IAC 5-30-11

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

Every effort is made to update Appendix C with the latest versions of Indiana laws, rules and policies relevant to Medicaid billing for health-related IEP-required services provided by public school corporations. **However, please note: law and rule changes may have occurred since this Tool Kit edition was released**; it is good practice to do periodic checks of the *Indiana Register*, http://www.in.gov/legislative/register/irtoc.htm, for any recent changes that may affect Medicaid service provision and billing for covered health-related IEP/IFSP services.

At Page *C4* is the Medicaid policy bulletin #E98-20 (Page C4) which recognizes the IEP/IFSP as the Prior Authorization for IEP/IFSP health-related services billed by school corporations. School corporations are exempt from other Medicaid Prior Authorization or Managed Care provider certification requirements when billing IEP services. To check for any recent Medicaid provider policy communications, visit http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx. Also see Appendix I for additional resources to help school corporations stay up to date on school-based Medicaid-claiming related policy and procedure changes.

Copies of documents included in Appendix C	Page #
IC 12-15-1-16 State Law Requiring School Corporations to Enroll in Medicaid	*C3*
Indiana Health Coverage Programs/IHCP School Corp Provider Bulletin #E98-20	*C4*
405 IAC 1-5-1 Medical records; contents and retention	*C6*
511 IAC 7-33-4 Indiana Special Education Rule, Medicaid Notices and Consent	*C8*
511 IAC 7-32-17 Indiana Special Education Rule, Definition of Consent	*C11*
405 IAC 5-22-5 Indiana Medicaid Reimbursement Rule for Outpatient Therapies	*C12*
405 IAC 5-22-6 Indiana Medicaid Prior Authorization Rule for Outpatient Therapies	*C13*
405 IAC 5-22-7 Indiana Medicaid Hearing Services Rule	*C15*
405 IAC 5-22-8 Indiana Medicaid Physical Therapy Services Rule	*C17*
IC 25-27 Physical Therapy and Physical Therapy Assistant Practice Act	*C18*
405 IAC 5-22-9 Indiana Medicaid Speech Pathology Services Rule	*C25*
880 IAC 1-2.1-1 Licensing Board Speech-language Pathology Support Personnel Rule	*C26*
405 IAC 5-22-11 Indiana Medicaid Occupational Therapy Services Rule	*C34*
IC 25-25.3 Occupational Therapy Practice Act	*C35*
844 IAC 10-5 and 844 IAC 10-6 OTA Training and Supervision Rules	*C37*
405 IAC 5-22-12 Indiana Medicaid Applied Behavior Analysis Therapy Rule	*C39*
IHCP Provider Bulletin #BT201606, Applied Behavior Analysis Therapy	*C41*
511 IAC 5-38 Indiana Medicaid Telemedicine Services Rule	*C45*
IHCP Provider Bulletin #BT2018-07 Telemedicine Services Policy	*C46*
405 IAC 5-20-1 Indiana Medicaid Mental Health Services Reimbursement Rule	*C48*
405 IAC 5-20-8 Indiana Medicaid Outpatient Mental Health Services Rule	*C49*
IC 20-28-12 Endorsement for Independent Practice School Psychologist Law	*C52*
515 IAC 2 Independent Practice School Psychologist Endorsement Rule	*C55*
IC 25-33-1-5.1 Health Service Provider in Psychology (HSPP) Endorsement Law	*C59*
IC 20-28-1-11 School Psychology Practice Act	*C61*
IHCP Provider Bulletin #BT201108, IEP Nursing and Transportation Services	*C62*
405 IAC 5-22-2 Indiana Medicaid IEP Nursing Services Rule	*C67*
405 IAC 5-36 Indiana Medicaid Diabetes Self-Management Training (DSMT) Rule	*C68*

Indiana Health Coverage Programs Provider Reference Modules re: Billing DSMT *C70*
405 IAC 5-30-11 Indiana Medicaid IEP Transportation Services Rule *C72*
IHCP Provider Bulletin #BT200505, Transportation Billing Guide for All Providers *C73*
IC 20-27-8 School Bus Driver Requirements Law *C94*
575 IAC 1 IDOE School Bus Specifications Rules *C99*
IC 9-25-4 Indiana Financial Responsibility Requirements for Vehicles Law *C110*
IHCP Bulletin # BT200934, Federal Requirement to Screen for Excluded Individuals *C113*
IHCP Provider Bulletin # BT201220, Ordering Prescribing Referring Provider NPI *C117*
IHCP Provider Bulletin # BT201233, Claims Edits to Verify OPI Provider NPI *C120*
IC 5-11-5.7 Medicaid False Claims and Whistleblower Protection Statute *C122*

Indiana Law Requiring All School Corporations to Enroll as Medicaid Service Providers

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 secretary 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; P.L.35-2016, SEC.35.

https://iga.in.gov/legislative/laws/2016/ic/titles/12/articles/15/chapters/1/#section-16

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

June 19, 1998

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

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

Prior Authorization No Longer Required for Special Education Services

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

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

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

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

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

Additional Information

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

Indiana Medicaid Rule on Medical Records Retention

Rule 5. Provider Records
NOTE: 405 IAC 1-5 was transferred from 470 IAC 5-5. Wherever in any promulgated text there appears a reference to 470 IAC 5-5, substitute 405 IAC 1-5.

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

Sec. 1. (a) Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program.
(b) All providers participating in the Indiana Medicaid program shall maintain, for a period of seven (7) years from the date Medicaid services are provided, such medical or other records, or both, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. A copy of a claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement. Such medical or other records, or both, shall include, at the minimum, the following information and documentation:
(1) The identity of the individual to whom service was rendered.
(2) The identity of the provider rendering the service.
(3) The identity and position of the provider employee rendering the service, if applicable.
(4) The date on which the service was rendered.
(5) The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.
(6) A detailed statement describing services rendered.
(7) The location at which services were rendered.
(8) The amount claimed through the Indiana Medicaid program for each specific service rendered.
(9) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.
(10) When a recipient is enrolled in therapy, and when required under Medicaid program rules, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy program.
(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-110; filed Aug 16, 1979, 3:30 p.m.: 2 IR 1383; filed Sep 23, 1982, 9:55 a.m.: 5 IR 2351; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3298; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:15 a.m.: 28 IR 2134; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-5-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-5-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-5-2 Disclosure of medical records
Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-22

Sec. 2. Records maintained by providers under section 1 of this rule shall be openly and fully disclosed and produced to the office of Medicaid policy and planning or any authorized representative, designee, or agent thereof, forthwith, upon reasonable notice and request. Such notice and request may be made in person, in writing, or by telephonic means. Failure on the part of any provider to comply with this section shall constitute an abuse of the Medicaid program under IC 12-15-22 and applicable federal law.
(Office of the Secretary of Family and Social Services; 405 IAC 1-5-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Indiana Special Education Rule on Initial and Annual Notice Requirements and Obtaining Medicaid Consent

511 IAC 7-33-4 Use of public and private insurance proceeds

Sec. 4. (a) A public agency may use Medicaid or other public benefits or insurance programs in which a student participates to provide or pay for services required under this article, as permitted under the public benefits or insurance program. With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency may not:

(1) require a parent to:
(A) sign up for or enroll in public benefits or insurance programs in order for the student to receive a free appropriate public education; or
(B) incur an out-of-pocket expense, such as the payment of a deductible or copay amount incurred in filing a claim for services provided, but may pay the cost that the parent otherwise would be required to pay; or
(2) use a student's benefits under a public benefits or insurance program if that use would:
(A) decrease available lifetime coverage or any other insured benefit;
(B) result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;
(C) increase premiums or lead to the discontinuation of benefits or insurance; or
(D) risk loss of eligibility for home and community based waivers, based on aggregate health-related expenditures.

(b) A public agency must provide written notice to the parent:

(1) before accessing the student's or the parent's public benefits or public insurance for the first time;
(2) prior to obtaining the one-time written parental consent as described in subsection (d); and
(3) annually thereafter.

(c) The written notice described in subsection (b) must:

(1) be provided in language that is understandable to the general public;
(2) be provided in the native language or other mode of communication used by the parent, unless it is clearly not feasible to do so; and
(3) include a statement that:
(A) The public agency must provide written notice and obtain written parental consent prior to accessing the student's or the parent's public benefits or public insurance for the first time.
(B) The parental consent form provided to the parent must specify the:
(i) personally identifiable information that the public agency may disclose;
(ii) purpose of the disclosure;
(iii) agency to which the disclosure may be made; and
(iv) parent understands and agrees that the public agency may access the public benefits or public insurance to pay for services for the student.

(C) The public agency may not:
(i) require parents to sign up or enroll in public benefits or public insurance programs in order for the student to receive a free appropriate public education;
(ii) require parents to incur an out-of-pocket expense such as the payment of a deductible or copay amount incurred in filing a claim for services provided pursuant to this part; and
(iii) use a student's benefits under a public benefits or insurance program if that use would:
(AA) decrease available lifetime coverage or any other insured benefit;
(BB) result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;
(CC) increase the premiums or lead to the discontinuation of benefits or insurance; or
(DD) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
(D) The parent has the right, at any time, to withdraw his or her consent to disclose personally identifiable information to the agency responsible for the administration of the state's public benefits or public insurance program.
(E) The parent's refusal to consent or withdrawal of consent to disclose personally identifiable information to the agency responsible for the administration of the state's public benefits or public insurance program does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.
(d) The written consent form shall:
(1) describe the personally identifiable information that the public agency may disclose
(2) specify the purpose of the disclosure;
(3) specify the agency to which the disclosure may be made; and
(4) include a statement that the parent understands and agrees that the public agency may access the public benefits or public insurance to pay for services for the student.
(e) The public agency shall obtain the parent's written consent prior to accessing the student's or the parent's public benefits or insurance for the first time.
(f) With regard to services required to provide a free appropriate public education to a student with a disability under this article, the public agency may access a parent's private insurance proceeds only if the parent provides informed consent as defined by 511 IAC 7-32-17. Each time the public agency proposes to access the parent's private insurance proceeds, it must do the following:
(1) Obtain informed parental consent as defined by 511 IAC 7-32-17.
(2) Inform the parent that refusal to permit the public agency to access the private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.
(g) If a public agency is unable to obtain informed parental consent to access the parent's private insurance, or public benefits or insurance when the parent would incur a cost for a specified service required under this article, the public agency may use its Part B federal funds to pay for the service in order to ensure a free appropriate public education is provided to the student. These funds may also be used to avoid financial cost to a parent who otherwise would consent to the use of private insurance or public benefits or insurance. If the parent would incur a cost,

such as a deductible or copay amounts, the public agency may use its Part B funds to pay the cost.

(h) Proceeds from public benefits or insurance or private insurance shall not be considered program income for purposes of 34 CFR 80.25 with respect to the administration of federal grants and cooperative agreements.
(i) If a public agency spends reimbursements from federal funds, such as Medicaid, for services under this article, those funds shall not be considered state or local funds for purposes of maintenance of effort provisions.
(j) Nothing in this article shall be construed to alter the requirements imposed on the state Medicaid agency, or any other agency administering a public benefits or insurance program by federal statute, regulations, or policy under Title XIX or Title XXI of the Social Security Act, or any other public benefits or insurance program.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Indiana Special Education Rule on Definition of Consent

511 IAC 7-32-17 "Consent" defined
Authority: IC 20-19-2-8; IC 20-19-2-16
Affected: IC 20-19-2; IC 20-35

Sec. 17. "Consent" means the following:

(1) The parent has been fully informed, in the parent's native language or other mode of communication, of all information relevant to the activity for which consent is sought.

(2) The parent understands and agrees in writing to the activity for which consent has been sought, and the consent:

(A) describes that activity; and

(B) lists the records, if any, that will be released and to whom.

(3) The parent understands that:

(A) granting consent is voluntary on the part of the parent; and

(B) the consent may be revoked at any time.

If the parent revokes consent, the revocation is not retroactive, that is, it does not negate an action that has occurred after the consent was given and before the consent was revoked.

(Indiana State Board of Education; 511 IAC 7-32-17; filed Jul 14, 2008, 1:24 p.m.: 20080813-IR-511080112FRA)

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

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

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

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

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 6. (a) Prior authorization is required for all therapy services with the following exceptions:
(1) Initial evaluations.
(2) Emergency respiratory therapy.
(3) Any combination of therapy ordered in writing prior to a recipient's discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.
(4) The deductible and copay for services covered by Medicare, Part B.
(5) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.
(6) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate.
(7) Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in sections 8, 10, and 11 of this rule.
(b) Unless specifically indicated otherwise, the following criteria for prior authorization of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:
(1) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a physician (doctor of medicine or doctor of osteopathy). A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization request and available for audit purposes.
(2) Therapy must be provided by a qualified therapist or qualified assistant under the direct supervision of the therapist as appropriate.
(3) Therapy must be of such a level of complexity and sophistication and the condition of the recipient must be such that the judgment, knowledge, and skills of a qualified therapist are required.
(4) Medicaid reimbursement is available only for medically reasonable and necessary therapy.
(5) Therapy rendered for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel, is not covered by Medicaid.
(6) Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy. Habilitative services for a recipient under eighteen (18) years of age

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

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

(1) Basic comprehensive audiometry include pre tone, air and bone threshold and discrimination. The above descriptions refer to testing of both ears.

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

405 IAC 5-22-8 Physical therapy services

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

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902)

Indiana Physical Therapy Practice Act

IC 25-27
ARTICLE 27. PHYSICAL THERAPISTS

IC 25-27-1
Chapter 1. Regulation of Physical Therapists by Medical Licensing Board

IC 25-27-1-1
Definitions

Sec. 1. For the purposes of this chapter:

(1) "Physical therapy" means the evaluation of, administration of, or instruction in physical rehabilitative and habilitative techniques and procedures to evaluate, prevent, correct, treat, alleviate, and limit physical disability, pathokinesiological function, bodily malfunction, pain from injury, disease, and any other physical disability or mental disorder, including:

(A) the use of physical measures, agents, and devices for preventive and therapeutic purposes;

(B) neurodevelopmental procedures;

(C) the performance, interpretation, and evaluation of physical therapy tests and measurements; and

(D) the provision of consultative, educational, and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain.

(2) "Physical therapist" means a person who practices physical therapy as defined in this chapter.

(3) "Physical therapist's assistant" means a person who assists in the practice of physical therapy as defined in this chapter.

(4) "Board" refers to the medical licensing board.

(5) "Committee" refers to the Indiana physical therapy committee established under section 4 of this chapter.

(6) "Person" means an individual.

(Formerly: Acts 1957, c.198, s.1; Acts 1971, P.L.379, SEC.1.) As amended by P.L.150-1986, SEC.4; P.L.259-1987, SEC.1; P.L.240-1989, SEC.1.

IC 25-27-1-2
Unlawful practices

Sec. 2. (a) Except as otherwise provided in this chapter, it is unlawful for a person to practice physical therapy or to profess to be a physical therapist, physiotherapist, or physical therapy technician or to use the initials "P.T.", "P.T.T.", or "R.P.T.", or any other letters, words, abbreviations, or insignia indicating that the person is a physical therapist, or to practice or to assume the duties incident to physical therapy without first obtaining from the board a license authorizing the person to practice physical therapy in this state.

(b) It is unlawful for a person to practice physical therapy other than upon the order or referral of a physician, podiatrist, psychologist, chiropractor, or dentist holding an unlimited license to practice medicine, podiatric medicine, psychology, chiropractic, or dentistry,

respectively. It is unlawful for a physical therapist to use the services of a physical therapist's assistant except as provided under this chapter. For the purposes of this subsection, the function of:

(1) teaching;
(2) doing research;
(3) providing advisory services; or
(4) conducting seminars on physical therapy;

is not considered to be a practice of physical therapy.

(c) Except as otherwise provided in this chapter, it is unlawful for a person to act as a physical therapist's assistant or to use initials, letters, words, abbreviations, or insignia indicating that the person is a physical therapist's assistant without first obtaining from the board a certificate authorizing the person to act as a physical therapist's assistant. It is unlawful for the person to act as a physical therapist's assistant other than under the direct supervision of a licensed physical therapist who is in responsible charge of a patient or under the direct supervision of a physician. However, nothing in this chapter prohibits a person licensed or registered in this state under another law from engaging in the practice for which the person is licensed or registered. These exempted persons include persons engaged in the practice of osteopathy, chiropractic, or podiatric medicine.

(d) This chapter does not authorize a person who is licensed as a physical therapist or certified as a physical therapist's assistant to:

(1) evaluate any physical disability or mental disorder except upon the order or referral of a physician, podiatrist, psychologist, chiropractor, or dentist;
(2) practice medicine, surgery (as described in IC 25-22.5-1-1.1(a)(1)(C)), dentistry, optometry, osteopathy, psychology, chiropractic, or podiatric medicine; or
(3) prescribe a drug or other remedial substance used in medicine.

(Formerly: Acts 1957, c.198, s.2; Acts 1971, P.L.379, SEC.2.) As amended by P.L.137-1985, SEC.8; P.L.157-1986, SEC.2; P.L.259-1987, SEC.2; P.L.240-1989, SEC.2; P.L.217-1993, SEC.4

IC 25-27-1-3
Repealed

(*Repealed by P.L.150-1986, SEC.14.)*

IC 25-27-1-3.1
Practice of certain occupations or professions and first aid not prohibited

Sec. 3.1. This chapter does not prohibit any of the following:

(1) The practice of any occupation or profession for which a person is licensed, certified, or registered in Indiana by a state agency. The persons who are exempted by this subdivision include persons licensed, certified, or registered to practice osteopathy, chiropractic, or podiatric medicine.
(2) The practice of any health care occupation or profession by a person who is practicing within the scope of the person's education and experience.
(3) The performance of any first aid procedure incidental to a person's employment or volunteer duties.
(4) The performance of an emergency first aid procedure by any person.

As added by P.L.150-1986, SEC.5.

IC 25-27-1-4
Indiana physical therapy committee

Sec. 4. (a) There is created a five (5) member Indiana physical therapy committee to assist the board in carrying out this chapter regarding the qualifications and examinations of physical therapists and physical therapist's assistants. The committee is comprised of:

(1) three (3) physical therapists;

(2) a licensed physician; and

(3) one (1) member who is a resident of the state and who is not associated with physical therapy in any way, other than as a consumer.

(b) The governor shall make each appointment for a term of three (3) years. Each physical therapist appointed must:

(1) be a licensed physical therapist meeting the requirements of this chapter;

(2) have had not less than three (3) years experience in the actual practice of physical therapy immediately preceding appointment; and

(3) be a resident of the state and actively engaged in this state in the practice of physical therapy during incumbency as a member of the committee.

(Formerly: Acts 1957, c.198, s.4; Acts 1971, P.L.379, SEC.3.) As amended by Acts 1981, P.L.222, SEC.195; P.L.150-1986, SEC.6.

IC 25-27-1-5
Determination of qualifications; administration of examinations; standards for competent practice

Sec. 5. (a) The committee shall:

(1) pass upon the qualifications of physical therapists who apply for licensure and physical therapist's assistants who apply for certification;

(2) provide all examinations either directly or by delegation under subsection (c);

(3) determine the applicants who successfully pass examinations;

(4) license qualified applicants; and

(5) propose rules concerning the competent practice of physical therapy to the board.

(b) The board shall adopt rules, considering the committee's proposed rules, establishing standards for the competent practice of physical therapy.

(c) The committee may approve and utilize the services of a testing company or agent to prepare, conduct, and score examinations.

(d) The board shall adopt rules, considering the committee's proposed rules, concerning a continuing competency requirement for the renewal of a:

(1) license for a physical therapist; and

(2) certificate for a physical therapist's assistant.

(Formerly: Acts 1957, c.198, s.5; Acts 1971, P.L.379, SEC.4.) As amended by Acts 1981, P.L.222, SEC.196; P.L.150-1986, SEC.7; P.L.259-1987, SEC.3; P.L.197-2011, SEC.116.

IC 25-27-1-6
Evidence of qualification

Sec. 6. (a) Each applicant for a license as a physical therapist or certification as a physical therapist's assistant must present satisfactory evidence that the applicant:

(1) does not have a conviction for a crime that has a direct bearing on the applicant's ability

to practice competently; and

(2) has not been the subject of a disciplinary action initiated by the licensing agency of another state or jurisdiction on the grounds that the applicant was unable to practice as a physical therapist or physical therapist's assistant without endangering the public.

(b) Each applicant for a license as a physical therapist must submit proof to the committee of the applicant's graduation from a school or program of physical therapy that meets standards set by the committee. Each applicant for a certificate as a physical therapist's assistant must present satisfactory evidence that the applicant is a graduate of a two (2) year college level education program for physical therapist's assistants that meets the standards of the committee. At the time of making application, each applicant must pay a fee determined by the board after consideration of any recommendation of the committee.

(c) An applicant may appeal the committee's decision to deny licensure to the committee within fifteen (15) days after the applicant receives notification of the committee's decision. Upon receiving an appeal under this subsection, the committee shall set the matter for an administrative hearing under IC 4-21.5.

(Formerly: Acts 1957, c.198, s.6; Acts 1971, P.L.379, SEC.5.) As amended by Acts 1981, P.L.222, SEC.197; Acts 1982, P.L.113, SEC.66; P.L.150-1986, SEC.8; P.L.149-1987, SEC.78; P.L.152-1988, SEC.23; P.L.33-1993, SEC.48.

IC 25-27-1-7
Examination; reexamination

Sec. 7. (a) All examinations of the applicants for licensure as physical therapists or for certification as physical therapist's assistants shall be held in Indiana at least twice a year.

(b) Examinations shall include a written or computer examination which must test the applicant's knowledge of the basic and clinical sciences as they relate to physical therapy, physical therapy theory and procedures, and such other subjects as the committee may deem useful to test the applicant's fitness to practice physical therapy or to act as a physical therapist's assistant.

(c) Any qualified applicant who fails an examination and is refused a license or certificate may take another examination within the time limits set by the committee upon payment of an additional fee determined by the board after consideration of any recommendation of the committee.

(d) Nothing in this section shall be construed as a prohibition against any qualified applicant who has failed an examination from making further application for a license to practice physical therapy or for a certificate to act as a physical therapist's assistant when the application is accompanied by the fee determined by the board after consideration of any recommendation of the committee.

(Formerly: Acts 1957, c.198, s.7; Acts 1971, P.L.379, SEC.6.) As amended by P.L.136-1984, SEC.1; P.L.150-1986, SEC.9; P.L.173-1996, SEC.14.

IC 25-27-1-8
Issuance of license; renewal; reinstatement; temporary nonrenewable permit; retirement from practice

Sec. 8. (a) The committee shall license as a physical therapist each applicant who:

(1) successfully passes the examination provided for in this chapter; and

(2) is otherwise qualified as required by this chapter.

(b) All licenses and certificates issued by the committee expire on the date of each even-numbered year specified by the Indiana professional licensing agency under IC 25-1-5-4. A renewal fee established by the board after consideration of any recommendation of the committee must be paid biennially on or before the date specified by the Indiana professional licensing agency, and if not paid on or before that date, the license or certificate becomes invalid, without further action by the committee. A penalty fee set by the board after consideration of any recommendation of the committee shall be in effect for any reinstatement within three (3) years from the original date of expiration.

(c) An expired license or certificate may be reinstated by the committee up to three (3) years after the expiration date if the holder of the expired license or certificate:

(1) pays a penalty fee set by the board after consideration of any recommendation of the committee; and

(2) pays the renewal fees for the biennium.

If more than three (3) years have elapsed since expiration of the license or certificate, the holder may be reexamined by the committee. The board may adopt, after consideration of any recommendation of the committee, rules setting requirements for reinstatement of an expired license.

(d) The committee may issue not more than two (2) temporary permits to a physical therapist or physical therapist's assistant. A person with a temporary permit issued under this subsection may practice physical therapy only under the direct supervision of a licensed physical therapist who is responsible for the patient. A temporary permit may be issued to any person who has paid a fee set by the board after consideration of any recommendation of the committee and who:

(1) has a valid license from another state to practice physical therapy, or has a valid certificate from another state to act as a physical therapist's assistant; or

(2) has applied for and been approved by the committee to take the examination for licensure or certification, has not previously failed the licensure or certification examination in Indiana or any other state, and has:

(A) graduated from a school or program of physical therapy; or

(B) graduated from a two (2) year college level education program for physical therapist's assistants that meets the standards set by the committee.

The applicant must take the examination within the time limits set by the committee.

(e) A temporary permit issued under subsection (d) expires when the applicant becomes licensed or certified, or approved for endorsement licensing or certification by the committee, or when the application for licensure has been disapproved, whichever occurs first. An application for licensure or certification is disapproved and any temporary permit based upon the application expires when the applicant fails to take the examination within the time limits set by the committee or when the committee receives notification of the applicant's failure to pass any required examination in Indiana or any other state.

(f) A holder of a license or certificate under this chapter who intends to retire from practice shall notify the committee in writing. Upon receipt of the notice, the committee shall record the fact that the holder of the license or certificate is retired and release the person from further payment of renewal fees. If a holder of the license or certificate surrenders a license or certificate, reinstatement of the license or certificate may be considered by the committee upon

written request. The committee may impose conditions it considers appropriate to the surrender or reinstatement of a surrendered license or certificate. A license or certificate may not be surrendered to the committee without the written consent of the committee if any disciplinary proceedings are pending against a holder of a license or certificate under this chapter.
(Formerly: Acts 1957, c.198, s.8; Acts 1971, P.L.379, SEC.7.) As amended by Acts 1981, P.L.222, SEC.198; P.L.136-1984, SEC.2; P.L.150-1986, SEC.10; P.L.149-1987, SEC.79; P.L.48-1991, SEC.48; P.L.214-1993, SEC.59; P.L.244-1995, SEC.1; P.L.173-1996, SEC.15; P.L.1-2006, SEC.467.

IC 25-27-1-9
Foreign applicants; license or certificate by endorsement; fee

Sec. 9. (a) The committee may register and furnish a license or certify by endorsement any applicant who presents evidence satisfactory to the committee of being duly licensed to practice physical therapy or to act as a physical therapist's assistant in another state if the applicant is otherwise qualified as required in section 6 of this chapter. However, the committee shall register and furnish a license or certificate by endorsement to any applicant who is licensed to practice physical therapy or to act as a physical therapist's assistant in another state if:

(1) the applicant is otherwise qualified as required under section 6(a) and 6(b) of this chapter; and

(2) the applicant has successfully passed a licensure examination in another state equal to or exceeding the examination standards of Indiana.

At the time of making an application, the applicant shall pay a fee determined by the board after consideration of any recommendation of the committee.

(b) The committee may license as a physical therapist or certify as a physical therapist's assistant any person who has graduated as a physical therapist or physical therapist's assistant, whichever is appropriate, in a foreign country from an educational program approved by the committee if the applicant presents satisfactory evidence to the committee that the applicant:

(1) does not have a conviction for:

(A) an act that would constitute a ground for disciplinary sanction under IC 25-1-9; or

(B) a crime that has a direct bearing on the applicant's ability to practice competently; and

(2) has not been the subject of a disciplinary action initiated by the licensing agency of another state or jurisdiction on the grounds that the applicant was unable to practice as a physical therapist or physical therapist's assistant without endangering the public;

and that the applicant has successfully passed the physical therapy licensure or physical therapist's assistant certification examination provided for by this chapter. However, the committee, in evaluating an educational program under this subsection shall approve at least three (3) credential evaluating agencies acceptable to the board for the purpose of evaluating educational programs.

(c) At the time of making an application under subsection (b), the applicant shall pay a fee determined by the board after consideration of any recommendation of the committee.
(Formerly: Acts 1957, c.198, s.9; Acts 1971, P.L.379, SEC.8.) As amended by Acts 1981, P.L.222, SEC.199; Acts 1982, P.L.113, SEC.67; P.L.136-1984, SEC.3; P.L.150-1986, SEC.11; P.L.259-1987, SEC.4; P.L.152-1988, SEC.24; P.L.96-1990, SEC.15; P.L.2-1995, SEC.97; P.L.244-1995, SEC.2.

IC 25-27-1-10
Repealed
(*Repealed by Acts 1981, P.L.222, SEC.296.)*

IC 25-27-1-10.1
Repealed
(*Repealed by P.L.152-1988, SEC.30.)*

IC 25-27-1-11
Refund of fees
Sec. 11. The fees collected under this chapter shall under no circumstances be refunded to the applicant.
(Formerly: Acts 1957, c.198, s.11.) As amended by Acts 1981, P.L.222, SEC.201; P.L.150-1986, SEC.13.

IC 25-27-1-12
Violation of chapter; injunction
Sec. 12. A person who violates this chapter commits a Class B misdemeanor. In addition the board may, in the name of the state, through the attorney general, apply in any court to enjoin any person from practicing physical therapy or acting as a physical therapist's assistant, in violation of IC 25-27-1-2.
(Formerly: Acts 1957, c.198, s.12; Acts 1971, P.L.379, SEC.10.) As amended by Acts 1978, P.L.2, SEC.2546.

http://www.in.gov/legislative/ic/archive/2011/ic/2011/title25/ar27/ch1.html

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

880 IAC 1-2.1-2 Educational requirements for SLP aide
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 2. The minimum educational requirement for an SLP aide shall be a high school degree or equivalent. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-2; filed Oct 6, 2003, 5:15 p.m.: 27 IR 534; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

880 IAC 1-2.1-3 Educational requirements for SLP associate
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 3. (a) The minimum educational requirement for an SLP associate is an associate degree or its equivalent from an accredited institution in the area for which the applicant is requesting to be registered.
(b) As used in this section, "equivalent" means having completed the following:

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

880 IAC 1-2.1-3.1 Educational requirements for SLP assistant
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 3.1. (a) The minimum educational requirement for an SLP assistant is a bachelor's degree or its equivalent in communication disorders from an accredited institution in the area for which the applicant is requesting to be registered.
(b) One hundred (100) hours of clinical practicum is required and must be supervised by an SLP licensed by the board. These hours may be completed before the degree is conferred or during a paid experience. Of the one hundred (100) hours obtained, seventy-five (75) shall be obtained with direct face-to-face patient/client contact, and the remaining twenty-five (25) hours may be

obtained through observation of assessment and therapy. The direct face-to-face patient/client contact hours must be obtained in the
following categories:
(1) A minimum of twenty (20) hours in speech disorders.
(2) A minimum of twenty (20) hours in language disorders.
(3) The remaining hours may be obtained in any of the following areas:
(A) Speech disorders.
(B) Language disorders.
(C) Hearing disorders.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-3.1; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)

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

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

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

880 IAC 1-2.1-7 Activities prohibited by the SLP support personnel
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 7. SLP support personnel may not perform any of the following activities:
(1) Administer:
(A) standardized or nonstandardized diagnostic tests; or
(B) formal or informal evaluations;
or interpret test results.

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

880 IAC 1-2.1-8 Tasks that may be delegated to the SLP support personnel
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 8. The following tasks may be delegated to SLP support personnel if the tasks have been planned by the supervisor and the SLP support personnel have been provided with adequate training to perform the task competently:
(1) Assist the supervisor with speech-language and hearing screenings (without interpretation).
(2) Follow documented treatment plans or protocols developed by the supervisor.

(3) Document patient or client performance and report information to the supervising SLP, for example, the following:
(A) Tallying data for the speech-language pathologist.
(B) Preparing the following:
(i) Charts.
(ii) Records.
(iii) Graphs.
(4) Assist the supervisor during assessment of patients or clients.
(5) Assist with informal documentation as directed by the supervisor.
(6) Assist with clerical duties, such as:
(A) preparing materials; and
(B) scheduling activities;
as directed by the supervisor.
(7) Perform checks and maintenance of equipment.
(8) Support the supervisor in the following:
(A) Research projects.
(B) Inservice training.
(C) Public relations programs.
(9) Assist with the following departmental operations:
(A) Scheduling.
(B) Record keeping.
(C) Safety and maintenance of supplies and equipment.
(10) Collect data for quality improvement.
(11) Exhibit compliance with the following:
(A) Regulations.
(B) Reimbursement requirements.
(C) SLP aide, SLP associate, and SLP assistant job responsibilities.
(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-8; filed Oct 6, 2003, 5:15 p.m.: 27 IR 536; filed Aug 25, 2008,3:07 p.m.: 20080924-IR-880070671FRA)

880 IAC 1-2.1-9 Supervisors; responsibilities
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 9. (a) Before utilizing SLP support personnel, the supervisor shall carefully delineate the role and tasks of the SLP support personnel, including the following:
(1) Specific lines of responsibility and authority.
(2) Assurance that the SLP support personnel are responsible only to the supervisor in all patient/client activities. The supervisor must assess individual patient/client needs when deciding the appropriateness of a support personnel service delivery model.
(b) When SLP support personnel assist in providing treatment, the supervisor of the SLP support personnel shall do the following:
(1) The supervisor of the SLP aide shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. The supervisor must:
(A) be physically present within the same building as the SLP aide whenever direct client care is provided; and (B) directly provide a minimum of thirty-three percent (33%) of the patient's or client's treatment weekly.

(2) The supervisor of the SLP associate shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. Supervision days and times should be alternated to ensure that all patients/clients receive direct treatment from the supervisor at least once every two (2) weeks. At no time should an SLP associate perform tasks when a supervisor cannot be reached by:
(A) personal contact;
(B) telephone;
(C) pager; or
(D) other immediate means.
(3) The supervisor for the SLP assistant shall provide direct supervision a minimum of twenty percent (20%) weekly for the first ninety (90) days of work and ten percent (10%) weekly thereafter. Supervision days and times should be alternated to ensure that all patients/clients receive direct treatment from the supervisor at least once every two (2) weeks. At no time should an SLP assistant perform tasks when a supervisor cannot be reached by:
(A) personal contact;
(B) telephone;
(C) pager; or
(D) other immediate means.
(4) The supervisor must determine supervision needs. The amount of supervision may be increased depending on the:
(A) competency of the SLP support personnel;
(B) needs of the patients or clients served; and
(C) nature of the assigned tasks.
However, the minimum standard must be maintained. Indirect supervision activities may include, but are not limited to, record review, phone conferences, or audio/video tape review.
(5) Determine the responsibilities assigned to the SLP support personnel based upon the:
(A) educational level;
(B) training; and
(C) experience;
of the support personnel.
(6) Evaluate each patient or client before treatment.
(7) Outline and direct the specific program for the clinical management of each client serviced by the SLP support personnel.
(8) Every five (5) working days, review all data and documentation on clients seen for treatment by the SLP support personnel.
(9) Ensure that, at the termination of services, the case is reviewed by the speech-language pathologist responsible for the client.
(c) The supervisor shall not permit SLP support personnel to make decisions regarding the:
(1) diagnosis;
(2) management; or
(3) future disposition;
of clients.
(d) The supervisor must officially designate SLP support personnel as such on all clinical records.
(e) The supervisor must be present when the SLP support personnel provide direct client treatment outside the designated practice setting.

(f) The supervisor may designate a licensed speech-language pathologist to supervise SLP support personnel under his or her supervision during vacation periods or illness, but for not longer than a thirty (30) day period.
(g) Within ten (10) days after the termination of the supervision of SLP support personnel, the supervisor:
(1) shall notify the board, in writing, of the:
(A) termination; and
(B) date of the termination; and
(2) may designate a licensee to serve as an interim supervisor for a period not to exceed thirty (30) days upon approval of the board. An interim supervisor is not required to pay a fee for the thirty (30) day period.
(h) A supervisor may not supervise more than two (2) SLP support personnel at one (1) time.
(i) In order to supervise SLP support personnel, a speech-language pathologist must:
(1) hold a current license as a speech-language pathologist as issued by the board for a minimum of two (2) years before registering and supervising SLP support personnel; and
(2) have at least three (3) years of clinical experience.
(j) A supervisor assumes professional responsibility for services provided under their supervision. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-9; filed Oct 6, 2003, 5:15 p.m.: 27 IR 536; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

880 IAC 1-2.1-10 SLP aides previously registered under 880 IAC 1-2
Authority: IC 25-35.6-1-8; IC 25-35.6-2-2
Affected: IC 25-35.6-1-2
Sec. 10. SLP aides previously registered under 880 IAC 1-2, which meet the educational requirements of:
(1) section 2 of this rule, shall be registered as an SLP aide;
(2) section 3 of this rule, shall be registered as an SLP associate; and
(3) section 3.1 of this rule, shall be registered as an SLP assistant;
without the necessity of filing an additional application under section 4 of this rule. *(Speech-Language Pathology and Audiology Board; 880 IAC 1-2.1-10; filed Oct 6, 2003, 5:15 p.m.: 27 IR 537; filed Aug 25, 2008, 3:07 p.m.: 20080924-IR-880070671FRA)*

405 IAC 5-22-11 Occupational therapy services
Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15
Sec. 11. Occupational therapy services are subject to the following restrictions:
(1) Occupational therapy services must be performed by a licensed occupational therapist or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. An evaluation must be performed by a licensed occupational therapist in order for reimbursement to be made.
(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include occupational therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the recipient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(3) General strengthening exercise programs for recuperative purposes are not covered by Medicaid.
(4) Passive range of motion services are not covered by Medicaid as the only or primary modality of therapy.
(5) Medicaid reimbursement is not available for occupational therapy psychiatric services.
(6) Occupational therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate, do not require prior authorization.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; errata filed May 4, 2016, 12:47 p.m.: 20160518-IR-405160170ACA)

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Indiana Occupational Therapy Practice Act

IC 25-23.5-1
Chapter 1. Definitions

IC 25-23.5-1-1
Application of definitions
Sec. 1. The definitions in this chapter apply throughout this article.
As added by P.L.238-1989, SEC.1.

IC 25-23.5-1-2
"Board"
Sec. 2. "Board" refers to the medical licensing board of Indiana.
As added by P.L.238-1989, SEC.1.

IC 25-23.5-1-3
"Committee"
Sec. 3. "Committee" refers to the occupational therapy committee established under IC 25-23.5-2-1.
As added by P.L.238-1989, SEC.1.

IC 25-23.5-1-3.5
"Examination"
Sec. 3.5. "Examination" refers to a nationally recognized test for occupational therapists that has been approved by the board under IC 25-23.5-5-4.5.
As added by P.L.197-2007, SEC.60.

IC 25-23.5-1-4
"Occupational therapist"
Sec. 4. "Occupational therapist" means a person who practices occupational therapy.
As added by P.L.238-1989, SEC.1.

IC 25-23.5-1-5
"Practice of occupational therapy"
Sec. 5. "Practice of occupational therapy" means the functional assessment of learning and performance skills and the analysis, selection, and adaptation of exercises or equipment for a person whose abilities to perform the requirements of daily living are threatened or impaired by physical injury or disease, mental illness, a developmental deficit, the aging process, or a learning disability. The term consists primarily of the following functions:

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

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

As added by P.L.238-1989, SEC.1. Amended by P.L.197-2007, SEC.61.

IC 25-23.5-1-5.5
Repealed
(*Repealed by P.L.197-2011, SEC.153.)*

IC 25-23.5-1-6
"Occupational therapy assistant"
Sec. 6. "Occupational therapy assistant" means a person who provides occupational therapy services under the supervision of an occupational therapist.
As added by P.L.238-1989, SEC.1.

IC 25-23.5-1-7
"Person"
Sec. 7. "Person" means an individual.
As added by P.L.238-1989, SEC.1.

http://www.in.gov/legislative/ic/code/title25/ar23.5/ch1.html

Indiana Occupational Therapy Aide Training and Supervision Rules

844 IAC 10-5-5 Supervision of occupational therapy assistant
Authority: IC 25-23.5-2-5; IC 25-23.5-2-6
Affected: IC 25-1-5-3; IC 25-23.5
Sec. 5. Under the supervision of an occupational therapist, an occupational therapy assistant may contribute to the screening and evaluation process. The occupational therapy assistant may also contribute to the following:
(1) The development and implementation of the intervention plan.
(2) The monitoring and documentation of progress.
(3) The discontinuation or discharge from care or transitioning to another level of care.
The occupational therapy assistant may not independently develop the intervention plan or initiate treatment. *(Medical Licensing Board of Indiana; 844 IAC 10-5-5; filed Nov 14, 1991, 3:30 p.m.: 15 IR 582; readopted filed Nov 9, 2001, 3:16 p.m.: 25 IR 1325; readopted filed Oct 4, 2007, 3:34 p.m.: 20071031-IR-844070053RFA; filed Mar 24, 2009, 11:38 a.m.: 20090422-IR-844080418FRA)*

844 IAC 10-5-6 Documentation
Authority: IC 25-23.5-2-5; IC 25-23.5-2-6
Affected: IC 25-1-5-3; IC 25-23.5
Sec. 6. The occupational therapist shall countersign within seven (7) calendar days all documentation written by the occupational therapy assistant, which will become part of the patient's permanent record. *(Medical Licensing Board of Indiana; 844 IAC 10-5-6; filed Nov 14, 1991, 3:30 p.m.: 15 IR 582; readopted filed Nov 9, 2001, 3:16 p.m.: 25 IR 1325; readopted filed Oct 4, 2007, 3:34 p.m.: 20071031-IR-844070053RFA)*

844 IAC 10-6-1 Training programs
Authority: IC 25-23.5-2-6
Affected: IC 25-23.5-2
Sec. 1. An occupational therapy aide is an unlicensed or uncertified person who assists in the practice of occupational therapy. Therefore, before an occupational therapy aide may be involved in the provision of direct services to patients, the occupational therapy aide shall have received site-specific training that is appropriate and consistent with the role and function of the aide in the facility to which he or she is assigned. Well-defined and documented training programs are required for the occupational therapy aide to ensure the delivery of quality services. *(Medical Licensing Board of Indiana; 844 IAC 10-6-1; filed Sep 1, 2000, 2:04 p.m.:*
24 IR 23; readopted filed Nov 16, 2006, 10:52 a.m.: 20061129-IR-844060240RFA)

844 IAC 10-6-2 Indirect and direct patient services
Authority: IC 25-23.5-2-6
Affected: IC 25-23.5-2
Sec. 2. An occupational therapy aide may contribute to indirect patient services through the provision of the following:
(1) Routine department maintenance.
(2) Transportation of patients.
(3) Preparation and setting up of treatment equipment.
(4) Performing clerical activities.
An aide, with direct on-site supervision of a licensed occupational therapist or, when appropriate, a certified occupational therapy assistant, may provide direct patient service. *(Medical Licensing Board of Indiana; 844 IAC 10-6-2; filed Sep 1, 2000, 2:04 p.m.: 24 IR 23; readopted filed Nov 16, 2006, 10:52 a.m.: 20061129-IR-844060240RFA; filed Mar 24, 2009, 11:38 a.m.: 20090422-IR-844080418FRA)*

844 IAC 10-6-3 Direct supervision
Authority: IC 25-23.5-2-6
Affected: IC 25-23.5-2
Sec. 3. Direct supervision means that the supervising occupational therapist or occupational therapy assistant shall:
(1) be on the premises, immediately available, in person, and responsible at all times whenever an occupational therapy aide is performing direct client services; and
(2) examine each client prior to the treatment session of the purpose of determining whether a portion of the treatment may be delegated to the occupational therapy aide.
(Medical Licensing Board of Indiana; 844 IAC 10-6-3; filed Sep 1, 2000, 2:04 p.m.: 24 IR 24; readopted filed Nov 16, 2006, 10:52 a.m.: 20061129-IR-844060240RFA)

Indiana Medicaid Applied Behavioral Analysis Therapy Services Rule

405 IAC 5-22-12 Applied behavioral analysis therapy services

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

Sec. 12. (a) ABA therapy services shall be available to an individual who:

(1) is eligible for Medicaid services;

(2) has been diagnosed as having autism spectrum disorder by a qualified provider; and

(3) has a completed diagnostic evaluation.

A qualified provider, when completing such evaluation, shall utilize the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) at the time of the evaluation and include a recommended treatment referral for ABA therapy services.

(b) Services shall be available from the time of initial diagnosis through twenty (20) years of age.

(c) The following providers may provide ABA therapy services:

(1) A health services provider in psychology (HSPP).

(2) A licensed or board certified behavior analyst.

(3) A credentialed registered behavior technician (RBT).

(d) Services shall be reimbursed subject to the following restrictions:

(1) Services performed by a bachelor-level board certified behavior analyst (BCaBA) or a credentialed RBT shall be supervised by a master's (BCBA) or doctoral level board certified behavior analyst (BCBA-D), or an HSPP.

(2) Services provided by a credentialed RBT shall be reimbursed at seventy-five percent (75%) of the rate on file.

(e) A provider described in subsection (c) shall develop a treatment plan for each recipient eligible for services under this section. Treatment plans shall be focused on addressing specific behavioral issues and community integration. All treatment plans shall include a projected length of therapy. The treatment plan shall be based on criteria such as the individual's:

(1) needs;

(2) age;

(3) school attendance, including any homeschooling; and

(4) other daily activities as documented in the treatment plan not otherwise excluded from coverage under subsection (I) *[sic, subsection (k)]*.

(f) All covered ABA therapy services shall be subject to prior authorization. A provider shall abide by the prior authorization requirements under 405 IAC 5-3, with the exception that a BCBA may also submit a prior authorization request to the office for review and approval. Each prior authorization request shall include, at a minimum, the following:

(1) The individual's treatment plan and supporting documentation.

(2) The number of therapy hours requested and supporting documentation.

(3) Other documentation as requested by the office.

(g) Prior approval for the initial course of treatment may be approved for up to six (6) months. In order to continue providing ABA therapy services, a provider shall submit a new prior authorization request and receive approval. The prior authorization request shall include an updated treatment plan along with the documentation specified in subsection (f)(2) and (f)(3).

(h) ABA therapy services shall only be available to a recipient for a period not to exceed forty (40) hours per week. ABA therapy services extending beyond forty (40) hours per week of direct

therapy must be medically necessary and requires additional prior authorization. The office shall not approve any prior authorization request that provides ABA therapy services for a period longer than six (6) months at one (1) time.

(i) Determinations for hours and duration shall not be based upon any of the following:

(1) Other therapies that do not address the specific behaviors being targeted.

(2) Any standardized formulas used to deduct hours based upon daily living activities.

(j) Short term, adjunctive hours may be requested outside of the standard therapy prior authorization if one (1) of the following conditions occurs:

(1) Sudden increase in self-injurious behaviors.

(2) Sudden increase in aggression or aggressive behaviors.

(3) Increase in elopement behaviors.

(4) Regression in major self-care or language activities.

(5) A shift in family or home dynamic.

(6) Development of a non-mental health related comorbidity or health crisis with the patient.

(k) As follows, coverage under this section shall not be available for services that:

(1) Focus solely on recreational outcomes.

(2) Focus solely on educational outcomes.

(3) Are duplicative, such as services rendered under an individualized educational plan that address the same behavioral goals using the same techniques as the treatment plan.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-12; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; errata filed May 4, 2016, 12:47 p.m.: 20160518-IR-405160170ACA; filed Jan 30, 2019, 8:35 a.m.: 20190227-IR-405180249FRA)

Indiana Health Coverage Programs Provider Bulletin on ABA Therapy Services

Note: IEP-required ABA services rendered by a qualified provider who is a School Corporation employee or contractor are billed with the NPI of the School Corporation.

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201606 JANUARY 19, 2016

This bulletin is a replacement for BT201605, which was published January 15, 2016. This bulletin corrects language included in error in the original publication. Under ***Provider requirements*** on page 3, the original publication incorrectly stated "*Services performed by a BCBA must be under the direct supervision of a BCBA-D or HSPP.*" This sentence is incorrect. BCBAs can perform ABA therapy services independently. Further, IHCP billing requirements were clarified to indicate that ABA services rendered by a BCBA-D, BCBA, BCaBA, or RBT must be billed under the NPI of an IHCP-enrolled physician or HSPP, because behavior analysts are not currently enrolled independently. BT201605 should be disregarded.

IHCP adds coverage of applied behavioral analysis therapy

Effective February 6, 2016, applied behavioral analysis (ABA) therapy is covered for the treatment of autism spectrum disorder (ASD) for members 20 years of age and younger. ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. Coverage applies to dates of service (DOS) on or after February 6, 2016, for all IHCP programs, subject to limitations established for certain benefit packages.

ABA therapy is available to members from the time of initial diagnosis through 20 years of age when it is medically necessary for the treatment of ASD. ABA therapy services require prior authorization (PA), subject to the criteria outlined in *Indiana Administrative Code 405 IAC 5-3*. PA requests must include, at a minimum, the following:

- Individual's treatment plan and supporting documentation
- Number of therapy hours being requested and supporting documentation
- Other documentation as requested to support medical necessity

Treatment plans must include measures and progress specific to language skills, communication skills, social skills, and adaptive functioning. The individual treatment plan must be specific to the individual's needs and include justification and supporting documentation for the number of hours requested. The number of hours must give consideration to the individual's age, school attendance requirements, and other daily activities. The treatment plan must include a clear schedule of planned services and must substantiate that all identified interventions are consistent with ABA techniques.

Generally, ABA therapy is limited to a period of 3 years and should not exceed 40 hours per week. Services beyond these limitations may be approved with PA when the services are medically necessary.

Initial course of ABA therapy

An initial course of ABA therapy is subject to PA and is covered when *all* the following criteria are met:

- A diagnosis of ASD has been made by a qualified provider.
- The individual has completed a comprehensive diagnostic evaluation performed by a qualified provider.
- The individual is 20 years of age or younger.
- The goals of the intervention are appropriate for the individual's age and impairment.
- Documentation is provided that describes an individual treatment plan developed by a licensed or certified behavior analyst and includes *all* the following:
  - The identified behavioral, psychological, family, and medical concerns
  - Measurable short-term, intermediate, and long-term goals that are based on standardized assessments relative to age-expected norms and that address the behaviors and impairments for which the intervention is to be applied *Note: The goals should include baseline measurements, progress to date, and an anticipated time line for achievement, based on both the initial assessment and subsequent interim assessments over the duration of the intervention.*
  - Plans for parent/guardian training and school transition
  - Documentation that ABA services will be delivered by an appropriate provider licensed or certified as a behavior analyst (see *Provider requirements*).

Providers completing the comprehensive diagnostic evaluation must use a standardized assessment tool. Additionally, the evaluation must include a recommended treatment referral for ABA therapy that specifies the projected length of treatment. ABA therapy assessments and reassessments do not require PA.

PA for the initial course of therapy may be approved for up to six months. To continue providing ABA therapy beyond the initial authorized time frame, providers must submit a new PA request and receive approval.

Continued courses of ABA therapy

Continuation of ABA therapy beyond the initial course is subject to PA and may be approved if *all* the following criteria are met:

- The individual has met the criteria for an initial course of ABA.
- The individual treatment plan is updated and submitted, as required.
- Developmental testing was conducted no later than two months after the initial course of ABA treatment began, to establish a baseline in the areas of social skills, communications skills, language skills, and adaptive functioning.
- The individual treatment plan includes age- and impairment-appropriate goals and measures of progress in social skills, communication skills, language skills, and adaptive functioning.
- For each goal in the individual treatment plan, the following is documented:
  - Progress to date
  - Anticipated time line for achievement of each goal based on both the initial assessment and subsequent interim assessments over the duration of the intervention
- Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning is documented.

Table 1 – Procedure codes covered for ABA therapy for DOS on or after February 6, 2016

Code	Description
96150 U1	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment; ABA Therapy Assessment provided by BCBA, BCBA-D, or HSPP
96150 U2	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment; ABA Therapy Assessment provided by BCaBA
96151 U1	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment; ABA Therapy Re-assessment provided by BCBA, BCBA-D, or HSPP
96151 U2	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment; ABA Therapy Re-assessment provided by BCaBA
96152 U1	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96152 U2	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by BCaBA
96152 U3	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by RBT
96153 U1	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96153 U2	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by BCaBA
96153 U3	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by RBT
96154 U1	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96154 U2	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by BCaBA
96154 U3	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by RBT
96155 U1	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96155 U2	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by BCaBA
96155 U3	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by RBT

IHCP *bulletin* BT201606 JANUARY 19, 2016

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.

Indiana Medicaid Telemedicine Services Rule

Rule 38. Telemedicine Services

405 IAC 5-38-1 General provisions (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)*

405 IAC 5-38-2 Definitions

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

Sec. 2. The following definitions apply throughout this rule:

(1) "Distant site" means a site at which a provider is located while providing health care services through telemedicine.

(2) "Interactive television" or "IATV" means the videoconferencing equipment at the distant and originating site that allows real time, face-to-face consultation.

(3) "Originating site" means any site at which a patient is located at the time health care services through telemedicine are provided to the individual.

(4) "Store and forward" means the transmission of a patient's medical information from an originating site to the provider at a distant site without the patient being present for subsequent review by a health care provider at the distant site.

Restrictions placed on store and forward reimbursement in this rule shall not disallow the permissible use of store and forward technology to facilitate reimbursable services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-2; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jun 1, 2018, 2:36 p.m.: 20180627-IR-405180060FRA)

405 IAC 5-38-3 Description of service

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

Sec. 3. (a) In any telemedicine encounter, there will be the following:

(1) A distant site.

(2) An originating site.

(3) An attendant to connect the patient to the provider at the distant site.

(4) A computer or television monitor to allow the patient to have:

(A) real-time;

(B) interactive; and

(C) face-to-face;

communication with the distant provider via IATV technology.

(b) Services may be rendered in an inpatient, outpatient, or office setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-3; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jun 1, 2018, 2:36 p.m.: 20180627-IR-405180060FRA)

405 IAC 5-38-4 Limitations

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-13-7-3

Sec. 4. Telemedicine shall be limited by the following conditions:

(1) The patient must:

(A) be physically present at the originating site; and

(B) participate in the visit.

(2) The physician or practitioner who will be examining the patient from the distant site must determine if it is medically necessary for a medical professional to be at the originating site. Separate reimbursement for a provider at the originating site is payable only if that provider's presence is medically necessary. Adequate documentation must be maintained in the patient's medical record to support the need for the provider's presence at the originating site during the visit. Such documentation is subject to postpayment review. If a health care provider's presence at the originating site is medically necessary, billing of the appropriate evaluation and management code is permitted.

(3) Reimbursement for medically necessary telemedicine services is available to the following providers regardless of the distance between the provider and member:

(A) Federally qualified health centers.

(B) Rural health clinics.

(C) Community mental health centers.

(D) Critical access hospitals.
(E) A provider, as determined by the office to be eligible, providing a covered telemedicine service.
(4) Store and forward technology is not reimbursable by Medicaid. The use of store and forward technology is permissible as defined under section 2(4) of this rule.
(5) The following service or provider types may not be reimbursed for telemedicine:
(A) Ambulatory surgical centers.
(B) Outpatient surgical services.
(C) Home health agencies or services.
(D) Radiological services.
(E) Laboratory services.
(F) Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
(G) Anesthesia services or nurse anesthetist services.
(H) Audiological services.
(I) Chiropractic services.
(J) Care coordination services with the member not present.
(K) Durable medical equipment (DME) and home medical equipment (HME) providers.
(L) Optical or optometric services.
(M) Podiatric services.
(N) Physical therapy services.
(O) Transportation services.
(P) Services provided under a Medicaid home and community-based waiver.
(Q) Provider to provider consultations.
(Office of the Secretary of Family and Social Services; 405 IAC 5-38-4; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Jun 1, 2018, 2:36 p.m.: 20180627-IR-405180060FRA)

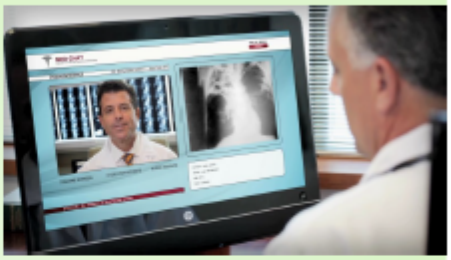
Indiana Health Coverage Programs Provider Bulletin on Telemedicine Services

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201807 MARCH 2, 2018

IHCP revises policy for telemedicine services

Effective April 1, 2018, the Indiana Health Coverage Programs (IHCP) is revising its coverage policy regarding telemedicine services to align with *Indiana Code (IC)*.



- The IHCP is revising policy terminology to match terminology used in *IC 25-1-9.5* by replacing references to "hub site" and "spoke site" with the following terms:
  - **Distant site** (formerly hub site): Location of the provider rendering healthcare services
  - **Originating site** (formerly spoke site): Location where the patient is physically located when services are provided through telemedicine
- The IHCP will eliminate the requirement that telemedicine services are covered only when the **distant site** (the location of the provider rendering services) and the **originating site** (the physical location of the patient) are greater than 20 miles apart. **The distance requirement will be eliminated for all provider types eligible to render telemedicine services (see *IC 12-15-5-11*).**

This policy change applies to all IHCP programs, subject to limitations established for certain benefit packages and applies retroactively to dates of service (DOS) on or after **October 1, 2017**.

Also, to further clarify, *Indiana Code* does allow a provider to use telemedicine to prescribe a controlled substance to a not-previously examined patient. Opioids, however, **cannot** be prescribed via telemedicine, **except** in cases in which the opioid is a partial agonist (such as buprenorphine) **and** is being used to treat or manage opioid dependence.

When billing telemedicine services for fee-for-service (FFS) members, providers are encouraged to use place of service (POS) code 02 – *The location where health services and health related services are provided or received, through a telecommunication system*. The POS code 02 describes services furnished via telemedicine. Questions about billing telemedicine services for managed care members should be directed to the managed care entity (MCE) with which the member is enrolled.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.

Page 1 of 1

Indiana Medicaid Rules on Coverage and Reimbursement for Mental Health Services

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

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

405 IAC 5-20-8 Outpatient mental health services
Authority: IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3
Sec. 8. Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:
(1) Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.
(2) Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.
(3) The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:
(A) The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven (7) days of the intake process.
This review by the physician, psychiatrist, or HSPP must be documented in writing.
(B) The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.
(4) Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:
(A) Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable *[sic]* and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.

(B) Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.
(C) Services may be provided for consumers of all ages who are not at imminent risk to harm to *[sic]* self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers must have a diagnosed or suspected behavioral health condition and one (1) of the following:
(i) A short-term deficit in daily functioning.
(ii) An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.
(D) Program standards shall be as follows:
(i) Services must be ordered and authorized by a psychiatrist.
(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).
(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty-four (24) hours following admission to the program.
(iv) A psychiatrist must actively participate in the case review and monitoring of care.
(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.
(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.
(vii) For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record.
(viii) For consumers under eighteen (18) years of age, a minimum of one (1) family encounter per five (5) business days of episode of care is required.
(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
(x) Programs must not mix consumers receiving partial hospitalization services with consumers receiving outpatient behavioral health services.
(E) Exclusions shall be as follows:
(i) Consumers at imminent risk of harm to self or others are not eligible for services.
(ii) Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.
(iii) Consumers who cannot actively engage in psychotherapy are not eligible for services.
(iv) Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.
(v) Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.
(5) Medicaid will reimburse for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.
(6) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:
(A) A physician.
(B) An HSPP.
(C) A practitioner listed in subdivision (7).
(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:

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

Indiana Law on School Psychologist Independent Practice Endorsement (IPE)

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

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

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

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

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

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

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

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

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

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

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

(i) Consultations with teachers and parents.

(ii) Intervention services, excluding psychotherapy.

(iii) Functional behavior assessments.

(iv) Behavior improvement plans.

(v) Progress monitoring.

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

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

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

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

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

(10) Pass the examination provided by the department.

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

IC 20-28-12-4

Provision of services on private basis

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

(1) A developmental center.

(2) A public school or private school.

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

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

Rule 1. General Provisions

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

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

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

(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-3; filed May 28, 1998, 5:10 p.m.: 21 IR 3835; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529; errata filed Jul 11, 2005, 10:00 a.m.: 28 IR 3308)

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

licensed under IC 25-22.5, a psychologist licensed under IC 25-33, or a school psychologist endorsed under this article that meets the following requirements:
(A) The fifty-two (52) hours must be completed within at least twenty-four (24) consecutive months but not less than twelve (12) months.
(B) Not more than one (1) hour of supervision may be included in the total for each week.
(C) At least nine hundred (900) hours of direct client contact must take place during the total period under clause (A).
(8) Furnish satisfactory evidence to the board that the applicant does not have a conviction for a crime that has a direct bearing on the applicant's ability to practice competently.
(9) Furnish satisfactory evidence to the board that the applicant has not been the subject of a disciplinary action by a licensing or certification agency of any jurisdiction on the grounds that the applicant was not able to practice as a school psychologist without endangering the public.
(10) Pass the examination provided by the board.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-4; filed May 28, 1998, 5:10 p.m.: 21 IR 3836; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529; errata filed Jul 11, 2005, 10:00 a.m.: 28 IR 3308)

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

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

515 IAC 2-1-6 Disclosure of information

Authority: IC 20-28-2-6; IC 20-28-12
Affected: IC 20-28-12
Sec. 6. A school psychologist who is endorsed under this article may not disclose any information acquired from persons with whom the school psychologist has dealt in a professional capacity, except under the following circumstances:
(1) Trials for homicide when the disclosure related directly to the fact or immediate circumstances of the homicide.
(2) Proceedings:
(A) to determine mental competency; or
(B) in which a defense of mental incompetency is raised.
(3) Civil or criminal actions against a school psychologist for malpractice.
(4) Upon an issue as to the validity of a document.

(5) If the school psychologist has the expressed consent of the client or, in the case of a client's death or disability, the express consent of the client's legal representative.
(6) Circumstances under which privileged communication is lawfully invalidated.
(Advisory Board of the Division of Professional Standards; 515 IAC 2-1-6; filed May 28, 1998, 5:10 p.m.: 21 IR 3837; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)

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

(d) An individual seeking an exemption under this section must apply to the board before July 1, 1998. *(Advisory Board of the Division of Professional Standards; 515 IAC 2-2-1; filed May 28, 1998, 5:10 p.m.: 21 IR 3837; readopted filed Sep 25, 2001, 9:43 a.m.: 25 IR 529)*

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

Health Service Provider in Psychology (HSPP)

IC 25-33-1-5.1

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

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

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

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

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

(4) Possesses a doctoral degree in psychology:

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

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

(5) Is not in violation of this chapter or rules adopted by the board under section 3 of this chapter.

(6) Has paid the fee set by the board under section 3 of this chapter.

(7) Has passed the examination required and administered by the board.

(b) If an applicant has been disciplined by a licensing agency in another state or jurisdiction on the ground that the applicant was unable to competently practice psychology, the applicant must submit proof, satisfactory to the board, that the reasons for disciplinary sanction by the other licensing agency are no longer valid.

(c) The board shall endorse as a health service provider in psychology an individual who:

(1) has a doctoral degree in clinical psychology, counseling psychology, school psychology, or another applied health service area of psychology;

(2) is licensed under this section, section 5.3, or section 9 of this chapter;

(3) has at least two (2) years of experience in a supervised health service setting in which one (1) year of experience was obtained in an organized health service training program and in which at least one (1) year of experience was obtained after the individual received the individual's doctoral degree in psychology; and

(4) complies with the continuing education requirements under IC 25-33-2 (*emphasis added*)**.**

(d) An individual who received a doctoral degree in clinical psychology, counseling psychology, school psychology, or other applied health service area in psychology before September 1, 1983, may satisfy one (1) year of the two (2) year supervised health setting experience requirement under subsection (c) by successfully completing a preceptorship program. The individual must apply in writing to the board and the board must approve the program. The preceptorship program must:

(1) consist of at least one thousand eight hundred (1,800) hours of clinical, counseling, or school psychology work experience;

(2) consist of at least one hundred (100) hours of direct supervision of the individual by a psychologist, at least fifty (50) hours of which must involve the diagnosis of mental and

behavioral disorders and at least fifty (50) hours of which must involve the treatment of mental and behavioral disorders;

(3) be completed in a health service setting that provides services in the diagnosis and treatment of mental and behavioral disorders;

(4) be under the supervision of a psychologist who meets the requirements for endorsement under this section; and

(5) be completed within two (2) years after the date the program is started.

(e) If an individual applies to the board under subsection (d), the board shall apply each hour of work experience the individual completes after applying to the board and before the board approves the preceptorship program to the one thousand eight hundred (1,800) hour work experience requirement under subsection (d)(1).

As added by P.L.249-1985, SEC.4. Amended by P.L.149-1987, SEC.97; P.L.152-1988, SEC.27; P.L.96-1990, SEC.16; P.L.33-1993, SEC.68; P.L.140-1993, SEC.11; P.L.1-1994, SEC.128.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Indiana Law on the Practice of School Psychology

IC 20-28-1-11
"School psychology"

Sec. 11. "School psychology" means the following:

(1) Administering, scoring, and interpreting educational, cognitive, career, vocational, behavioral, and affective tests and procedures that address a student's:

(A) education;
(B) developmental status;
(C) attention skills; and
(D) social, emotional, and behavioral functioning;

as they relate to the student's learning or training in the academic or vocational environment.

(2) Providing consultation, collaboration, and intervention services (not including psychotherapy) and providing referral to community resources to:

(A) students;
(B) parents of students;
(C) teachers;
(D) school administrators; and
(E) school staff;

concerning learning and performance in the educational process.

(3) Participating in or conducting research relating to a student's learning and performance in the educational process:

(A) regarding the educational, developmental, career, vocational, or attention functioning of the student; or
(B) screening social, affective, and behavioral functioning of the student.

(4) Providing inservice or continuing education services relating to learning and performance in the educational process to schools, parents, or others.

(5) Supervising school psychology services.

(6) Referring a student to:

(A) a speech-language pathologist or an audiologist licensed under IC 25-35.6 for services for speech, hearing, and language disorders; or
(B) an occupational therapist licensed under IC 25-23.5 for occupational therapy services;

by a school psychologist who is employed by a school corporation and who is defined as a practitioner of the healing arts for the purpose of referrals under 42 CFR 440.110.

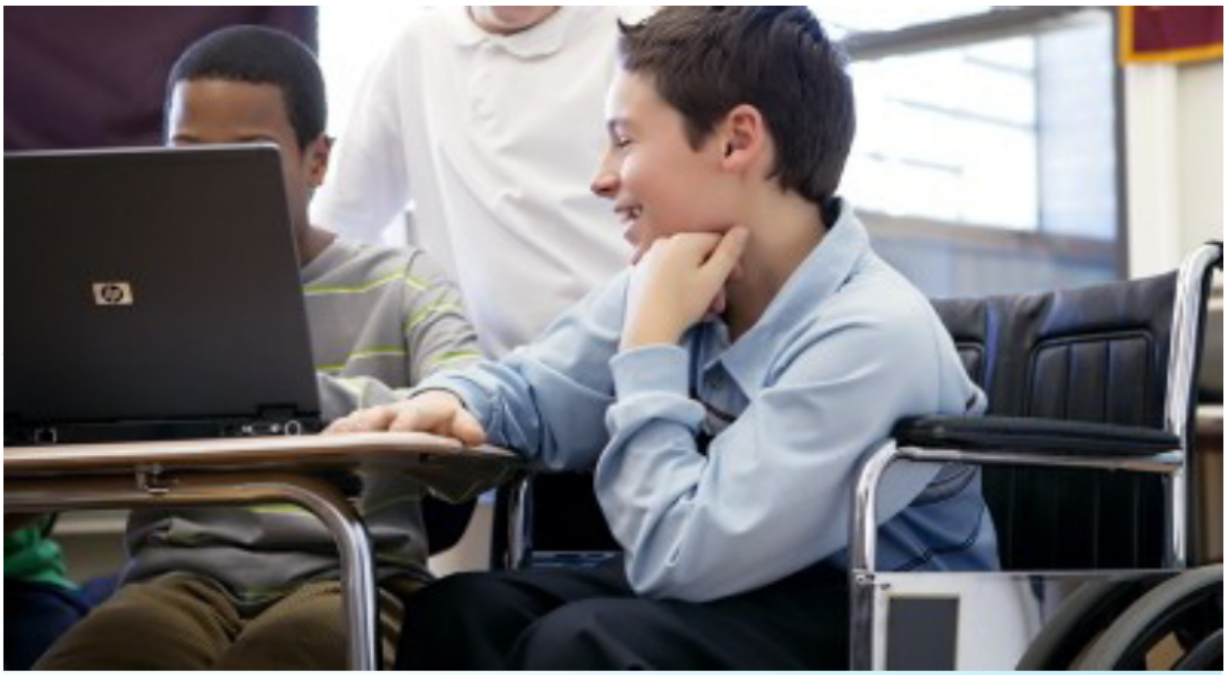
The term does not include the diagnosis or treatment of mental and nervous disorders, except for conditions and interventions provided for in state and federal mandates affecting special education and vocational evaluations as the evaluations relate to the assessment of handicapping conditions and special education decisions or as the evaluations pertain to the placement of children and the placement of adults with a developmental disability.

As added by P.L.1-2005, SEC.12. Amended by P.L.157-2006, SEC.9; P.L.99-2007, SEC.175; P.L.197-2007, SEC.14.

Indiana Medicaid Policy Bulletin on IEP Nursing and Transportation services

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201108 APRIL 5, 2011



Coverage of IEP-related nursing and transportation services

The Indiana Health Coverage Programs (IHCP) provides coverage for nursing services and transportation services provided by public school corporations for students with health-related nursing and transportation needs identified in Individualized Education Programs (IEPs). The Office of Medicaid Policy and Planning (OMPP) and representatives from the Indiana Department of Education (DOE) developed the instructions in this bulletin to assist school corporations in billing for these services. School corporations may submit claims to the IHCP for nursing and transportation services provided on or after July 1, 2010, to Medicaid-enrolled students with health-related nursing and transportation needs identified in IEPs.

IEP nursing service

Medicaid reimbursement is available for IEP nursing services rendered by a registered nurse (RN) employed by or under contract with a Medicaid-enrolled school corporation provider when the services are medically necessary, as ordered by a physician and provided pursuant to a Medicaid-enrolled student's IEP. The IEP is the prior authorization for the IEP nursing services; thus, no additional prior authorization is necessary. School corporations should bill the Current Procedural Terminology (CPT®[1]) code 99600 TD TM and the appropriate number of units based on accurate start and stop times.

[1] *CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Continue

IEP nursing services

CPT Code	Description	Billing Unit	Reimbursement
99600 TD TM	IEP-related nursing services	15 minutes	$9.97 per 15 minutes

Aggregate daily total care time should be billed. If total daily care is eight minutes or more, the provider may round the units up to the 15-minute unit of service and bill one unit of 99600 TD TM. If total daily care time is seven minutes or less, the provider cannot round this up, and therefore, cannot bill for it.

Documentation of IEP nursing services must include the start and stop times for each IEP nursing service provided per date of service. Documentation of IEP nursing services provided off-site or during a school field trip must note the place of service and include a description of the beginning and ending dates and times of the school field trip. The student's IEP must specifically authorize the Medicaid-covered IEP service for which there is a documented medical need.

Coverage and reimbursement of CPT 99600 TD TM includes all services performed in accordance with the scope of practice for a registered nurse. Thus, CPT 99600 TD TM is an all-inclusive code, including, but not limited to, administration of oral medication and nebulizer treatments. The exception to this is diabetes self-management training (DSMT). If DSMT is provided pursuant to a Medicaid-enrolled student's IEP, the most appropriate code should be billed with the IEP-related modifier TM to identify it as an IEP-related service. Providers are reminded that, as with all IEP nursing services, DSMT must be medically necessary and provided pursuant to a Medicaid-enrolled student's IEP. Additionally, all other requirements and guidelines stated in IHCP provider communications, including the *IHCP Provider Manual* and provider banners and bulletins, must be met. Further information may also be found in *School Corporation Medicaid Billing Tool Kit, Chapter 8.2,* located on the Indiana Department of Education Web site (www.doe.in.gov).

IEP nursing services – DSMT

CPT Code	Description
G0108 TM	Diabetes outpatient self-management training services, individual, per 30 minutes (IEP related)
G0109 TM	Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes (IEP related)

IEP transportation service

Medicaid reimbursement is available for IEP transportation services rendered by personnel employed by or contractors of a Medicaid-enrolled school corporation provider when the services are medically necessary and provided pursuant to a Medicaid-enrolled student's IEP. IEP-related transportation services are not covered when provided by a member of the child's family, unless that person is employed by or a contractor of the school corporation.

IEP transportation services must be authorized in the child's IEP and must be provided to enable the child to receive another Medicaid-covered service identified in the child's IEP. The IEP is the prior authorization for the IEP transportation service; thus, no additional prior authorization is necessary. Two types of IEP transportation services are covered

Continue

on a day when the child received another Medicaid-covered IEP service: (1) a trip from home to school and the return trip (school to home); and (2) a trip from school or home to an off-site Medicaid service provider and the return trip (off-site Medicaid provider to school or home). IEP transportation services include transportation of a child who resides in an area that does not typically have school bus service when that child's IEP stipulates a medical need for transportation, and all other requirements are met.

IEP transportation services shall be provided using a type of vehicle that is appropriate for the child's disability and which meets the specifications established in:

- *575 IAC 1-5*;
- *575 IAC 1-5.5*; or
- *575 IAC 1-1-1 (a)* through *(h)*.

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

When billing IEP transportation services, modifier TM must be attached to the end of all transportation billing codes to identify the service as IEP related. Additionally, school corporations should follow all IHCP transportation guidelines and rules, as stated in IHCP banners and bulletins, including *BT200505*, and the *IHCP Provider Manual*. Additional information may be located in *School Corporation Medicaid Billing Tool Kit, Chapter 8.2,* located on the Indiana Department of Education Web site (www.doe.in.gov). The only transportation guidelines and regulations from which school corporations are exempt are listed below:

- Prior authorization requirement – The student's IEP serves as the prior authorization for IEP transportation services; thus, no additional PA is required, regardless of the number of one-way trips.
- Enrollment requirements set out in *405 IAC 5-4-2* – When transportation services provided conform with *405 IAC 5-30-11*, and requirements set out in *IC 20-27* are met.
- Copayment requirement – Pursuant to federal law, transportation copayments should not be collected by school corporations for members who receive IEP transportation services.
- Member's signature on documentation – Member's signature is not a documentation requirement for IEP transportation services. However, school corporations are responsible for all other transportation documentation requirements identified in IHCP bulletins and banners, including BT200505, and the *IHCP Provider Manual*. Additional information may also be found in *School Corporation Medicaid Billing Tool Kit, Chapter 8.2,* located on the Indiana Department of Education Web site (www.doe.in.gov). This includes the member's Medicaid identification number, which may be documented on the trip log by office personnel.

The IHCP defines a trip as *transporting a member from the initial point of pickup to the drop-off point at the final destination*. The member being transported must be present in the vehicle in order for IHCP reimbursement to be available. The IEP transportation must be the least expensive type of transportation that meets the medical needs of the member. Additionally, providers are expected to transport members along the shortest, most efficient route to and from a designation. Providers must bill all transportation services according to the level of care rendered, not the vehicle type.

Continue

For a complete list of transportation codes, please refer to Chapter 8, Section 4, of the *IHCP Provider Manual* and IHCP banners and bulletins, including *BT200505*. When billing IEP transportation services, school corporations should attach the information modifier TM to the end of all appropriate transportation billing codes to identify the services as IEP related. It is anticipated that the most frequently billed IEP-related transportation codes will be those for common ambulatory services (CAS) and nonambulatory services (NAS). The CAS and NAS code sets follow. Common ambulatory services (CAS), also referred to as *commercial* ambulatory services, may be provided to a member who is able to walk. Claims for ambulatory members transported in a vehicle equipped to transport nonambulatory members must be billed according to the CAS level of service and rate, and thus, not billed according to the vehicle type. Nonambulatory services (NAS) are transportation services provided to nonambulatory members who must travel in wheelchairs to or from an IHCP-covered service.

IEP-Related Common Ambulatory Service (CAS)

Note: CAS transportation indicates level of service rendered, not vehicle type.

HCPCS Code	Description
A0425 U3 TM	Ground mileage, per statute mile; CAS (TM = IEP related)
T2001 TM	Non-emergency transportation, patient attendant/escort (CAS) (TM = IEP related)
T2003 TM	Non-emergency transportation, encounter/trip (CAS) (TM = IEP related)
T2004 TM	Non-emergency transportation, commercial carrier, multi-pass (CAS) (TM = IEP related)
T2007 U3 TM	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (½) hour increments; CAS (TM = IEP related)

IEP-Related Nonambulatory Service (NAS)

Note: NAS transportation indicates level of service rendered, not vehicle type.

HCPCS Code	Description
A0130 TM	Non-emergency transportation, wheelchair van base rate (TM = IEP related)
A0130 TK TM	Non-emergency transportation, wheelchair van base rate; extra patient or passenger, non-ambulance (TM = IEP related)
A0130 TT TM	Non-emergency transportation, wheelchair van base rate; individualized service provided to more than one patient in same setting (TM = IEP related)
A0130 U6 TM	Non-emergency transportation, wheelchair van base rate; additional attendant (TM = IEP related)
A0425 U5 TM	Ground mileage, per statute mile; NAS (TM = IEP related)
T2007 U5 TM	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (½) hour increments; NAS (TM = IEP related)

Continue

IHCP *bulletin* BT201108 APRIL 5, 2011

Although the first 10 miles of a CAS or NAS trip are automatically deducted from each one-way trip, CAS and NAS providers must bill for all mileage, including the first 10 miles, to ensure proper reimbursement. For trips of less than 10 miles, the provider is not required to bill mileage; however, if mileage is billed, the mileage processes as a denied line item. Providers must bill the IHCP for whole units only. Partial mileage units must be rounded to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles.

QUESTIONS?

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

COPIES OF THIS BULLETIN

If you need additional copies of this bulletin, please download them from indianamedicaid.com. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Indiana Medicaid Rule on IEP Nursing Services – Section 2(c)

405 IAC 5-22-2 Nursing services; prior authorization requirements
Authority: IC 12-15
Affected: IC 12-13-7-3
Sec. 2. (a) Medicaid reimbursement is available for services rendered by registered nurses, licensed practical nurses, and home health agencies who are Medicaid providers, subject to the following:
(1) Prior authorization is required for all nursing services, except services ordered in writing by a physician prior to the recipient's discharge from an inpatient hospital, which may continue for a period not to exceed one hundred twenty (120) units within thirty (30) days of discharge without prior authorization and except as noted in subsection (c). Prior authorization requests may be submitted by an authorized representative of the home health agency. The prior authorization form must contain the information specified in 405 IAC 5-3-5. In addition, the following information must be submitted with the prior authorization request form:
(A) A copy of the written plan of treatment, signed by the attending physician.
(B) An estimate of the costs for the requested services as ordered by the physician and as set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
(2) Prior authorization shall include consideration of the following:
(A) Written order of a physician.
(B) Services must be provided according to a plan of treatment developed in coordination with the attending physician.
(C) The attending physician must review the plan of treatment every sixty (60) days and reorder the service if medically reasonable and necessary.
(D) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of nursing services, must be attached to the prior authorization request and available for postpayment audit purposes.
(E) Additional hours of nursing service may be authorized for ventilator dependent patients who have a developed plan of home health care providing it is cost effective and prevents repeated or prolonged stays in an acute care facility.
(b) Reimbursement is not available for care provided by family members or other individuals residing with the recipient.
(c) Medicaid reimbursement is available for IEP nursing services when the services are medically necessary, consistent with the definition set forth in 405 IAC 5-2-13.2, and provided pursuant to a Medicaid enrolled student's IEP. The following apply to IEP nursing services:
(1) The IEP is the prior authorization for IEP nursing services, when provided by a Medicaid participating school corporation.
(2) The school corporation must bill for the appropriate start and stop time or times of IEP nursing services. Documentation of IEP nursing services must include:
(A) The start and stop time or times for each IEP nursing service provided per date of service.
(B) The place of service and a description of the beginning and ending date or dates and time or times if the IEP services provided off-site or during a school field trip.
(3) The Medicaid enrolled student's IEP must:
(A) specifically authorize the Medicaid covered IEP nursing service; and
(B) demonstrate there is a medical need for the IEP nursing service.
(4) The reimbursement rate will be set by the office.
(Office of the Secretary of Family and Social Services; 405 IAC 5-22-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; filed Sep 27, 1999, 8:55 a.m.: 23 IR 317; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

Indiana Medicaid Rule on Diabetes Self Management Training

Rule 36. Diabetes Self Management Training
405 IAC 5-36-1 DSMT policy; definitions
Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5-6
Sec. 1. (a) Reimbursement is available for diabetes self management training (hereinafter "DSMT"), as defined in this rule and when provided in accordance with all applicable provisions of this rule, provider bulletins, provider manuals, and the provider agreement.
(b) As used in this rule, "DSMT" means diabetes self management training and is comprised of those services provided in accordance with IC 27-8-14.5-6. These services are intended to enable the patient to, or enhance the patient's ability to, properly manage their diabetic condition, thereby optimizing their own therapeutic regimen. Examples of DSMT include, but are not limited to, the following:
(1) Instruction regarding the diabetic disease state, nutrition, exercise, and activity.
(2) Medications counseling.
(3) Blood glucose self-monitoring training.
(4) Foot, skin, and dental care.
(5) Behavior change strategies and risk factor reduction.
(6) Preconception care, pregnancy, and gestational diabetes.
(7) Accessing community health care systems and resources.
(c) As used in this rule, "health care professionals" means the following:
(1) Chiropractors.
(2) Dentists.
(3) Health facility administrators.
(4) Physicians.
(5) Nurses.
(6) Optometrists.
(7) Pharmacists.
(8) Podiatrists.
(9) Environmental health specialists.
(10) Audiologists.
(11) Speech-language pathologists.
(12) Psychologists.
(13) Hearing aid dealers.
(14) Physical therapists.
(15) Respiratory therapists.
(16) Occupational therapists.
(17) Social workers.
(18) Marriage and family therapists.
(19) Physician assistants.
(20) Athletic trainers.
(21) Dieticians.
(d) As used in this rule, a "unit" of DSMT service means a time period of fifteen (15) minutes. *(Office of the Secretary of Family and Social Services; 405 IAC 5-36-1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; errata*

filed Dec 9, 1999, 1:17 p.m.: 23 IR 814; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-36-2 Requirements for the provision of DSMT
Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5
Sec. 2. (a) DSMT must be medically necessary for the patient.
(b) DSMT must be ordered in writing by a physician or podiatrist licensed under applicable Indiana law.
(c) DSMT must be provided by a health care professional licensed under applicable Indiana law.
(d) The health care professional that provides DSMT must have specialized training in the management of diabetes. *(Office of the Secretary of Family and Social Services; 405 IAC 5-36-2; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-36-3 Limitations on coverage of DSMT
Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5
Sec. 3. (a) Coverage of DSMT is limited to sixteen (16) units of DSMT per recipient, per rolling calendar year without prior authorization. Additional units of DSMT may be authorized via the prior authorization process.
(b) Coverage of DSMT is limited to the following clinical circumstances:
(1) Receipt of a diagnosis of diabetes.
(2) Receipt of a diagnosis that represents a significant change in the patient's symptoms or condition.
(3) Re-education or refresher training.
(Office of the Secretary of Family and Social Services; 405 IAC 5-36-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

Indiana Health Coverage Programs Provider Reference Modules Excerpt on Billing DSMT

Diabetes Self-Care Management Training Services

Coverage and Billing Procedures

The IHCP covers diabetes self-care management training services. The IHCP defines self-care management training as services provided in accordance with the terms and provisions of *IC 27-8-14.5(6)*. The IHCP intends these services to enable the patient, or enhance the patient's ability to properly manage a diabetic condition, thereby optimizing the therapeutic regimen. The following are examples of diabetes self-care management training activities:

• Accessing community healthcare systems and resources

• Behavior changes, strategies, and risk factor reduction

• Blood glucose self-monitoring

• Instruction regarding the diabetic disease state, nutrition, exercise, and activity

• Insulin injection

• Foot, skin, and dental care

• Medication counseling

• Preconception care, pregnancy and gestational diabetes

The IHCP limits coverage to eight units or a total of four hours per member, per rolling calendar year. Providers can prior authorize additional units [Editor's NOTE: for IEP services, Indiana Medicaid recognizes the IEP as the Medicaid Prior Authorization for the service and no additional prior authorization is required]. The IHCP covers diabetes self-management training services for Package C members. ~~*Note: For RBMC members, send claims to the appropriate MCE.*~~

Practitioners Eligible to Provide Services

Healthcare practitioners, licensed, registered, or certified under applicable Indiana law, with specialized training in the management of diabetes that meets community standards, must provide the diabetes self-care management training services.
~~Practitioners eligible to provide diabetes self-management training services, but not currently enrolled as IHCP providers, can obtain additional information in *Chapter 4* of this manual. Eligible practitioners, such as pharmacists, who work for or own IHCP-enrolled pharmacies should bill for services rendered through the enrolled entity where services are provided. MCE contact information is included in *Chapter 1, Section 2* of this manual.~~ The following are examples of IHCP practitioners who **may** enroll and bill for direct care services or supervision of services:

• Audiologists

• Chiropractors

• Dentists

• Hearing aid dealers

• Nurses [Editor's note: for IEP services, the School Corp is the "enrolled provider" – the licensed R.N. employed by or under contract with the School Corp is the "Medicaid-qualified provider of service" for whose services the School Corp may bill in accordance with Medicaid rules]

• Occupational therapists

• Optometrists

• Pharmacists

• Physical therapists

• Physicians

• Podiatrists

• Respiratory therapists

• Speech and language pathologists

The following are examples of IHCP practitioners who **may not** enroll in the IHCP. Practitioners in this list must bill under the supervising practitioner's IHCP NPI:

Athletic trainers
Dietitians
Environmental health specialists
Health facility administrators
Marriage and family therapists
Physician assistants
Psychologists
Social workers

Providers are not entitled to reimbursement for any services provided to the general public at no charge [Editor's NOTE: per federal legislation exempting IDEA Part B and Part C services, this caveat is not applicable to IEP services provided by a school corporation]. Adherence to this program parameter is closely monitored by the IHCP Program Integrity Department.

Procedure Codes and Units of Service

Providers must bill for the service only on the *CMS-1500* or *837P transaction* using procedure code *G0108 – Diabetes outpatient self-management training services, individual per 30 minutes,* or *G0109 – Diabetes self-management training service, group session (2 or more), 30 minutes*. Providers should not round up to the next unit. Instead, providers should accumulate billable time equivalent to whole units and then bill. Limit service to eight units per member, or the equivalent of four hours, per rolling calendar year, applicable under any of the following circumstances:

Receipt of a diagnosis of diabetes
Receipt of a diagnosis that represents a significant change in the member's symptoms or condition
Re-education or refresher training

~~Providers can request authorization for additional units through the standard PA process~~. ~~The IHCP reviews the documentation for additional requested units of service for evidence of medical necessity~~. [Editor's NOTE: for IEP services, Indiana Medicaid recognizes the IEP as the Medicaid Prior Authorization for the service and no additional prior authorization is required]. Providers should bill the *usual and customary charge* for the units of service rendered.

Billing and rendering practitioners should maintain sufficient documentation of the respective functions to substantiate the medical necessity of the service rendered and the provision of the service itself. This requirement is in accordance with existing policies and regulations. Physicians and podiatrists ordering the service should maintain documentation in the usual manner. Examples of documentation that the provider of the service should maintain include (but are not limited to) written orders for the service, date rendering the service, amount of time used for the training session, general content of the training session, units of service billed, charge amount, pertinent patient history and clinical data, and practitioner notes from the training sessions.

Indiana Medicaid Rule on IEP Transportation Services

405 IAC 5-30-11 IEP transportation services
Authority: IC 12-15
Affected: IC 12-13-7-3; IC 20-27
Sec. 11. Medicaid reimbursement is available for IEP transportation services subject to the following limitations:
(1) Services are consistent with the definition set forth in 405 IAC 5-2-13.3.
(2) IEP transportation services must be listed in a Medicaid enrolled student's IEP and must be necessary to enable the student to receive other Medicaid covered services listed in the student's IEP.
(3) IEP transportation services:
(A) must be rendered by school corporation personnel or their contractor; and
(B) are not covered when provided by a member of the student's family if the person is not an employee of the school corporation.
(4) IEP transportation service must be provided using a type of vehicle that is appropriate for the student's disability and meets the specifications established in:
(A) 575 IAC 1-1-1(a) through 575 IAC 1-1-1(h);
(B) 575 IAC 1-5; or
(C) 575 IAC 1-5.5.
(5) Additional reimbursement is available for an attendant, subject to the limitations in 405 IAC 5-30-8(1) and 405 IAC 5-30-8(2), provided the student's IEP includes the need for an attendant and all other Medicaid requirements are met.
(6) Documentation for IEP transportation service claims, such as an ongoing trip log maintained by the provider of the transportation, must be maintained for audit purposes.
(7) Reimbursement is available for IEP transportation services subject to the requirements set forth in this rule and when provided in accordance with provider communications, including banners, bulletins, provider reference modules, and the provider agreement.
(8) School corporations are exempt from the transportation provider requirements set out in 405 IAC 5-4-2, when transportation services provided are in conformance with this rule and IC 20-27.
(Office of the Secretary of Family and Social Services; 405 IAC 5-30-11; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

Indiana Medicaid Policy Bulletin Applicable to All Transportation Services, except as noted in IEP Transportation Bulletin #BT201108

Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200505 MARCH 8, 2005

To: **All Transportation Providers**

Subject: **Transportation Billing Guide**

Table of Contents

Table of Contents 1
Types of Transportation Services and Definitions 2
Advanced Life Support – ALS 2
Basic Life Support – BLS 2
Commercial or Common Ambulatory Service – CAS 3
Non-Ambulatory Service (Wheelchair Van) – NAS 3
Taxi 3
Definition of a Trip 4
Multiple Destinations 4
Prior Authorization 5
Twenty One-Way Trip Limitation and Exemptions 5
Emergency Transportation Services 5
Hospital Admission or Discharge 5
Members on Renal Dialysis or Members Residing in Nursing Homes 6
Accompanying Parent or Attendant 6
Additional Attendant 6
Mileage 6
Mileage Units and Rounding 7
Multiple Passengers 7
Accompanying Parent or Attendant 8
Additional Attendant 9
Waiting Time 9
Ambulance Transportation Services 10
Level of Service Rendered Versus Level of Response 10
Ambulance Mileage 11
Neonatal Ambulance Transportation 11
Oxygen and Oxygen Supplies 12
Member Copayments 12
Exemptions to Copayments for Transportation Services 12
Federal Guidelines for Copayment Policy 12
Package C Transportation Services 13
Risk Based Managed Care Hoosier Healthwise Services 13
Non-covered Transportation Services 13
Documentation Requirements for Transportation Services 13
Registration Requirements 14
Transportation Code Sets 15

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

For more information visit www.indianamedicaid.com

Page 1 of 23

Commercial Ambulatory Service Provider 15
Non-Ambulatory Service Provider 16
Ambulance (ALS and BLS) Provider 17
Air Ambulance 19
Taxi Provider 20
Family Member Transportation Provider 21
Bus Provider 21
Prior Authorization Form 22
Documentation Form for Medicaid-Financed Transportation Services 23

> *Note: This billing guide replaces the information published in the* Transportation Coverage and Billing Procedures *subsection of Chapter 8 of the* Indiana Health Coverage Programs (IHCP) Provider Manual, *published July 2004. Future changes will be communicated through newsletters, bulletins, and banner page articles. Providers must monitor all future publications for possible changes.*

Types of Transportation Services and Definitions

Advanced Life Support – ALS

The Indiana Emergency Medical Services Commission (EMSC), *Title 836 of the Indiana Administrative Code (IAC)*, defines advanced life support (ALS) as follows:

- Care given at the scene of an accident, act of terrorism, or illness, care given during transport, or care given at the hospital by a paramedic, emergency medical technician-intermediate, and care that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced.

The term *advanced life support* may include any of the following acts of care.

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications
- Electrocardiogram interpretation
- Emergency management of trauma and illness

The IHCP provides reimbursement for medically necessary emergency and non-emergency ALS ambulance services when the level of service rendered meets the EMSC definition of ALS. Provider registration requirements for ambulance providers, including air ambulance, are listed on page 14 of this billing guide.

> *Note: In accordance with* Indiana Code (IC) 16-1-31, *vehicles and staff that provide emergency services must be certified by the EMSC to be eligible for reimbursement for transports involving either ALS or basic life support (BLS) services.*

Basic Life Support – BLS

BLS is defined by the EMSC as the following:

- Assessment of emergency patients

- Administration of oxygen
- Use of mechanical breathing devices
- Application of antishock trousers
- Performance of cardiopulmonary resuscitation (CPR)
- Application of dressings and bandage materials
- Application of splinting and immobilization devices
- Use of lifting and moving devices to ensure safe transport
- Use an automatic or semiautomatic defibrillator
- Administration of epinephrine through an auto-injector
- An emergency medical technician-basic advanced may perform the following.
  - Electrocardiogram interpretation
  - Manual external defibrillation
  - Intravenous fluid therapy

The term *basic life support* and BLS services do not include invasive medical care techniques or advanced life support. The IHCP provides reimbursement for medically necessary emergency and non-emergency BLS ambulance services when the level-of-service rendered meets the EMSC definition of BLS. Provider registration requirements for ambulance providers, including air ambulance, are listed on page 14 of this billing guide.

Note: More information about coverage and billing of ambulance services is included on page 10 of this billing guide.

Commercial or Common Ambulatory Service – CAS

The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Commercial or Common Ambulatory Service (CAS) transportation may be provided in any type of vehicle; however, providers must bill all transportation services according to the level of service rendered. For example, if transportation of an ambulatory member is provided by an ambulance, but no ALS or BLS services are medically necessary for the transport of the member, the ambulance provider must bill the CAS charges. Base rate, waiting time, and mileage are separately billable and reimbursed for CAS transportation. Provider registration requirements for commercial or common ambulatory carriers are listed on page 14 of this billing guide.

Non-Ambulatory Service (Wheelchair Van) – NAS

Non-ambulatory services (NAS) or wheelchair services are reimbursable when a member must travel **in a wheelchair** to or from an IHCP-covered service. Claims for ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. Base rate, waiting time, and mileage are separately billable and reimbursed for NAS transportation. Provider registration requirements for commercial non-ambulatory providers are listed on page 14 of this billing guide.

Taxi

Taxi providers transport ambulatory members and may operate under authority from a local governing body (city taxi or livery license). Taxi providers whose rates are regulated by local ordinance must bill

the metered or zoned rate, as established by local ordinance, and are reimbursed up to the maximum allowable fee. Taxi providers whose rates are not regulated by local ordinance are reimbursed the lower of their submitted charge or the maximum allowable fee based on trip length. Taxi providers are not separately reimbursed for mileage above the maximum allowable rate for the trip; however, mileage must be documented on the driver's ticket by odometer readings or mapping software. Registration requirements for taxi providers are listed on page 14 of this billing guide.

Definition of a Trip

For billing purposes, a *trip* is defined as transporting a member from the initial point of pick-up to the drop off point at the final destination. Transportation must be the least expensive type of transportation available that meets the medical needs of the member. Trips must be billed according to the level of service rendered and not according to the vehicle type. Providers must bill for all transportation services provided to the same member on the same date of service on one claim form.

If the provider makes a round trip for the same member, same date of service, and same level of base code, both runs should be submitted on the same detail with two units of service to indicate a round trip. Additionally, all mileage for the trip must be billed on the one detail with the total number of miles associated for the roundtrip.

If the provider transports a member on the same date of service, but different trip levels, for example the 'to' trip was a CAS trip, and the 'return' trip was a NAS trip with mileage for each base. These base trips must be billed on two different claim forms with the corresponding mileage for each base.

Note: In the Units field on the CMS-1500 *or Service Unit Count field on the* 837P, *the provider must use a 1 with the base unit code to indicate a one-way trip and a 2 to indicates a two-way trip. The transportation modifiers must be used to indicate the place of origin and destination for each service.*

Multiple Destinations

If the member is transported to multiple points in succession, the provider may not bill for a trip between each point of the destination. The following examples offer explanations of this concept:

- **Example 1**: A vehicle picks up a member at home and transports the member to the physician's office. This is a one-way trip.
- **Example 2:** A vehicle picks up a member from home and transports the member to the physician's office. The provider leaves, and later the same vehicle picks the member up from the physician's office and transports the member back to the member's home. This is considered two one-way trips.
- **Example 3**: A vehicle picks the member up from the physician's office and transports the member to the laboratory for a blood draw, waits outside the laboratory for the member, and then transports the member home. This is a one-way trip, even though there was a stop along the way. A stop along the way is not considered a separate trip.
- **Example 4:** A vehicle picks up Member A at the member's home and begins to transport the Member A to the dialysis center. Along the way, a stop is made to pick up Member B at a nursing home and both Member A and Member B are transported to the dialysis center. The stop at the nursing home is not considered a separate trip and the transportation of Member A from home to the dialysis center is considered a one-way trip.

Note: Information about the policy for multiple passengers is included in Table 1.3 on page 8 of this billing guide.

Prior Authorization

Prior authorization (PA) is required for the following transportation services:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions as described in this billing guide
- Trips of 50 miles or more one way, **including** all codes associated with the trip (wait time, parent or attendant, additional attendant, and mileage)
- Interstate transportation or transportation services rendered by a provider located out-of-state in a non-designated area.
- Train or bus services
- Airline or air ambulance services

PA requests must include a brief description of the anticipated care and description of the clinical circumstances necessitating the need for the transportation. HCE reviews the PA requests and sends copies of the decisions to the members and the rendering providers. Transportation providers may request authorization for members that exceed 20 one-way trips. Examples of situations that require frequent medical intervention include, but are not limited to, prenatal care, chemotherapy, and certain other therapy services. Additional trips are not approved for routine medical services. PA may be granted up to one year following the date of service.

Twenty One-Way Trip Limitation and Exemptions

Transportation is limited to 20 one-way trips per member, per rolling calendar year. Providers must request PA for members who exceed 20 one-way trips if frequent medical intervention is required. However, some services are exempt from the 20 one-way trip limitation. Information about those services is included in the following sections.

Emergency Transportation Services

Emergency ambulance transportation is exempt from the 20 one-way trip limitation. Providers must indicate that the transportation was an emergency by using the **Y** indicator in **Field 24I** on the *CMS-1500* or in the **Emergency Indicator** on the *837P*. Additional information about ambulance transportation services, including emergency transportation, is included on page 10 of this billing guide.

Hospital Admission or Discharge

Transportation services for transporting a member to a hospital for admission or for transporting the member home following discharge from the hospital are exempt from the 20 one-way trip limitation. This includes inter-hospital transportation when the member is discharged from one hospital for the purpose of admission to another hospital. The transportation modifiers must be used to indicate the place of origin and destination for each service.

> *Note: Transporting an IHCP member to or from a hospital for any reason unrelated to an admission or discharge is not exempt from the 20-trip limitation.*

Members on Renal Dialysis or Members Residing in Nursing Homes

Members on renal dialysis and members residing in nursing homes are exempt from the 20 one-way trip limitation. Claims for members undergoing dialysis or members in nursing homes must be filed with one of the diagnosis codes listed in Table 1.1. The diagnosis code should be entered on the *CMS-1500* or *837P*, and a **1** should be placed in **Field 24E** of the *CMS-1500* claim form or the **Diagnosis Code Pointer** on the *837P*, to indicate that the first diagnosis code applies.

> *Note: Transportation providers are only required to complete this field on the claim form for claims being submitted for dialysis or nursing home patients. Failure to complete this field correctly may result in the claim being denied when the member meets the 20 one-way trip limitation.*

Table 1.1 – Diagnosis Codes for Transportation of Renal Dialysis Patients and Patients Residing in Nursing Homes

Diagnosis Code	Usage
V56.0, V56.1, or V56.8	Patient undergoing renal dialysis
V70.5	Patient residing in nursing facility

Accompanying Parent or Attendant

Procedure codes for accompanying parent or attendant are not applied to the member's 20 one-way trip limitation. Prior authorization is required for an accompanying parent or attendant only when the trip exceeds 50 miles one-way. Additional information about the accompanying parent or attendant policy is included on page 8 of this billing guide.

Additional Attendant

Procedure codes *A0424 – Extra ambulance attendant, ground (ALS or BLS) or air (rotary or fixed wing)* and *A0130 U6 – Non-emergency transportation; wheelchair van, additional attendant*, are not applied to the member's 20 one-way trip limitation. Prior authorization is required for procedure codes A0424 and A0130 U6 when the trip exceeds 50 miles one-way. Additional information about the additional attendant policy is included on page 9 of this billing guide.

Mileage

Transportation providers are expected to transport members along the shortest most efficient route to and from a destination. All transportation providers must document mileage on the driver's ticket using odometer readings or mapping software programs. Reimbursement is available for mileage, in addition to the base rate, under the following circumstances:

- Ambulance providers are reimbursed for loaded mileage for **each mile** of the trip regardless of the type level of service being billed.
- CAS and NAS providers are reimbursed for loaded mileage when the member is transported more than ten miles one way.

- Taxi providers are not reimbursed for mileage and are not required to submit mileage with their claim. However, mileage must be documented on the driver's ticket using odometer readings or mapping software, as outlined in the documentation requirements section of this billing guide.
- Although the first 10 miles of a CAS or NAS trip are automatically deducted from each one-way trip, CAS and NAS providers must bill for **all** mileage, including the first 10 miles to ensure proper reimbursement. For trips less than 10 miles, the provider is not required to bill mileage; however, if mileage is billed, the mileage will process as a denied line item.
- Trips and associated mileage in excess of 50 miles one way require PA. If PA has not been obtained, reimbursement for mileage, the base rate, and any other transportation services related to the trip are denied. Providers must bill for all transportation services provided to the same member on the same date of service on one claim form.
- Providers must report mileage using procedure code A0425 and the appropriate U modifier for transportation services in conjunction with ALS, BLS, CAS, or NAS base rates. Mileage must not be fragmented. Mileage for round trips must be submitted on one detail line using the appropriate code listed in Table 1.2.
- Effective July 1, 2004, procedure code *S0215 – Non-emergency transportation; mileage, per mile,* was made non-reimbursable. Providers must bill the appropriate mileage code listed in Table 1.2. In addition, procedure code S0215 must not be reported with the codes listed in Table 1.2, or providers may be reimbursed incorrectly.

Table 1.2 – Mileage Codes and Descriptions

Code	Description
A0425 U1	ALS ground mileage, per statute mile
A0425 U2	BLS ground mileage, per statute mile
A0425 U3	CAS ground mileage, per statute mile
A0425 U5	NAS ground mileage, per statute mile

Mileage Units and Rounding

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

Multiple Passengers

When two or more members are transported simultaneously from the same county to the same vicinity for medical services, the second and subsequent member transported for medical services in a single CAS or NAS vehicle is reimbursed at one-half the base rate. The full base code, mileage, and waiting time are reimbursed for the first member only. For example, no mileage should be billed in conjunction with *T2004 - Non-emergency transport; commercial carrier, multi-pass, individualized service* provided to more than one patient in the same setting.

The IHCP does not provide reimbursement for multiple passengers in ambulances or family member vehicles. Additional reimbursement is not available for multiple passengers when the billing provider does not bill non-IHCP customers for these services. Table 1.3 shows the correct coding methods for multiple passengers.

Table 1.3 Coding Transportation for Multiple Passengers

Type of Transportation	First Member	Second and Subsequent Members
Commercial Ambulatory Services	T2003 for base rate A0425 U3 for mileage T2007 U3 for waiting time, if applicable	T2004 for base rate No reimbursement for mileage No reimbursement for waiting time
Non-Ambulatory Services	A0130 for base rate A0425 U5 for mileage T2007 U5 for waiting time, if applicable	A0130 TT for base rate No reimbursement for mileage No reimbursement for waiting time
Taxi, non-regulated, 0-5 miles	A0100 UA (no mileage)	A0100 UA TT (no mileage)
Taxi, non-regulated, 6-10 miles	A0100 UB (no mileage)	A0100 UB TT (no mileage)
Taxi, non-regulated, 11 or more miles	A0100 UC (no mileage)	A0100 UC TT (no mileage)

Note: PA for a base code includes both the base code and the multiple passenger code that corresponds to the approved base code. When last minute changes in scheduling modify the service from a single passenger to a multiple passenger, the provider must use the appropriate code.

Accompanying Parent or Attendant

Accompanying parent – When members younger than 18 years of age needs an adult to accompany them to a medical service, the provider should bill the appropriate accompanying parent or attendant code.

Accompanying attendant – When adult members need an attendant to travel or stay with them for a medical service, the provider should bill the appropriate accompanying parent or attendant code.

The following are guidelines for billing the accompanying parent or attendant codes:

- The procedure code for the base rate and the accompanying parent or attendant is billed under the IHCP member's identification number (RID).
- Additional reimbursement is not available for accompanying parent or attendant when the billing provider does not bill non-IHCP customers for like services.
- The provider must maintain documentation on the driver's ticket to support that the accompanying parent or attendant was transported with the IHCP member. This documentation must include the name, signature, and relation of the accompanying parent or attendant.

Table 1.4 lists the base rates and the applicable accompanying parent or attendant code. The provider must bill both the base code and the accompanying parent or attendant code using the member's information.

Table 1.4 – Procedure Codes for Accompanying Parent or Attendant

Type of Transportation	Base Code	Accompanying Parent/Attendant
Commercial Ambulatory Services	T2003	T2001
Non-Ambulatory Services	A0130	A0130 TK
Taxi, non-regulated, 0-5 miles	A0100 UA	A0100 UA TK
Taxi, non-regulated, 6-10 miles	A0100 UB	A0100 UB TK
Taxi, non-regulated, 11 or more miles	A0100 UC	A0100 UC TK

Additional Attendant

Transportation providers sometimes need an additional attendant to help load a member. An additional attendant is needed in situations where the driver cannot load the member without help, such as when wheelchair-bound member lives upstairs and the residence has no wheelchair ramp. This code is not subject the 20-trip limit; however, if the trip exceeds 50 miles one-way, prior authorization is required for all procedure codes, including additional attendant codes. The additional attendant who assists must be an employee of the billing provider and is not required to remain for the trip.

Providers must document the need for an additional attendant on the driver's ticket. The documentation is subject to post-payment review. The additional attendant is limited to a maximum of two extra units; although, usually one attendant is sufficient. Reimbursement for an additional attendant is limited to NAS or wheelchair van and ambulance transportation. For ambulance providers, the additional attendant is the third or fourth attendant, as ambulances are required to have two attendants.

Prior to the January 1, 2004, providers were instructed to use procedure code *Z5023 – Additional attendant transportation*. Local code Z5023 was crosswalked to national code *A0424 – Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)*. Procedure code A0424 did not include NAS or wheelchair van transportation. Effective immediately, procedure code *A0130 U6 – Non-ambulatory transportation; wheelchair van, additional attendant* is covered for NAS or wheelchair van additional attendant transportation. Procedure code A0130 U6 is covered retroactively to January 1, 2004, when the local code Z5023 was end-dated. Procedure code A0424 will continue to be covered for ambulance transportation when an additional attendant is required. Table 1.5 includes the procedure codes for additional attendant.

Table 1.5 – Procedure Codes for Additional Attendant

Type of Transportation	Procedure Code	Description
Non-ambulatory or wheelchair van transportation	A0130 U6	Non-ambulatory transportation; wheelchair van, U6 = additional attendant
Ambulance transportation (ALS and BLS)	A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)

Waiting Time

Waiting time in excess of 30 minutes is reimbursable only when the vehicle is parked outside the medical service provider, awaiting the return of the member to the vehicle **and** if the member is transported 50 miles or more one-way. PA must be obtained for all codes associated with trips of 50 miles or more one-way, including waiting time. The IHCP does not cover the first 30 minutes of waiting time; however, the total waiting time must be included on the claim, or the claim will not be paid appropriately.

For all procedure codes used to bill waiting time, one unit of service is billed for every 30 minutes of waiting time. When the provider has waited between 15 to 30 minutes, partial 30-minute increments should be rounded up to the next unit. For example, if the provider has waited 45 minutes, the units of service billed would be two or 2.0. Partial 30-minute increments less than 15 minutes, must be rounded down. For example, if the provider has waited one hour and ten minutes, the units of service billed for waiting time would be two or 2.0. Documentation, including start and stop times, must be maintained on the driver's ticket to support the waiting time billed.

Ambulance Transportation Services

The IHCP covers both emergency and non-emergency ALS and BLS ambulance transport services. Emergency ambulance services are exempt from the 20 one-way trip limit and do not require PA. In addition, emergency ambulance services are exempt from the copayment requirement. Providers must bill emergency services by using the **Y** indicator in **Field 24I** on the *CMS-1500* or in the **Emergency Indicator** on the *837P*, to indicate that the service rendered was an emergency. As a reminder, transportation must be the least expensive type of transportation available that meets the medical needs of the member.

> *Note: Air ambulance and interstate transportation services require PA. In addition, any transportation services provided by a provider located in an out-of-state, non-designated area require PA.*

Level of Service Rendered Versus Level of Response

All transportation services must be billed according to the level of service rendered and not the provider's level of response or vehicle type. The IHCP provides reimbursement for the both emergency and non-emergency ambulance services; however, ALS services are only covered when the level of service is medically necessary and BLS services are not appropriate due to the medical conditions of the member being transported. Ambulance providers should refer to the Indiana EMSC definitions of ALS and BLS services listed in *Title 836 of the IAC*. Ambulance providers must bill the IHCP according to the level of service rendered. The following examples explain the level of service policy:

- Example 1: ALS personnel and ambulance are dispatched. On arrival, the member is found to need emergency medical transport, but no ALS services. The BLS emergency transport code must be used. Subsequently, if no emergency is present, the non-emergency BLS ambulance transport code should be used to transport the member.
- Example 2: An ambulance is called to transport a member to a scheduled appointment. Upon arrival it is discovered that the member can instead be transported by a CAS service or wheelchair van. The ambulance provider can either call for the appropriate vehicle or transport the patient in the ambulance. If the ambulance provider transports the member, the appropriate CAS or NAS transportation code(s) must be used to bill the IHCP.

A complete listing of ambulance transportation codes is included in Table 1.11. The procedure codes listed in Tables 1.6 and 1.7 are valid for ambulance providers when used to bill for CAS or NAS level of service. Effective May 1, 2005, procedure codes A0426 U3, A0428 U3, A0426 U5, and A0428 U5 will no longer be reimbursable. Ambulance providers must bill the most appropriate CAS or NAS code listed in Tables 1.6 and 1.7 if the level of service does not meet the EMSC definition of ALS or BLS services. Ambulance providers are still permitted to bill A0425 U1 or A0425 U2 to be reimbursed for mileage.

Table 1.6 – Valid CAS Codes for Ambulance Providers

Procedure Code	Reimbursement	Description
T2003	$10.00	Non-emergency transportation, encounter/trip
T2007 U3	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS
A0426 U3	$10.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS
A0428 U3	$10.00	Ambulance service, basic life support, non-emergency transport; CAS

Table 1.7 – Valid NAS Codes for Ambulance Providers

Procedure Code	Reimbursement	Description
A0130	$20.00	Non-emergency transportation, wheel chair van base rate
A0130 U6	$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
T2007 U5	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS
A0426 U5	$20.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS
A0428 U5	$20.00	Ambulance service, basic life support, non-emergency transport; NAS

Note: Effective May 1, 2005, procedure codes A0426 U3, A0426 U5, A0428 U3, and A0428 U5 are no longer reimbursable. Procedure codes T2003 and T2007 U3 must be billed by ambulance providers when the level of service rendered is that of a CAS provider. Procedure codes A0130, A0130 U6, and T2007 U5 must be billed by ambulance providers when the level of service rendered is that of a NAS or wheelchair van provider. Ambulance providers are still permitted to bill A0425 U1 or A0425 U2 to be reimbursed for mileage.

Ambulance Mileage

Only loaded ambulance mileage is reimbursed for each mile of the trip. The provider's documentation must contain mileage from mapping software or odometer readings indicating starting and ending trip mileage. Ambulance mileage must be billed using *A0425 U1 – Ground mileage, per statute mile; ALS* or *A0425 U2 – Ground mileage, per statute mile; BLS.* The U1 and U2 modifier are used to differentiate between ALS and BLS mileage. Claims billed without the U1 or U2 modifier will deny, and providers will be required to resubmit with the appropriate modifier.

Neonatal Ambulance Transportation

Reimbursement is available for specialized neonatal ambulance services especially equipped for inter-hospital transfers of high-risk or premature infants only when the member has been discharged from one hospital for admission to another hospital. Procedure code *A0225 – Ambulance service, neonatal transport, base rate, emergency transport, one-way* must be used only for neonatal ambulance transport.

Oxygen and Oxygen Supplies

Procedure code *A0422 – Ambulance (ALS or BLS) oxygen, and oxygen supplies, life sustaining situation* **must not be billed** with ALS codes A0426, A0427, and A0433. These base codes for ALS transport include the reimbursement for supplies and oxygen in an ALS situation.

Procedure code A0422 can be billed with BLS codes A0428 or A0429, if medically necessary. Emergency Medical Technicians (EMTs) and paramedics must document the medical necessity for oxygen use in the medical record maintained by the provider.

Member Copayments

Transportation services require a copayment. Providers are advised to review *405 IAC 5-30-2* for complete copayment narratives.

The determination of the member's copayment amount is to be based on the reimbursement for the base rate or loading fee only. No copayment is required for an accompanying parent or attendant. Transportation providers may collect a copayment amount from the IHCP member equal to those listed in Table 1.8.

Table 1.8 – Transportation Copayments

Transportation Service	Member Copayment
Transportation services that pay $10.00 or less	$0.50 each one way trip
Transportation services that pay $10.01 to $50.00	$1 each one way trip
Transportation services that pay $50.01 or more	$2 each one way trip

Exemptions to Copayments for Transportation Services

The following services are exempt from the copayment requirement:

- Emergency ambulance services
- Services furnished to members younger than 18 years old
- Services furnished to pregnant women
- Services furnished to members who are in hospitals, nursing facilities (NFs), intermediate care facilities for the mentally retarded (ICFs/MR), or other medical institutions. This includes instances where a member is being transported for the purpose of admission or discharge.
- Transportation services provided under a Managed Care Organization (MCO) to its Hoosier Healthwise enrollees

Federal Guidelines for Copayment Policy

According to *42 CFR 447.15*, providers may not deny services to any member due to the member's inability to pay the copayment amount on the date of service. Pursuant to this federal requirement, this service guarantee does not apply to a member who is able to pay, nor does a member's inability to pay eliminate his or her liability for the copayment. It is the member's responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not paid on the date of service.

Package C Transportation Services

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson definition of emergency in *407 IAC 1-1-6*. Non-emergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician.

Risk Based Managed Care Hoosier Healthwise Services

Transportation services for risk-based managed care (RBMC) members are the responsibility of the MCO. Providers must contact the appropriate MCO for more information about transportation guidelines for RBMC members.

Non-covered Transportation Services

Reimbursement is not available for the following transportation services:

- One-way trips exceeding 20 per member, per rolling 12-month period, except when medically necessity for additional trips is documented through the PA process
- Trips of 50 miles or more one way, unless PA is obtained
- First 30 minutes of waiting time for any type of conveyance, including ambulance
- Non-emergency transportation provided by any of the following:
  - A volunteer with no vested or personal interest in the member
  - An interested individual or neighbor of the member
  - A caseworker or social worker
- Ancillary, non-emergency transportation charges including, but not limited to, the following:
  - Parking fees
  - Tolls
  - Member meals or lodging
  - Escort meals or lodging
- Disposable medical supplies, other than oxygen, provided by a transportation provider
- Transfer of durable medical equipment, either from the member's residence to place of storage, or from the place of storage to the member's residence
- Use of red lights and siren for an emergency ambulance call
- All inter-hospital transportation services, except when the member has been discharged from one hospital for admission to another hospital
- Delivery services for prescribed drugs, including transporting a member to or from a pharmacy to pick up a prescribed drug

Documentation Requirements for Transportation Services

Each claim must be supported with the following documentation on the driver's ticket or run sheet:

- Complete date of service, including day, month, and year of service, such as 3/15/04
- Complete member name and address of pick-up, including street address, city, county, state, and ZIP
- Member identification number

- Member signature – If the member is unable to sign, the driver should document that "the patient was unable to sign" and the reason for the inability
- Waiting time including the actual start and stop time of the waiting period, such as wait time from 1 p.m. to 3:20 p.m.
- Complete service provider name and address, including street address, city, county, state, and ZIP

> *Note: If the service provider's name is abbreviated on the driver's ticket, the provider must document the complete provider name or maintain a facility abbreviation listing. This will help to expedite the post-payment review process.*

- Name of the driver who provided transportation service
- Vehicle odometer reading at the beginning and end of the trip or mileage from mapping software, including the date the transportation service was provided and the specific starting and destination address. If mapping software is used, it must indicate the shortest route.

> *Note: All providers, including taxi providers, must document mileage using either odometer readings or mapping software. Taxi providers must document the distance traveled to support the metered or zoned rate or mileage code billed.*

- Indication of a one-way or round trip
- Indication of CAS or NAS transportation
- Name and relationship of any accompanying parent or attendant to support the accompanying parent or attendant code billed, if applicable

> *Note: When an attendant or parent is billed as part of the transport, the parent or attendant must also sign the driver's ticket.*

It is the provider's responsibility to verify that the member is being transported to or from a covered service. It is the provider's responsibility to maintain documentation that supports each transport and/or service provided. Transportation providers put themselves at risk of recoupment of payment if the required documentation is not maintained or covered services cannot be verified.

Registration Requirements

- **Commercial or Common Ambulatory and Non-Ambulatory Providers**
  - All for profit only CAS and NAS providers are required to certify annually through the Indiana Motor Carrier Services (MCS) and obtain a Motor Carrier Certification.
  - Providers must keep a copy of the certification for their records.
- **Taxi Providers**
  - Providers must have documentation showing operating authority from a local governing body (city taxi or livery license), if applicable.
  - Providers must keep a copy of the documentation for their records.
- **Ambulance**
  - Providers must have an Emergency Medical Services (EMS) Commission certification.
  - Providers must keep a copy of the certification for their records.
  - In accordance with *IC 16-1-31*, vehicles and staff that provide ambulance services must be certified by the EMS Commission to be eligible for reimbursement for transports involving either advanced life support or basic life support services. Failure to maintain the EMS Commission certification on all vehicles involved in transporting members results in termination of the *IHCP Provider Agreement.*

- **Bus**
  - Providers must have a MCS certificate from the Indiana Department of Revenue.
  - Providers must keep a copy of the certification for their records.
- **Family Member**
  - Providers must have an authorization letter from the local Office of Family and Children (OFC) (contact caseworker).
  - Providers must keep a copy of the authorization letter for their records.
- **Air Ambulance**
  - Providers must have EMS Commission Air Ambulance certification.
  - Providers must keep a copy of the certification for their records.

Chapter 4 of the *IHCP Provider Manual* includes detailed information about enrollment requirements and responsibilities. Providers who fail to maintain the required registration documentation may be referred to the appropriate governing agencies.

Transportation Code Sets

Effective July 1, 2004, transportation providers are limited to specific codes based on the provider specialty listed on the provider enrollment file. Tables 1.9 through 1.15 list the procedures codes allowed for each transportation provider specialty. Each table lists the transportation HCPCS code (or local code), the national code(s), reimbursement rates, and the procedure code description for each provider specialty. As a reminder, local HCPCS codes were end-dated effective December 31, 2003. The applicable national HCPCS code is listed for each end-dated local code. Due to several coverage changes that were made in 2004, the coverage dates are indicated, where applicable.

Commercial Ambulatory Service Provider

Table 1.9 – CAS Provider Code Set

264 Commercial Ambulatory Service (CAS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
S0215 (Non-reimbursable effective June 30, 2004)	$1.25	A0425 U3 (January 1, 2004 – present)	$1.25	Ground mileage, per statute mile; CAS
X3028 (End-dated December 31, 2003)	$10.00	T2003 U9 (January 1, 2004 – June 30, 2004) T2003 (July 1, 2004 – present)	$10.00	Non-emergency transportation, encounter/trip (CAS)
X3029 (End-dated December 31, 2003)	$5.00	T2004 TT (January 1, 2004 – June 30, 2004) T2004 (July 1, 2004 – present)	$5.00	Non-emergency transportation, commercial carrier, multi-pass (CAS)
X3030 (End-dated December 31, 2003)	$5.00	T2001 TK (January 1, 2004 – June 30, 2004) T2001 (July 1, 2004 – present)	$5.00	Non-emergency transportation, patient attendant/escort (CAS)

(Continued)

Table 1.9 – CAS Provider Code Set

264 Commercial Ambulatory Service (CAS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
Y9009 (End-dated December 31, 2003)	$4.25	T2007 U3 (January 1, 2004 – present)	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Note: As of July 1, 2004, T2003 U9, T2004 TT, and T2001 TK no longer require a modifier. Additional information is available in IHCP provider newsletter, NL200409, *published September 15, 2004.*

Non-Ambulatory Service Provider

Note: Ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. CAS codes are included in the NAS provider code set and listed at the end of Table 1.10.

Table 1.10 – NAS Provider Code Set

265 Non-Ambulatory Service (NAS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
S0215 (Non-reimbursable effective June 30, 2004)	$1.25	A0425 U5 (January 1, 2004 – present)	$1.25	Ground mileage, per statute mile; NAS
Y9001 (End-dated December 31, 2003)	$20.00	A0130 (January 1, 2004 – present)	$20.00	Non-emergency transportation, wheel chair van base rate
X3039 (End-dated December 31, 2003)	$10.00	A0130 TK (January 1, 2004 – present)	$10.00	Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance
Y9201 (End-dated December 31, 2003)	$10.00	A0130 TT (January 1, 2004 – present)	$10.00	Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting
Z5023 (End-dated December 31, 2003)	$5.00	A0130 U6 (January 1, 2004 – present)	$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
Y9009 (End-dated December 31, 2003)	$4.25	T2007 U5 (January 1, 2004 – present)	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS
S0215 (Non-reimbursable effective June 30, 2004)	$1.25	A0425 U3 (January 1, 2004 – present)	$1.25	Ground mileage, per statute mile; CAS

(Continued)

Table 1.10 – NAS Provider Code Set

265 Non-Ambulatory Service (NAS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
X3028 (End-dated December 31, 2003)	$10.00	T2003 U9 (January 1, 2004 – June 30, 2004) T2003 (July 1, 2004 – present)	$10.00	Non-emergency transportation, encounter/trip (CAS)
X3029 (End-dated December 31, 2003)	$5.00	T2004 TT (January 1, 2004 – June 30, 2004) T2004 (July 1, 2004 – present)	$5.00	Non-emergency transportation, commercial carrier, multi-pass (CAS)
X3030 (End-dated December 31, 2003)	$5.00	T2001 TK (January 1, 2004 – June 30, 2004) T2001 (July 1, 2004 – present)	$5.00	Non-emergency transportation, patient attendant/escort (CAS)
Y9009 (End-dated December 31, 2003)	$4.25	T2007 U3 (January 1, 2004 – present)	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Note: Ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. CAS codes are included in the NAS provider code set and are listed in Table 1.10.

Ambulance (ALS and BLS) Provider

Note: Transportation must be billed according to the level of service rendered. Therefore, CAS and NAS codes are included in the Ambulance (ALS and BLS) provider code set and are listed in Table 1.11. More information about coverage and billing of ambulance services is included on page 10 of this billing guide.

Table 1.11 – Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
A0070 (End-dated December 31, 2003)	$15.00	A0422 (January 1, 2004 – present)	$15.00	Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation
A0390 (Non-reimbursable effective March 31, 2004)	$4.00	A0425 U1 (April 1, 2004 – present)	$4.00	Ground mileage, per statute mile; ALS

(Continued)

A0380 (Non-reimbursable effective March 31, 2004)	$3.50	A0425 U2 (April 1, 2004 – present)	$3.00	Ground mileage, per statute mile; BLS

Table 1.11 – Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
A0420 (Non-reimbursable effective March 31, 2004)	$20.00	A0420 U1 (April 1, 2004 – present)	$20.00	Ambulance waiting time ALS, one-half (1/2) hour increments
A0420 (Non-reimbursable effective March 31, 2004)	$20.00	A0420 U2 (April 1, 2004 – present)	$20.00	Ambulance waiting time BLS, one-half (1/2) hour increments
A0426 (No changes)	$85.00	A0426 (No changes)	$85.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427 (No changes)	$150.00	A0427 (No changes)	$150.00	Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)
A0428 (No changes)	$85.00	A0428 (No changes)	$85.00	Ambulance service, basic life support, non-emergency transport; (BLS)
A0429 (No changes)	$100.00	A0429 (No changes)	$100.00	Ambulance service, basic life support, emergency transport, (BLS-emergency)
A0433 (No changes)	$150.00	A0433 (No changes)	$150.00	Advanced ALS (Level 2)
A0434 (Non-reimbursable effective March 31, 2004)	$158.30	A0225 (April 1, 2004 – present)	$150.00	Ambulance service, neonatal transport, base rate, emergency transport, one-way
A0999 (No changes)	Manual	A0999 (No changes)	Manual	Unlisted ambulance service
Z5023 (End-dated December 31, 2003)	$5.00	A0424 (January 1, 2004 – present)	$5.00	Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)
N/A	N/A	A0426 U3 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	$10.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS
N/A	N/A	A0426 U5 (January 1, 2004 – May 1, 2005) Use A0130 effective May 1, 2005.	$20.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS

(Continued)

N/A	N/A	A0428 U3 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	$10.00	Ambulance service, basic life support, non-emergency transport; CAS

Table 1.11 – Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
N/A	N/A	A0428 U5 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	$20.00	Ambulance service, basic life support, non-emergency transport; NAS
N/A	N/A	T2003 (Replacement code for A0426 U3 and A0428 U3, effective May 1, 2005.)	$10.00	Non-emergency transportation, encounter/trip (CAS)
N/A	N/A	A0130 (Replacement code for A0426 U5 and A0428 U5, effective May 1, 2005.)	$20.00	Non-emergency transportation, wheel chair van base rate (NAS)
N/A	N/A	T2007 U3 (Use this code for waiting time when the transport is a CAS level of service.)	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS
Z5023 (End-dated December 31, 2003)	$5.00	A0130 U6 (January 1, 2004 - present)	$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
N/A	N/A	T2007 U5 (Use this code for waiting time when the transport is a NAS level of service.)	$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS

Note: Transportation must be billed according to the level of service rendered. Therefore, CAS and NAS codes are included in the Ambulance (ALS and BLS) provider code set and are listed in Table 1.11. More information about coverage and billing of ambulance services is included on page 10 of this billing guide.

Air Ambulance

Table 1.12 – Air Ambulance Code Set

261 Air Ambulance				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
A0140 (No changes)	Manual	A0140 (No changes)	Manual	Non-emergency transportation and air travel (private or commercial), intra or interstate

(Continued)

A0430 (No changes)	Manual	A0430 (No changes)	Manual	Ambulance service, conventional air service transport, one way (fixed wing)
A0431 (No changes)	Manual	A0431 (No changes)	Manual	Ambulance service, conventional air service, transport, one way (rotary wing)
A0999 (No changes)	Manual	A0999 (No changes)	Manual	Unlisted ambulance service

Taxi Provider

Table 1.13 – Taxi Code Set

263 Taxi Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
X3031 (End-dated December 31, 2003)	$6.00	A0100 UA (January 1, 2004 – present)	$6.00	Taxi, rates non-regulated, 0-5 miles
X3032 (End-dated December 31, 2003)	$10.00	A0100 UB (January 1, 2004 – present)	$10.00	Taxi, rates non-regulated, 6-10 miles
X3033 (End-dated December 31, 2003)	$15.00	A0100 UC (January 1, 2004 – present)	$15.00	Taxi, rates non-regulated, 11 or more miles
X3034 (End-dated December 31, 2003)	$3.00	A0100 TK UA (January 1, 2004 – present)	$3.00	Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant
X3036 (End-dated December 31, 2003)	$5.00	A0100 TK UB (January 1, 2004 – present)	$5.00	Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant
X3038 (End-dated December 31, 2003)	$7.50	A0100 TK UC (January 1, 2004 – present)	$7.50	Taxi, rates non-regulated, 11 or more miles for accompanying parent/attendant
X3035 (End-dated December 31, 2003)	$3.00	A0100 TT UA (January 1, 2004 – present)	$3.00	Taxi, rates non-regulated, 0-5 miles for multiple passengers
X3037 (End-dated December 31, 2003)	$5.00	A0100 TT UB (January 1, 2004 – present)	$5.00	Taxi, rates non-regulated, 6-10 miles for multiple passengers
Y9210 (End-dated December 31, 2003)	$7.50	A0100 TT UC (January 1, 2004 – present)	$7.50	Taxi, rates non-regulated, 11 or more miles for multiple passengers
Y9010 (End-dated December 31, 2003)	$15.00	A0100 U4 (January 1, 2004 – present)	$15.00	Non-emergency transportation; taxi, suburban territory

Family Member Transportation Provider

Table 1.14 – Family Member Transportation Provider Code Set

266 Family Member Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
Y9012 (End-dated December 31, 2003)	$0.28	A0090 (January 1, 2004 – present)	$0.28	Non-emergency transportation, per mile-vehicle provided by individual (family member, self, neighbor) with vested interest

Bus Provider

Table 1.15 – Bus Provider Code Set

262 Bus Provider				
Transportation HCPCS Code	**Rate**	**National HCPCS Code**	**Rate**	**Description**
N/A	N/A	A0110	Max fee $25.00 (January 1, 2004 – June 30, 2004) Manual (June 30, 2004 – present)	Non-emergency transportation and bus, intra or interstate carrier

Indiana Law on School Bus Driver Requirements

IC 20-27-8
Chapter 8. School Bus Drivers

IC 20-27-8-1
School bus driver or school bus monitor; requirements
Sec. 1. (a) An individual may not drive a school bus for the transportation of students or be employed as a school bus monitor unless the individual satisfies the following requirements:
(1) Is of good moral character.
(2) Does not use intoxicating liquor during school hours.
(3) Does not use intoxicating liquor to excess at any time.
(4) Is not addicted to any narcotic drug.
(5) Is at least:
(A) twenty-one (21) years of age for driving a school bus; or
(B) eighteen (18) years of age for employment as a school bus monitor.
(6) In the case of a school bus driver, holds a valid public passenger chauffeur's license or commercial driver's license issued by the state or any other state.
(7) Possesses the following required physical characteristics:
(A) Sufficient physical ability to be a school bus driver, as determined by the committee.
(B) The full normal use of both hands, both arms, both feet, both legs, both eyes, and both ears.
(C) Freedom from any communicable disease that:
(i) may be transmitted through airborne or droplet means; or
(ii) requires isolation of the infected person under 410 IAC 1-2.3.
(D) Freedom from any mental, nervous, organic, or functional disease that might impair the person's ability to properly operate a school bus.
(E) Visual acuity, with or without glasses, of at least 20/40 in each eye and a field of vision with one hundred fifty (150) degree minimum and with depth perception of at least eighty percent (80%).
(b) This subsection applies to a school bus monitor. Notwithstanding subsection (a)(5)(B), a school corporation or school bus driver may not employ an individual who is less than twenty-one (21) years of age as a school bus monitor unless the school corporation or school bus driver does not receive a sufficient number of qualified applicants for employment as a school bus monitor who are at least twenty-one (21) years of age. A school corporation or school bus driver shall maintain a record of applicants, their ages, and their qualifications to show compliance with this subsection.
As added by P.L.1-2005, SEC.11.

IC 20-27-8-2
School bus driver driving summary
Sec. 2. (a) Before a school corporation enters into a:
(1) contract with a school bus driver; or
(2) fleet contract under IC 20-27-5;
the school corporation shall obtain, at no fee from the bureau of motor vehicles, a copy of the school bus driver's driving summary for the last seven (7) years as maintained by the bureau of motor vehicles or the equivalent agency in another state.

(b) To obtain a copy of the school bus driver's driving summary as required under subsection (a), the school corporation shall provide the bureau of motor vehicles with the following information:

(1) The school bus driver's name.

(2) The school bus driver's Social Security number.

(3) Any other information required by the bureau of motor vehicles.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-3

Consumption or possession of controlled substance; offense

Sec. 3. (a) As used in this section, "controlled substance" has the meaning set forth in IC 35-48-1.

(b) An individual who is a school bus driver and who knowingly and intentionally:

(1) consumes a controlled substance or an intoxicating liquor within six (6) hours before:

(A) going on duty; or

(B) operating a school bus; or

(2) consumes or possesses a controlled substance or an intoxicating liquor while on duty or while operating a school bus;

commits a Class A misdemeanor.

(c) It is a defense in a prosecution under this section if a controlled substance is consumed or possessed in accordance with a medical prescription issued by an Indiana physician to the individual who consumes or possesses the controlled substance.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-4

School bus driver; physical examination certificate

Sec. 4. An individual who is or intends to become a school bus driver must obtain a physical examination certificate stating that the individual possesses the physical characteristics required by section 1(a)(7) of this chapter. The certificate shall be made by a physician who is licensed in Indiana or a state bordering Indiana after the physician has conducted a physical examination of the school bus driver or prospective school bus driver. The physician shall be chosen by the school bus driver or prospective driver, who shall pay for the examination.

As added by P.L.1-2005, SEC.11. Amended by P.L.82-2009, SEC.1.

IC 20-27-8-5

School bus driver; public passenger chauffeur license; physical examination timing

Sec. 5. (a) When an individual holds a contract to serve or is serving as a school bus driver at the time the individual obtains a public passenger chauffeur's license, the individual shall undergo the physical examination required by section 4 of this chapter at about the same time as the individual acquires the chauffeur's license. The certificate of examination and qualification shall be filed not more than seven (7) days after the examination.

(b) When an individual executes a contract to drive a school bus or begins serving as a school bus driver after obtaining a public passenger chauffeur's license, the individual may not drive a school bus unless:

(1) the individual files a certificate of a physical examination made at the time the

individual last secured a public passenger chauffeur's license; or

(2) if a certificate was not made at the time of the prior examination or is unobtainable, the individual undergoes a new physical examination and files a certificate from that examination.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-6

School bus driver; additional physical examination

Sec. 6. A governing body may, at any time, require a school bus driver operating a school bus for the school corporation to submit to a physical examination by an Indiana physician selected by the corporation. The school corporation shall pay the cost of an examination under this section.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-7

Transportation or fleet contract; compensation

Sec. 7. When a school bus driver operates under a transportation or fleet contract, the compensation for the school bus driver or fleet contractor is determined and fixed by the contract on a per diem basis for the number of days on which:

(1) the calendar of the school corporation provides that students are to attend school;

(2) the driver is required by the school corporation to operate the bus on school related activities; and

(3) inservice training is required by statute or authorized by the school corporation, including the safety meeting workshops required under section 9 of this chapter.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-8

School bus driver employment contract; compensation

Sec. 8. The compensation of a school bus driver who is employed by a school corporation on a school year basis under an employment contract shall be fixed in the employment contract. *As added by P.L.1-2005, SEC.11.*

IC 20-27-8-9

Annual safety meeting; attendance required

Sec. 9. A school bus driver, including a school bus driver who drives a bus for a nonpublic school, shall attend an annual safety meeting or workshop. A safety meeting or workshop may not exceed two (2) days in any one (1) calendar year.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-10

Preservice school bus driver safety experience and education requirements

Sec. 10. (a) An individual who does not have at least thirty (30) days experience in driving a school bus during the three (3) year period immediately preceding the effective date of the individual's assignment as a school bus driver for a public or nonpublic school that is accredited by the state board within Indiana shall satisfactorily complete a preservice school bus driver safety education training course. The course may not exceed forty (40) hours.

(b) Course attendance must be completed:

(1) before the assignment of an individual required to take the course as a school

bus driver; or

(2) if immediate assignment is necessary, upon the completion of the next scheduled course following the assignment.

(c) The state superintendent shall provide instructors, adequate meeting facilities, registration forms, a uniform course of instruction, and all other necessary materials for the preservice school bus driver safety education meetings.
As added by P.L.1-2005, SEC.11.

IC 20-27-8-10.5
Special purpose bus driver safety plan
Sec. 10.5. (a) Not later than September 1, 2009, the department shall:

(1) develop;

(2) provide to the general assembly and the public; and

(3) implement;

a plan to promote safe driving practices for drivers of special purpose buses.

(b) The plan developed under subsection (a) must provide clear, concise information concerning statutes and rules that affect special purpose buses and special purpose bus drivers.

(c) The department shall update the plan developed under subsection (a) as necessary.

(d) The department shall distribute the plan developed under subsection (a) in the most cost effective manner, as determined by the department.
As added by P.L.146-2009, SEC.5.

IC 20-27-8-11
Annual safety meeting; time and place
Sec. 11. The committee shall fix the date, time, and place for the annual safety meetings or workshops. *As added by P.L.1-2005, SEC.11.*

IC 20-27-8-12
Conduct of annual safety meeting
Sec. 12. The committee and the superintendent of the state police department shall provide instructors, adequate meeting facilities, and all other necessary facilities for the annual school bus driver safety meetings or workshops. The committee and the state police superintendent shall also prepare and furnish a uniform course of instruction to be used in the meetings or workshops. *As added by P.L.1-2005, SEC.11.*

IC 20-27-8-13
Annual safety meeting; registration
Sec. 13. (a) The committee shall provide a uniform system for the registration of school bus drivers who are required to attend the annual safety meetings or workshops. This registration system must do the following:

(1) Accurately reflect the attendance of each school bus driver at each session of the annual meeting or workshop.

(2) Provide a registration form indicating the school bus driver's name and legal address, and the name of the school the school bus driver represents.

(b) The state superintendent shall supervise registration of school bus drivers at the annual safety meetings or workshops.

(c) The principal of each school shall prepare and collect the attendance records of school bus drivers who attend any safety meeting or workshops and shall make a written report of the attendance records to the state superintendent not more than ten (10) days

after the meeting or workshop.

(d) Records of attendance shall be filed in the office of the state superintendent and maintained there as public records for at least three (3) years.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-14

Annual safety meeting; nonattendance

Sec. 14. If a school bus driver for a school corporation fails or refuses to attend a school bus driver meeting or workshop, the governing body of the school corporation shall deduct one (1) day's compensation for each day of absence.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-15

School bus driver training certification

Sec. 15. (a) The driver of a school bus for a public or nonpublic school that is accredited by the state board shall have in the school bus driver's possession, while transporting passengers, a certificate that states the school bus driver has:

(1) enrolled in or completed a course in school bus driver safety education as required under sections 9 and 10 of this chapter; or

(2) operated a school bus at least thirty (30) days during the three (3) year period preceding the effective date of the school bus driver's employment.

(b) A certificate of enrollment in or completion of the course or courses in school bus driver safety education shall be prescribed by the committee and completed by the designated representative of the committee.

(c) A driver of a school bus who fails to complete the school bus driver safety education course or courses, as required, shall be reported by the person who conducted the course to the committee and to the school corporation where the school bus driver is employed or under contract.

(d) A driver of a school bus who fails to complete the school bus driver safety education course or courses, as required, may not drive a school bus within Indiana while transporting a student.

As added by P.L.1-2005, SEC.11.

IC 20-27-8-16

Violation

Sec. 16. Except as provided in section 3(b) of this chapter, a person who knowingly, intentionally, or recklessly violates this chapter commits a Class C misdemeanor.

As added by P.L.1-2005, SEC.11. Amended by P.L.231-2005, SEC.39.

Indiana Department of Education Rules on School Bus Specifications

575 IAC 1-1-1 Applicability of specifications; definitions
Authority: IC 20-27-3-4
Affected: IC 20-27-2-8
Sec. 1. (a) The definitions in this section apply throughout this article.
(b) "School bus" means any motor vehicle, other than a special purpose bus as defined in IC 20-27-2-8, designed and constructed for the accommodation of more than ten (10) passengers that is used for the transportation of Indiana school children. The term includes either the chassis or the body, or both the chassis and the body.
(c) "School children" means children enrolled in private schools in grades kindergarten through twelve (12) and all children enrolled in public school corporations.
(d) "Type A school bus" means a conversion or body constructed upon a van-type or cutaway front-section vehicle with a left side driver's door, designed for carrying more than ten (10) persons. The term includes two (2) classifications:
(1) Type A-1, with a gross vehicle weight rating of ten thousand (10,000) pounds and under; and
(2) Type A-2, with a gross vehicle weight rating over ten thousand (10,000) pounds.
(e) "Type B school bus" means a conversion or body constructed and installed upon a van or front-section vehicle chassis or stripped chassis with a vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. Part of the engine is beneath and/or behind the windshield and beside the driver's seat. The entrance door is behind the front wheels.
(f) "Type C school bus" means a body installed upon a flat back cowl chassis with a gross vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. All of the engine is in front of the windshield. The entrance door is behind the front wheels.
(g) "Type D school bus" means a body installed upon a chassis with the engine mounted in the front, midship, or rear with a gross vehicle weight rating of more than ten thousand (10,000) pounds and designed for carrying more than ten (10) persons. The engine may be behind the windshield and beside the driver's seat, at the rear of the bus, behind the rear wheels, or midship between the front and rear axles. The entrance door is ahead of the front wheels.
(h) "Vehicles for transporting handicapped students" means vehicles designed and constructed to meet the requirements for the appropriate size school buses with specialized equipment as prescribed under 575 IAC 1-5. *(State School Bus Committee; Sec I; filed Feb 10, 1978, 3:31 p.m.: Rules and Regs. 1979, p. 323; filed Apr 14, 1981, 11:30 a.m.: 4 IR 778, eff Jul 1, 1981; filed Jun 20, 1988, 8:50 a.m.: 11 IR 3819; filed Mar 19, 2001, 11:32 a.m.: 24 IR 2467; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; errata filed Jun 27, 2005, 1:45 p.m.: 28 IR 3583; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)*

Rule 5. Vehicles for Transporting the Handicapped Ordered for Purchase and Initially Placed in Service on or after July 1, 1988

575 IAC 1-5-1 General requirements

Authority: IC 20-27-3-4
Affected: IC 20-27-3-4; IC 20-27-5-9; IC 20-27-9
Sec. 1. General Requirements
(1) Vehicles constructed and designed for transporting handicapped children shall comply generally with the standards for school buses, but due to the need for special equipment, modifications to these minimum standards must be made.
(2) All buses, whether modified or constructed for the transportation of handicapped children must meet or exceed the requirements, as set forth for the applicable type school bus except as provided herein under Special Equipment.
(State School Bus Committee; Sec V, General Requirements; filed Feb 10, 1978, 3:31 pm: Rules and Regs. 1979, p. 398; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)

575 IAC 1-5-2 Special equipment

Authority: IC 20-27-3-4
Affected: IC 20-27-3-4; IC 20-27-5-9; IC 20-27-9
Sec. 2. Special Equipment
(1) Special Service Door
(A) Special service door opening shall be located on right side of bus and far enough to the rear to prevent door, when open, from obstructing right front service door. Door opening shall be not less than 30 inches in width.
(B) Door shall be constructed of two (2) panels of approximate equal width, equipped with hinges and securely hinged to side of bus and each panel shall open outward. Forward panel shall be flush with rear panel or provided with overlapping flange to close space where door panels meet and weather seal shall be provided to close all door edges.
(i) Special service door may be one (1) single panel meeting all requirements set forth under 1.a and 1.b (subsections (1)(A) and (1)(B) of this section).
(C) Two (2) panel door shall be equipped with at least two-point fastening device to floor level and header on, both, rear door panel and forward door panel and single door panel shall be equipped with two-point fastening device to floor level and header, all manually controlled or operated.
(D) Door shall be equipped with device that will actuate audible signal, located in driver compartment, when doors are not securely closed. Exception: When two-panel door is used, with front panel overlapping rear panel, audible signal shall be actuated when front panel is opened but may be deactivated when rear panel is opened.
(E) Each door shall contain fixed or movable window, aligned with lower line of other windows of bus and as nearly as practicable, of same size as other bus windows.
(F) Each door panel shall open outward and positive fastening device shall be installed to hold each door panel in open position.
(G) Door panel shall be constructed so as to be equivalent in strength and materials to other school bus doors.
(H) When ramps are used, door panels shall cover ramp container opening. When specific construction requires an opening in the floor, door panels shall extend below to full length of skirt.

(I) Floor shall be adequately supported at front and rear of door opening to support front with same strength as other floor portions.
(2) Ramp
(A) If ramp is used, it shall be of sufficient strength and rigidity to support wheel chair, occupant and attendant. It shall be equipped with protective flange on each longitudinal side to keep wheel chair on ramp.
(B) Ramp floor shall be unflattened expanded metal, covered by flat plate, except in the walking area of ramp. In addition, the flat plate area shall be covered with a non-skid material.
(C) Ramp shall be of such weight and equipped with handle or handles, to permit one person to put ramp in place or return it to storage position.
(D) Provisions shall be made to secure ramp to side of bus for use without danger of detachment and ramp shall be connected to bus at floor level in such a manner as to permit easy access of wheels of wheel chairs to floor of bus.
(E) Ramp shall be of at least 80 inches in length for Type II buses and at least 88 inches in length for Type I buses, and width shall conform generally to width of door opening.
(F) Dustproof and waterproof enclosed container shall be provided if ramp is stored under the floor.
(3) Power Lift
(A) If power lift is used, it shall be of sufficient strength, rigidity, and capacity to lift a minimum of 500 pounds and shall be designed so as to be operable through four complete full load cycles with engine off.
(B) Power lift platform shall be not less than 26 inches in width nor less than 45 inches long for double-door installation and not less than 26 inches in width nor less than 41 inches long for single door installation, including guard panels or rails.
(C) Power lift platform shall be covered with non-skid material.
(D) Self-adjusting steel (or equivalent) ramp of sufficient width to minimize incline to lift platform shall be attached to lift platform. Ramp shall be equipped with non-skid material.
(E) Power lift shall be controlled from panel within the bus or by a portable control unit which shall be adjacent to the lift and shall be capable of operation by attendant standing upon lift when lift is in any position.
(F) A device shall be installed which will prevent operation of lift until doors are in open position.
(G) All chains, wires, and other mechanisms, except lift control panel, necessary to effect upward and downward movement of lift platform, shall be concealed and installed in such a manner so as to prevent accessibility by children.
(4) Guard Panel
(A) Guard panels shall be installed at both rear and front edges of special service door opening, extending into bus. If power lifts are used, and when construction requires opening in the floor, a chain shall be installed between guard panels to enclose area of power lift.
(B) Restraining barriers shall be installed immediately to the rear of the driver's platform and immediately to the rear of the step-well on buses which are constructed and equipped so as the wheel chair spaces are located in front portion of bus.
(5) Wheel Chairs

(A) Positive fastening devices shall be provided, attached to floor or walls, or both, that will securely hold wheel chair in position when in bus.
(B) Distance between the rearmost extremeties of the wheelchair (measured at floor line) when the wheelchair is in any position and the outside rear of the bus shall be not less than eight (8) inches on Type I buses and not less than six (6) inches on Type II buses.
NOTE: Parents or guardians of wheel chair pupils are encouraged to provide pupil restraining devices, attached to the wheel chair.
(6) Seat Restraining Devices
(A) Seat frames shall be equipped with rings or other devices to which belts or restraining harness for each passenger may be attached or otherwise equipped so as to be in full compliance with any applicable Federal Motor Vehicle Safety Standard.
(7) Aisle
(A) All aisles, including aisle leading to emergency door shall have a minimum clearance of not less than 12 inches.
(8) Special Seats
(A) Longitudinal seats, not exceeding 45 inches in length are permissible over the wheel housings. If used, such seats shall be securely fastened and equipped with seat arm rests and positive pupil restraining devices.
(9) Fuel System
(A) The fuel tank shall be manufacturers' standard; mounted, filled, and vented outside of body and shall conform to all requirements set forth under Federal Motor Vehicle Safety Standard (FMVSS) No. 301.
(10) Battery
(A) Battery shall be 12 volt of either Conventional a (lead-antimony) or Maintenance Free Sealed (lead-calcium) design.
(B) Minimum capacity shall be 100 reserve minutes and 430 CCA (cold cranking amperes) at 0 degrees F. per S-537A standard. (Essentially meets 70 amperes per hour capacity.)
(C) Handicapped vehicles equipped with power lifts shall have storage battery capacity sufficient, when fully charged, to satisfy electrical demand of lift through (4) complete full load cycles, with engine off and have sufficient capacity left to re-start engine.
(11) Special Light
(A) Light shall be placed inside bus, over special service door, and shall be operated from door area to adequately illuminate the special service door area.
(12) Grab Handle
(A) Grab handles shall be provided on each side of front right service door on buses constructed for the transportation of handicapped children.
(State School Bus Committee; Sec V, Special Equipment; filed Feb 10, 1978, 3:31 pm: Rules and Regs. 1979, p. 398; filed Apr 14, 1981, 11:30 am: 4 IR 796, eff Jul 1, 1981; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA)

Rule 5.5. Vehicles for Transporting the Handicapped Ordered for Purchase and Initially Placed in Service on or after
July 1, 1990
575 IAC 1-5.5-1 General requirements
Authority: IC 20-27-3-4

Affected: IC 20-27; IC 20-35
Sec. 1. (a) A bus constructed and designed for transporting handicapped children must comply with the standards outlined in 575 IAC 1-1 through 575 IAC 1-4. Modifications to some of the standards are necessary to accommodate the special equipment necessary to transport handicapped students.
(b) Any school bus used to transport a child confined to a wheelchair or other device that prohibits the use of the regular passenger service door, must be equipped with a power lift. If a special unloading device is needed for unusual circumstances, a waiver from the school bus committee is required.
(c) A bus transporting more than two (2) wheelchair-confined students must have at least a one hundred (100) amp alternator.
(d) All special needs children must be properly and appropriately restrained for safe transportation. Special needs children means children defined under IC 20-35.
(e) Federal Motor Vehicle Safety Standards referred to in this rule are found at 49 CFR Ch. V (10-1-89 Edition), Part 571, and are herein incorporated and made a part of this rule by reference. Copies of these federal standards are on file with the department of education or may be obtained from the U.S. Government Printing Office, Washington, D.C. *(State School Bus Committee; 575 IAC 1-5.5-1; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; errata filed Jun 27, 2005, 1:45 p.m.: 28 IR 3583; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-2 Aisles

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 2. The aisle leading from the wheelchair area to all emergency doors must be at least thirty (30) inches wide. *(State School Bus Committee; 575 IAC 1-5.5-2; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR- 575070225ACA)*

575 IAC 1-5.5-3 Wheelchairs

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 3. (a) A student who can reasonably be moved from the student's wheelchair, stroller, or special seating device must be transferred during transportation to and from school to:
(1) an original equipment manufacturer forward facing vehicle seat equipped with dynamically tested occupant restraints; or
(2) a child seat that complies with the requirements of Federal Motor Vehicle Safety Standard (FMVSS) 213.
(b) A wheelchair must be adequately secured during transportation. An occupied wheelchair must face forward.
(c) Occupied three-wheeled, cart-type units and other stroller-type devices may not be transported in a school bus unless there is impact test evidence to demonstrate that the unit can be secured under impact loading conditions using a four-point strap-type tiedown.
(d) Manufacturers of the three-wheeled, cart-type units and other stroller-type devices must verify that the unit can be secured under impact loading conditions.

(e) A wheelchair or stroller-type unit designed and approved by the manufacturer for use during transportation must be used according to the manufacturer's instructions.
(f) The distance between the rearmost part of a secured wheelchair and the outside rear of the bus must be at least the following:
(1) Six (6) inches on Type A and Type B buses.
(2) Eight (8) inches on Type C and Type D buses.
(State School Bus Committee; 575 IAC 1-5.5-3; filed May 24, 1990, 4:20 p.m.: 13 IR 1855; filed May 21, 1992, 5:00 p.m.: 15 IR 2220; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1649; readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

575 IAC 1-5.5-4 Wheelchair and occupant restraint systems

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 4. (a) A strap-type wheelchair securement system must be provided that meets the following requirements:
(1) Anchors to the floor of the bus at four (4) or more places.
(2) Attaches to the wheelchair at a minimum of two (2) front and two (2) rear securement points.
(3) Complies with Society of Automotive Engineers Recommended Practice J-2249.
(4) A wheelchair that weighs two hundred (200) pounds or greater, transported on a school bus, ten thousand (10,000) pounds or less in gross vehicle weight, must be secured with more than two (2) rear tiedown straps.
(5) A wheelchair that weighs two hundred fifty (250) pounds or greater, transported on a school bus exceeding ten thousand (10,000) pounds in gross vehicle weight, must be secured with more than two (2) rear tiedown straps.
(b) An occupant restraint system must be provided for each wheelchair occupant that complies with Society of Automotive Engineers Recommended Practice J-2249 such that it meets the following requirements:
(1) Includes upper and lower torso restraints.
(2) Has been tested at thirty (30) miles per hour and twenty (20) G frontal impact conditions which have been verified by the manufacturer of the occupant restraint system.
(3) If the occupant restraining devices are incorporated in the wheelchair restraining devices, the load imposed on the anchorage system is the sum of the loads specified for the wheelchair restraint devices and the occupant restraint system.
(4) Has a lap belt attached to the wheelchair or tiedown system at an angle of forty-five (45) degrees or greater to the horizontal.
(5) Has a shoulder belt attached to the tiedown strap at or below the hip point of the occupant, or has a shoulder belt attached to the lap belt.
(6) Has the upper end of the shoulder belt attached to the vehicle at or above the height of the occupant's shoulder.
(7) Does not transfer occupant forces to the wheelchair.
(c) Static load tests must be as follows:
(1) Conducted with appropriate size washers and steel plating or with actual tiedown/restraint washers and backing plates on the underside of sheet metal floors to adequately distribute the applied loads.

(2) Verified by the school bus manufacturer or other engineering test facility.
(State School Bus Committee; 575 IAC 1-5.5-4; filed May 24, 1990, 4:20 p.m.: 13 IR 1856; errata, 13 IR 2005; filed May 21, 1992, 5:00 p.m.: 15 IR 2221; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1649; readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.:20070725-IR-575070225ACA)

575 IAC 1-5.5-5 Power lift

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 5. (a) The lifting mechanism must:
(1) be able to lift a minimum load of eight hundred (800) pounds;
(2) have a battery that, when the bus engine is off, will sustain the electrical demand of the lift through four (4) complete full load cycles and then restart the bus engine;
(3) be located on the right side of the bus body;
(4) have manual controls in the event of a power failure;
(5) not permit the platform to fall if the power fails while the lift is in operation;
(6) have controls that enable the operator to activate the lift while standing on the platform;
(7) have a circuit breaker or fuse connecting the lift motor to the power source; and
(8) have limit switches or bypass valves to prevent excess pressure from building in the hydraulic system when the platform is upright or extended.
(b) The power lift must:
(1) have a clear horizontal opening and platform large enough to accommodate a thirty (30) inch wide wheelchair on the bus;
(2) be confined within the perimeter of the bus body when not in use;
(3) mechanically lock when the lift is in the upright position by means other than a support or lug on the door;
(4) move smoothly and rest solidly on the ground;
(5) have sides at least one and one-half (1½) inches high on the platform;
(6) be designed to prevent the operator from being entangled in the lift during raising and lowering of the platform;
(7) have a skid-resistant platform surface;
(8) have a self-adjusting, skid-resistant inclined plate on the outer edge to facilitate movement from the ground to the platform;
(9) have a plate or panel on the outer edge to prevent a wheelchair from rolling off when the platform is raised; and
(10) have padding on the crossbar on the top of the lift, if the lift is equipped with a crossbar.
(c) The power lift may have a handrail. *(State School Bus Committee; 575 IAC 1-5.5-5; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; filed May 21, 1992, 5:00 p.m.: 15 IR 2221; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-6 Regular service entrance door

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 6. (a) There must be three (3) riser steps approximately equal in height in the entrance well of Type C and Type D buses. The first step must not be less than ten (10)

inches or more than fourteen (14) inches from the ground based on standard chassis specifications.
(b) An additional fold-out lower step may be provided to make the lowest step no more than six (6) inches from the ground.
(c) A bus constructed for transportation of handicapped children must have grab handles located on each side of the regular service door. *(State School Bus Committee; 575 IAC 1-5.5-6; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-7 Special light

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 7. A bus must have interior light(s) that:
(1) are automatically or manually activated;
(2) sufficiently illuminate the lift area; and
(3) are activated from the door area.
(State School Bus Committee; 575 IAC 1-5.5-7; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

575 IAC 1-5.5-8 Special service entrance

Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 8. (a) Bus bodies may have a special service entrance to accommodate a wheelchair lift. The special service entrance must meet the following specifications:
(1) The entrance opening must be on the right side of the bus.
(2) The entrance must be located so the doors, when open, do not obstruct the right front regular service door.
(3) If the entrance extends below the floor of the body skirt, reinforcements must be installed at the front and back of the floor opening to support the floor and give the same strength as other floor openings.
(4) A drip molding must be located above the opening that diverts water from the entrance.
(5) The entrance must be wide enough to accommodate a mechanical lift, lift accessories, and the lift platform.
(6) Entrance door posts and headers must be reinforced.
(b) A school corporation may purchase a bus with a special service entrance with the intention of using it to transport handicapped students in the future. While the bus is used to transport nonhandicapped students the special service door must:
(1) be sealed and inoperable;
(2) have no handles; and
(3) have the words NOT AN EXIT placed in black letters at least two (2) inches high above the door on the interior and exterior of the bus.
(c) When a school corporation decides to use a bus under subsection (b) to transport handicapped students, it must remove the words NOT AN EXIT from above the door.
(d) The entrance must have interior padding at least three (3) inches wide and one (1) inch thick covering the full width of the top of each door opening. *(State School Bus*

Committee; 575 IAC 1-5.5-8; filed May 24, 1990, 4:20 p.m.: 13 IR 1857; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

575 IAC 1-5.5-9 Special service entrance door

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 9. (a) The special service entrance door(s) must meet the following specifications:
(1) All doors must open outward.
(2) The door(s) must have an opening wide enough to permit proper operation of a lift meeting the requirements of section 5 of this rule, but may not exceed forty-three (43) inches in width.
(3) If the special service entrance opening is more than forty-three (43) inches wide, two (2) doors must be used.
(4) The door must have fastening devices to hold it open.
(5) The doors must be weather sealed.
(6) Buses with two (2) doors must have a flange on the forward door that overlaps the edge of the rear door when closed.
(7) Power doors may be used, but the design must provide for manual operation from inside the bus.
(8) The door materials, colors, lettering, and other exterior features must correspond with or match adjacent sections of the bus body, except for rub rails.
(9) The door materials, panels, and structural strength must be equivalent to the regular service and emergency doors.
(10) The door must have a switch that prevents the power lift from operating when the platform door is closed.
(b) If manually operated dual doors are used, the following specifications must be met:
(1) The rear door must have at least a one-point fastening device that fastens to the header.
(2) The forward mounted door must have at least three (3) fastening devices which fasten to:
(A) the header;
(B) the floor line of the body; and
(C) the rear door.
(3) The fastening devices must provide maximum safety when the doors are closed.
(4) The door and hinge mechanisms must be constructed to withstand the same use as a regular service door.
(c) The doors must have windows that are:
(1) set in rubber; and
(2) within one (1) inch of the lower line of the adjacent sash.
(d) There must be a device in the driver's compartment that activates a red, flashing visible signal when the ignition is on and the special service door is not securely closed.
(e) Seats may be placed in front of an inoperable door of a bus described under section 8(b) of this rule. *(State School Bus Committee; 575 IAC 1-5.5-9; filed May 24, 1990, 4:20 p.m.: 13 IR 1858; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-10 Panels
Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 10. (a) A restraining barrier or seat back that meets FMVSS 222 must be located in front of any forward facing seat.
(b) A bus with wheelchair spaces located in the front portion of the bus must have padded protection panels behind the driver's platform and in back of the front step well. The bottom of the panel cannot be more than three (3) inches from the floor of the bus.
(c) If modification for a power lift requires an opening in the floor, a chain must be installed between the protection panels to enclose the lift area.
(d) A protection panel must be located between the inner lift frame structure and the bus sidewall. The panel must extend from the top of the window to no more than three (3) inches from the floor. *(State School Bus Committee; 575 IAC 1-5.5-10; filed May 24, 1990, 4:20 p.m.: 13 IR 1858; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)*

575 IAC 1-5.5-11 Special requirements
Authority: IC 20-27-3-4
Affected: IC 20-27
Sec. 11. (a) Any passenger seat that has a child safety seat or restraint system attached to it must:
(1) have a reinforced frame; and
(2) meet the requirements of FMVSS 208, 209, and 210.
(b) All child safety seats or restraint systems used in a school bus must be secured to a bus seat in a manner prescribed and approved by the manufacturer, and must meet safety specifications as follows:
(1) A child weighing less than fifty (50) pounds must be transported in a child safety seat or restraint system meeting FMVSS 213.
(2) A child weighing less than thirty (30) pounds must be transported in a car seat meeting FMVSS 213.
(3) A child weighing less than thirty (30) pounds with a tracheostomy must be transported in a car seat without a shield or armrest.
(4) A safety seat used to transport a child under twenty (20) pounds must be attached to the bus seat in a rearward facing position.
(c) Lap boards attached to wheelchairs or to adaptive equipment must be removed and secured separately during transport.
(d) All respiratory related equipment, such as oxygen, aspirators, and ventilators, must be securely mounted or fastened to a wheelchair, bus seat, bus floor, or to the bus wall below the window line during transit.
(e) Tanks of compressed oxygen transported in a school bus may be no larger than twenty-two (22) cubic feet and must be securely mounted inside the bus. Tanks must have valves and regulators that are protected against breakage. Tanks must be secured to avoid exposure to intense heat, flames, sparks, or friction.
(f) Any liquid oxygen container transported in a school bus may be no larger than thirty-eight (38) cubic feet and must be securely mounted and fastened to prevent damage and exposure to intense heat.

(g) Subsection (a) applies to school buses ordered for purchase and initially placed in service on or after July 1, 1990. School buses ordered for purchase and initially placed in service prior to July 1, 1990, may comply with subsection (a). *(State School Bus Committee; 575 IAC 1-5.5-11; filed May 24, 1990, 4:20 p.m.: 13 IR 1859; filed May 21, 1992, 5:00 p.m.: 15 IR 2222; readopted filed Oct 10, 2001, 3:37 p.m.: 25 IR 938; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-75070225ACA)*

575 IAC 1-5.5-12 Applicability of rule

Authority: IC 20-27-3-4
Affected: IC 20-27

Sec. 12. (a) The revisions of 575 IAC 1-5, effective July 1, 1981, apply to all school buses ordered for purchase or placed in production for use in Indiana before June 30, 1990.
(b) The requirements of this rule apply to all school buses ordered for purchase and initially placed in service on or after July 1, 1990.
(c) Sections 3(a), 3(c) through 3(e), and 11(b) through 11(f) of this rule apply to all school buses regardless of when the school buses were ordered or placed in service.
(State School Bus Committee; 575 IAC 1-5.5-12; filed May 24, 1990, 4:20 p.m.: 13 IR 1859; filed May 21, 1992, 5:00 p.m.: 15 IR 2222; filed Mar 9, 2000, 7:45 a.m.: 23 IR 1650; readopted filed Aug 18, 2006, 10:12 a.m.: 20060830-IR-575060138RFA; readopted filed Jun 19, 2007, 10:10 a.m.: 20070704-IR-575070225RFA; errata filed Jul 6, 2007, 10:04 a.m.: 20070725-IR-575070225ACA)

Indiana Law Regarding Financial Responsibility Requirements for Vehicles

IC 9-25-4 Chapter 4. Financial Responsibility
IC 9-25-4-1 Persons, generally, who must meet minimum standards; violation; suspension of license or vehicle registration Sec. 1. (a) This section does not apply to an electric personal assistive mobility device. (b) A person may not: (1) register a vehicle; or (2) operate a vehicle on a public highway; in Indiana if financial responsibility is not in effect with respect to the motor vehicle under section 4 of this chapter. (c) A person who violates this section is subject to the suspension of the person's current driving license or vehicle registration, or both, under this article. *As added by P.L.2-1991, SEC.13. Amended by P.L.105-1991, SEC.1; P.L.59-1994, SEC.3; P.L.143-2002, SEC.8.*
IC 9-25-4-2 Recovery vehicle operators; duty to meet minimum standards; registration of recovery vehicles; proof of financial responsibility; retention of records Sec. 2. A person who operates a recovery vehicle must meet the minimum standards for financial responsibility that are set forth in section 6 of this chapter. A recovery vehicle may be registered only if proof of financial responsibility in amounts required under this section is produced at the time of registration. The bureau shall retain a record of that proof in the bureau's files. *As added by P.L.2-1991, SEC.13.*
IC 9-25-4-3 Continuous maintenance Sec. 3. Financial responsibility in one (1) of the forms required under this chapter must be continuously maintained as long as a motor vehicle is operated on a road, street, or highway in Indiana. *As added by P.L.2-1991, SEC.13.*
IC 9-25-4-4 When financial responsibility in effect; necessary provisions in and approval of insurance policies Sec. 4. (a) For the purposes of this article, financial responsibility is in effect with respect to a motor vehicle if: (1) a motor vehicle liability insurance policy issued with respect to the vehicle; (2) a bond executed with respect to the vehicle under section 7 of this chapter; or (3) the status of the owner or operator of the vehicle as a self-insurer, as recognized by the bureau through the issuance of a certificate of self-insurance under section 11 of this chapter; provides the ability to respond in damages for liability arising out of the ownership, maintenance, or use of the motor vehicle in amounts at least equal to those set forth in section 5 or 6 of this chapter. (b) A motor vehicle liability policy under this article must contain the terms, conditions, and provisions required by statute and must be approved by the state insurance commissioner. *As added by P.L.2-1991, SEC.13.*
IC 9-25-4-5 Minimum amounts of financial responsibility Sec. 5. Except as provided in section 6 of this chapter, the minimum amounts of financial responsibility are as follows: (1) Subject to the limit set forth in subdivision (2), twenty-five thousand dollars ($25,000) for bodily injury to or the death of one (1) individual. (2) Fifty thousand dollars ($50,000) for bodily injury to or the death of two (2) or more individuals in any one (1) accident. (3) Ten thousand dollars ($10,000) for damage to or the destruction of property in one (1) accident. *As added by P.L.2-1991, SEC.13.*
IC 9-25-4-6 Recovery vehicles; minimum amounts of financial responsibility Sec. 6. (a) The minimum standards for financial responsibility for a Class A recovery vehicle are a combined single limit of seven hundred fifty thousand dollars ($750,000) for bodily injury and property damage in any one (1) accident or as follows: (1) Subject to the limit set forth in subdivision (2), five hundred thousand dollars ($500,000) for bodily injury to

or the death of one (1) individual. (2) One million dollars ($1,000,000) for bodily injury to or the death of two (2) or more individuals in any one (1) accident. (3) One hundred thousand dollars ($100,000) for damage to or the destruction of property in one (1) accident. (b) The minimum standards for financial responsibility for a Class B recovery vehicle are a combined single limit of three hundred thousand dollars ($300,000) for bodily injury and property damage in any one (1) accident or as follows: (1) Subject to the limit set forth in subdivision (2), one hundred thousand dollars ($100,000) for bodily injury to or the death of one (1) individual. (2) Three hundred thousand dollars ($300,000) for bodily injury to or the death of two (2) or more individuals in any one (1) accident. (3) Fifty thousand dollars ($50,000) for damage to or the destruction of property in one (1) accident. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-7 Methods of proving financial responsibility Sec. 7. Proof of financial responsibility when required under this article may be given by any of the following methods: (1) Proof that a policy or policies of motor vehicle liability insurance have been obtained and are in full force and effect. (2) Proof that a bond has been duly executed. (3) Proof that deposit has been made of money or securities. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-8 Proof of financial responsibility; filing insurance policy certificate Sec. 8. Proof of financial responsibility may be made by filing with the bureau the written certificate of an insurance carrier authorized to do business in Indiana certifying that the carrier has issued to or for the benefit of the person furnishing the proof and named as the insured a motor vehicle liability policy meeting the requirements of this chapter and having the terms, conditions, and specifications that the bureau requires. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-9 Bonds as proof of financial responsibility; notice of bond cancellation; recovery on claims arising before cancellation Sec. 9. (a) A person required to give proof of financial responsibility may file with the bureau a bond under this section. The bond shall be executed by the person giving the proof and by a surety company authorized to transact business in Indiana. (b) The bureau may not accept a bond unless the bond is conditioned for payments in amounts and under the same circumstances as would be required in a motor vehicle liability policy furnished by the person giving proof of financial responsibility under this article. (c) A bond filed under this section may not be canceled unless ten (10) days written notice of cancellation is given to the bureau. Cancellation of a bond under this subsection does not prevent recovery on the bond due to a right or cause of action arising before the date of cancellation. *As added by P.L.2-1991, SEC.13.*

IC 9-25-4-10 Deposits with treasurer of state as proof of financial responsibility; grounds for and amount of limitations on execution; proof of absence of unsatisfied judgments Sec. 10. (a) A person required to give proof of financial responsibility under this article may give proof of financial responsibility by delivering to the bureau a receipt from the treasurer of state showing a deposit with the treasurer of state of one (1) of the following: (1) Forty thousand dollars ($40,000) in cash or securities that may legally be purchased by savings banks. (2) Trust funds with a market value of forty thousand dollars ($40,000). (b) Money and securities deposited under this section are subject to execution to satisfy a judgment under this article within the limits of coverage and subject to the limits on amounts required by this chapter for motor vehicle liability policies. Money and securities deposited under this section are not

subject to attachment or execution for a reason not listed under this article. (c) The treasurer of state may not accept a deposit or issue a receipt for a deposit under this section, and the bureau may not accept a receipt for a deposit under this section, unless the person making the deposit provides evidence that there are no unsatisfied judgments against the person making the deposit registered in the office of the circuit court clerk of the county where the person making the deposit resides. *As added by P.L.2-1991, SEC.13.*
IC 9-25-4-11 Certificate of self-insurance; cancellation Sec. 11. (a) The bureau may, upon the application of a person, issue a certificate of self-insurance when the bureau is satisfied that the person making the application is possessed and will continue to be possessed of the ability to pay a judgment obtained against the person making the application. A certificate may be issued authorizing a person to act as a self-insurer for property damage, bodily injury, or death. (b) After not less than five (5) days notice and a hearing concerning the notice, the department may upon reasonable grounds cancel a certificate of self-insurance. Failure to pay a judgment within thirty (30) days after the judgment becomes final constitutes a reasonable ground for the cancellation of a certificate of self-insurance. (c) The bureau may only issue a certificate of self-insurance under rules adopted to implement this section. *As added by P.L.2-1991, SEC.13.*

Indiana Medicaid Bulletin on Obligation to Screen for Individuals and Entities Excluded from Medicaid Participation

INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER BULLETIN

BT200934 SEPTEMBER 23, 2009

To: **All Providers**

Subject: **Requirement to Screen for Excluded Individuals and Entities**

Overview

The purpose of this bulletin is to remind all providers of their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and to review the calculation of overpayments to excluded individuals or entities.

General

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal healthcare programs (as defined in *Section 1128B(f)* of the *Social Security Act* – the Act), based on the authority contained in various sections of the Act, including *Sections 1128, 1128A, and 1156*.

Payment Ban for Excluded Providers

When the HHS-OIG has excluded a provider, Federal healthcare programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (*Section 1903(i)(2)* of the Act; and *42 CFR section 1001.1901(b)*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- Payment to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether the individual or entity provides direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

For more information visit http://www.indianamedicaid.com

Page 1 of 4

knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded (*42 CFR section 1001.1901(b)*).

The listing below[1] sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by healthcare entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients, and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901(c)*). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections *1903(d)(2)(A)* and *1903(i)(2)* of the Act, and are therefore subject to recoupment.

---

[1] *This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.*

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (*Section 1128A(a)(6)* of the Act; and *42 CFR section 1003.102(a)(2)*)

Provider Requirements for Determination of Excluded Individuals or Entities

All current providers and providers applying to participate in the Medicaid program shall take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Providers shall screen all employees and contractors to determine whether any of them have been excluded.
- Providers are required to agree to comply with this obligation as a condition of enrollment.
- Providers can search the HHS-OIG Web site by the names of any individual or entity. Providers must search the HHS-OIG Web site monthly to capture exclusions and reinstatements that have occurred since the last search.
- Providers are required to immediately report to the State any exclusion information discovered by contacting the Provider and Member Concern Line at 317-347-4527 in the Indianapolis local area or toll free at 1-800-457-4515.

Where Providers Can Look for Excluded Parties

The HHS-OIG maintains the List of Excluded Individuals and Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal healthcare programs. The LEIE Web site is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The online search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal healthcare programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds.

Additional Information

The latest information regarding the IHCP can be found in the IHCP newsletters at http://www.indianamedicaid.com/ihcp/Publications/newsletters.asp. IHCP bulletins and banners pages can be accessed at http://www.indianamedicaid.com/ihcp/index.asp.

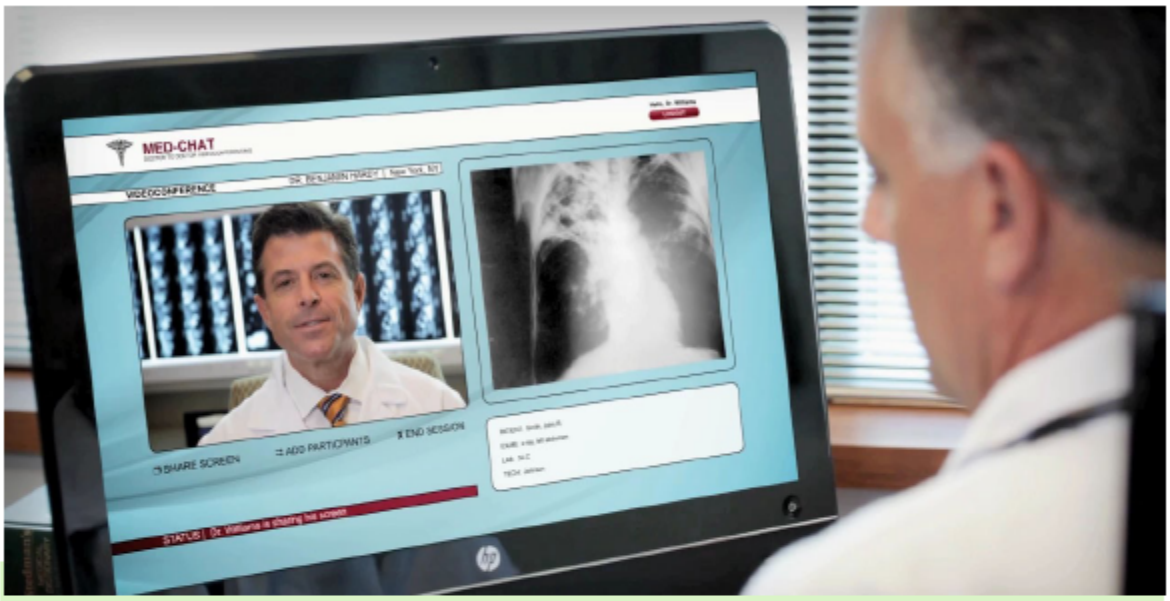
Contact Information

Questions regarding this bulletin may be directed to Customer Assistance at (317) 655-3240 or toll free at 1-800-577-1278.

Indiana Medicaid Bulletin on Requirement to include Ordering, Prescribing and Referring (OPR) Provider NPI on Medicaid Claim for Ordered Service

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201220 JUNE 5, 2012



The IHCP addresses new requirement for ordering, prescribing, and referring providers

In order for Medicaid to reimburse for services or medical supplies that require a provider's order, prescription, or referral, the *Affordable Care Act* (*42 CRF Parts 405, 447, 455, 457*, and *498*) requires that the ordering, prescribing, or referring provider be enrolled in Medicaid. Compliance with this requirement necessitates changes to Indiana Health Coverage Programs (IHCP) claims and provider enrollment processes.

Claims processing changes to be implemented

For dates of service on and after October 1, 2012, when providers with the following specialties submit claims for services or supplies that require an order, prescription, or referral, the submitting providers will be required to include the National Provider Identifier (NPI) of the provider who ordered, prescribed, or referred the services or supplies:

- Home health agencies (050)
- Physical therapists (170)
- Occupational therapists (171)
- Speech and hearing therapists (173)

Please note:

If you render services or provide medical supplies in response to a provider's order, prescription, or referral, this requirement may affect your reimbursement.

Continue

IHCP *bulletin* BT201220 JUNE 5, 2012

- Pharmacies (240)
- Durable medical equipment (DME)/medical supply dealers – including pharmacies (250)
- Home medical equipment (HME) providers – including pharmacies (251)
- Independent laboratories (280)
- Mobile laboratories (281)
- Independent diagnostic testing facilities (IDTF) (282)
- Independent diagnostic testing facilities (IDTF) mobile (283)
- Free-standing x-ray clinics (290)
- Mobile x-ray clinics (291)
- Free-standing renal dialysis clinics (300)
- Pathologists (333)

The IHCP's claims processing will monitor whether the ordering, prescribing, or referring provider is enrolled in the IHCP. Claims will deny if the ordering, prescribing or referring provider is not enrolled. Additional information about this requirement will be communicated in future IHCP publications.

New provider category for ordering, prescribing, and referring providers

To address this new requirement, and to encourage nonenrolled providers to enroll in the IHCP, a new category of enrollment has been created: ordering, prescribing, referring (OPR) provider. Providers already enrolled as IHCP providers do not need to do anything new. Providers not otherwise enrolled as IHCP providers can enroll as OPR providers. This new OPR provider category is appropriate for practitioners who:

- May occasionally see an individual who is an IHCP member who needs additional services or supplies that will be covered by the Medicaid program; and
- Do not want to be enrolled as another IHCP provider type; and
- Do not plan to submit claims to the IHCP for payment of services rendered.

Beginning June 28, 2012, the new OPR Provider enrollment packet will be posted on the Provider Enrollment pages of indianamedicaid.com. The OPR packet will be a simplified application that asks for minimal information from providers who only order, prescribe, and refer IHCP members for services or supplies.

For providers who choose to enroll as OPR providers, it is important to remember that an OPR provider cannot submit claims to the IHCP for payment for services rendered. If the provider wishes to be able to submit claims, enrollment as another IHCP provider type will be required.

Continue

IHCP bulletin BT201220 JUNE 5, 2012

IHCP providers will be able to verify the IHCP enrollment status of an ordering, prescribing, or referring provider before providing services or supplies. To supplement the existing Provider Search function, a directory of OPR providers will be maintained on indianamedicaid.com as providers enroll.

For more information about the changes to billing and the new OPR provider enrollment category, watch for upcoming IHCP publications and educational events, or contact Customer Assistance at (317) 655-3240 or 1-800-577-1278.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com. To receive email notices of future IHCP publications, subscribe to IHCP Email Notifications.

Indiana Medicaid Bulletin on Claims Edits that Check for the Ordering, Prescribing or Referring Provider NPI on Claims for Services

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201233 AUGUST 28, 2012

Claims adjudication process to validate ordering, prescribing, and referring (OPR) practitioners

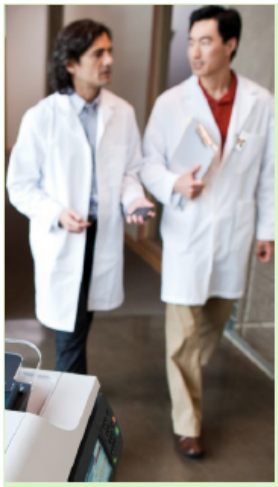
When providing services or medical supplies resulting from an order, prescription, or referral, federal regulations require providers to include the National Provider Identifier (NPI) of the ordering, prescribing, or referring practitioner on Medicaid claims. Reimbursement to the billing provider requires the ordering, prescribing, or referring (OPR) practitioner to be enrolled in Medicaid.

To comply with these provisions, effective October 1, 2012, the Indiana Health Coverage Programs (IHCP) claims adjudication process will verify both the presence of a valid OPR practitioner NPI and the OPR practitioner's enrollment in the IHCP. Claim payments will be affected as follows:

- Medical claims with dates of service on or after October 1, 2012, will deny if an NPI for the OPR practitioner is not present on the claim, or if the OPR practitioner is not enrolled as an IHCP provider.
- Pharmacy claims with dates of service from October 1, 2012, through December 31, 2012, will post an OPR edit informing the billing provider if the NPI for the OPR prescriber is not present; if the prescriber does not have prescriptive

Continue

IHCP *bulletin* BT201233 AUGUST 28, 2012



authority set forth in *IC 16-42-19-5*; or if the prescriber is not enrolled as an IHCP provider. The edit will not result in a claim denial.

- Pharmacy claims with dates of service on or after January 1, 2013, will deny with the OPR edit informing the billing provider if the NPI for the OPR prescriber is not present; if the prescriber does not have prescriptive authority set forth in *IC 16-42-19-5*; or if the prescriber is not enrolled as an IHCP provider.

Key claim processing points

- Inclusion of an NPI for the OPR practitioner applies to paper claims, electronic claims submitted via Web interChange, and 837 *Health Insurance Portability and Accountability Act* (HIPAA) 5010 or National Council for Prescription Drug Programs (NCPDP) D.0 electronic transactions. Providers are to report the NPI of the OPR practitioner in the appropriate field locator based on the following table:

Field locators for reporting OPR practitioners' NPIs

Claim form	Field locator
CMS-1500	17b (Referring NPI)

Indiana's State Statute on Medicaid False Claims and Whistleblower Protection

IC 5-11-5.7
Chapter 5.7. Medicaid False Claims and Whistleblower Protection

IC 5-11-5.7-1
Application; definitions

Sec. 1. (a) This chapter applies only to claims, requests, demands, statements, records, acts, and omissions made or submitted in relation to the Medicaid program described in IC 12-15.

(b) The following definitions apply throughout this chapter:

(1) "Claim" means a request or demand for money or property, whether under a contract or otherwise, and whether or not the state has title to the money or property, that:

(A) is presented to an officer, employee, or agent of the state; or

(B) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the state's behalf or to advance a state program or interest, and if the state:

(i) provides or has provided any part of the money or property that is requested or demanded; or

(ii) will reimburse the contractor, grantee, or other recipient for any part of the money or property that is requested or demanded.

(2) "Documentary material" means:

(A) the original or a copy of a book, record, report, memorandum, paper, communication, tabulation, chart, or other document;

(B) a data compilation stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret the data compilations; and

(C) a product of discovery.

(3) "Investigation" means an inquiry conducted by an investigator to ascertain whether a person is or has been engaged in a violation of this chapter.

(4) "Knowing", "knowingly", or "known" means that a person, regarding information:

(A) has actual knowledge of the information;

(B) acts in deliberate ignorance of the truth or falsity of the information; or

(C) acts in reckless disregard of the truth or falsity of the information;

and requires no proof of specific intent to defraud.

(5) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(6) "Obligation" means an established duty, whether or not the duty is fixed, arising from:

(A) an express or implied contractual relationship;

(B) a grantor-grantee relationship;

(C) a licensor-licensee relationship;

(D) a fee-based or similar relationship;

(E) a statute;

(F) a rule or regulation; or

(G) the retention of an overpayment.

(7) "Person" includes a natural person, a corporation, a firm, an association, an organization, a partnership, a limited liability company, a business, or a trust.

(8) "Product of discovery" means the original or duplicate of:

(A) a deposition;

(B) an interrogatory;

(C) a document;

(D) a thing;

(E) a result of the inspection of land or other property; or

(F) an examination or admission;

IC 5-11-5.7-2
Liability for knowingly presenting, making, or using false claims, false records or statements, fraud, conspiracy; exemptions

Sec. 2. (a) This section does not apply to a claim, record, or statement concerning income tax (IC 6-3).

(b) A person who:

(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim;

(3) has possession, custody, or control of property or money used, or to be used, by the state, and knowingly delivers, or causes to be delivered, less than all of the money or property;

(4) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, with intent to defraud the state, authorizes issuance of a receipt without knowing that the information on the receipt is true;

(5) knowingly buys or receives, as a pledge of an obligation or debt, public property from an employee who is not lawfully authorized to sell or pledge the property;

(6) knowingly:

(A) makes, uses, or causes to be made or used, a false record or statement concerning an obligation to pay or transmit money or property to the state; or

(B) conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state;

(7) conspires with another person to perform an act described in subdivisions (1) through (6); or

(8) causes or induces another person to perform an act described in subdivisions (1) through (6);

is, except as provided in subsection (c), liable to the state for a civil penalty of at least five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000), as adjusted by the federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note, Public Law 101-410), and for up to three (3) times the amount of damages sustained by the state. In addition, a person who violates this section is liable to the state for the costs of a civil action brought to recover a penalty or damages.

(c) If the factfinder determines that the person who violated this section:

(1) furnished state officials with all information known to the person about the violation not later than thirty (30) days after the date on which the person obtained the information;

(2) fully cooperated with the investigation of the violation; and

(3) did not have knowledge of the existence of an investigation, a criminal prosecution, a civil action, or an administrative action concerning the violation at the time the person provided information to state officials;

the person is liable for a penalty of not less than two (2) times the amount of damages that the state sustained because of the violation. A person who violates this section is also liable to the state for the costs of a civil action brought to recover a penalty or damages.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-3
Concurrent jurisdiction to investigate violations; civil action; certification of findings; intervention; disqualification; certification; filing of civil action; no bond requirement

Sec. 3. (a) The:
(1) attorney general; and
(2) inspector general;
have concurrent jurisdiction to investigate a violation of section 2 of this chapter.

(b) If the attorney general discovers a violation of section 2 of this chapter, the attorney general may bring a civil action under this chapter against a person who may be liable for the violation.

(c) If the inspector general discovers a violation of section 2 of this chapter, the inspector general shall certify this finding to the attorney general. The attorney general may bring a civil action under this chapter against a person who may be liable for the violation.

(d) If the attorney general or the inspector general is served by a person who has filed a civil action under section 4 of this chapter, the attorney general has the authority to intervene in that action as set forth in section 4 of this chapter.

(e) If the attorney general:
(1) is disqualified from investigating a possible violation of section 2 of this chapter;
(2) is disqualified from bringing a civil action concerning a possible violation of section 2 of this chapter;
(3) is disqualified from intervening in a civil action brought under section 4 of this chapter concerning a possible violation of section 2 of this chapter;
(4) elects not to bring a civil action concerning a possible violation of section 2 of this chapter; or
(5) elects not to intervene under section 4 of this chapter;
the attorney general shall certify the attorney general's disqualification or election to the inspector general.

(f) If the attorney general has certified the attorney general's disqualification or election not to bring a civil action or intervene in a case under subsection (e), the inspector general has authority to:
(1) bring a civil action concerning a possible violation of section 2 of this chapter; or
(2) intervene in a case under section 4 of this chapter.

(g) The attorney general shall certify to the inspector general the attorney general's disqualification or election under subsection (e) in a timely fashion, and in any event not later than:
(1) sixty (60) days after being served, if the attorney general has been served by a person who has filed a civil action under section 4 of this chapter; or
(2) one hundred eighty (180) days before the expiration of the statute of limitations, if the attorney general has not been served by a person who has filed a civil action under section 4 of this chapter.

(h) A civil action brought under section 4 of this chapter may be filed in:
(1) a circuit or superior court in Marion County; or
(2) a circuit or superior court in the county in which a defendant or plaintiff resides.

(i) The state is not required to file a bond under this chapter.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-4
Civil action for violations on behalf of a person or the state; requirements; dismissal of claim; serving of complaint; extensions of time; intervention

Sec. 4. (a) A person may bring a civil action for a violation of section 2 of this chapter on behalf of the person and on behalf of the state. The action:

(1) must be brought in the name of the state; and
(2) may be filed in a circuit or superior court in:
(A) the county in which the person resides;
(B) the county in which a defendant resides; or
(C) Marion County.

(b) Except as provided in section 5 of this chapter, an action brought under this section may be dismissed only if:

(1) the attorney general or the inspector general, if applicable, files a written motion to dismiss explaining why dismissal is appropriate; and
(2) the court issues an order:
(A) granting the motion; and
(B) explaining the court's reasons for granting the motion.

(c) A person who brings an action under this section shall serve:

(1) a copy of the complaint; and
(2) a written disclosure that describes all relevant material evidence and information the person possesses;

on both the attorney general and the inspector general. The person shall file the complaint under seal, and the complaint shall remain under seal for at least sixty (60) days. The complaint shall not be served on the defendant until the court orders the complaint served on the defendant following the intervention or the election not to intervene of the attorney general or the inspector general. The state may elect to intervene and proceed with the action not later than sixty (60) days after it receives both the complaint and the written disclosure.

(d) For good cause shown, the attorney general or the inspector general may move the court to extend the time during which the complaint must remain under seal. A motion for extension may be supported by an affidavit or other evidence. The affidavit or other evidence may be submitted in camera.

(e) Before the expiration of the time during which the complaint is sealed, the attorney general or the inspector general may:

(1) intervene in the case and proceed with the action, in which case the attorney general or the inspector general shall conduct the action; or
(2) elect not to proceed with the action, in which case the person who initially filed the complaint may proceed with the action.

(f) The defendant in an action filed under this section is not required to answer the complaint until twenty-one (21) days after the complaint has been unsealed and served on the defendant.

(g) After a person has filed a complaint under this section, no person other than the attorney general or the inspector general may:

(1) intervene; or
(2) bring another action based on the same facts.

(h) If the person who initially filed the complaint:

(1) planned and initiated the violation of section 2 of this chapter; or
(2) has been convicted of a crime related to the person's violation of section 2 of this chapter;

upon motion of the attorney general or the inspector general, the court shall dismiss the person as a plaintiff.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-5
Attorney general and inspector general responsibilities in intervention; authorization; dismissal of action; settlement; limitations; discovery

Sec. 5. (a) If the attorney general or the inspector general intervenes in an action under section 4 of this chapter, the attorney general or the inspector general is responsible for prosecuting the action and is not bound by an act of the person who initially filed the complaint. The attorney general or the inspector general may do the following:

(1) File a complaint.

(2) Amend the complaint of a person who has brought an action under section 4 of this chapter, to:

(A) clarify or add detail to the claims in which the state is intervening; or

(B) add additional claims to which the state contends the state is entitled to relief.

(3) Move for a change of venue to Marion County if the attorney general or the inspector general files a motion for change of venue not later than ten (10) days after the attorney general or the inspector general intervenes.

For statute of limitation purposes, a pleading filed by the attorney general or the inspector general relates back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the state arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the original filed complaint. Except as provided in this section, the person who initially filed the complaint may continue as a party to the action.

(b) With the approval of the court, the attorney general or the inspector general may dismiss the action after:

(1) notifying the person who initially filed the complaint; and

(2) the court has conducted a hearing at which the person who initially filed the complaint was provided the opportunity to be heard on the motion.

The court may consider a request by the attorney general or the inspector general to dismiss the action but is not bound by the request. Additionally, the court may permit the attorney general or inspector general to be dismissed from the case and may permit the person who initially filed the complaint to continue to prosecute the action.

(c) The attorney general or the inspector general may settle the action if a court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable in light of the circumstances. Upon a showing of good cause, the court may:

(1) conduct the settlement hearing in camera; or

(2) lift all or part of the seal to facilitate the investigative process or settlement.

The court may consider an objection to the settlement brought by the person who initially filed the complaint, but is not bound by this objection.

(d) Upon a showing by the attorney general, the inspector general, or the defendant that unrestricted participation by the person who initially filed the complaint:

(1) will interfere with or unduly delay the prosecution of the case by the attorney general or the inspector general;

(2) will involve the presentation of repetitious or irrelevant evidence, or evidence introduced for purposes of harassment; or

(3) will cause the defendant to suffer undue burden or unnecessary expense;

the court may impose reasonable limitations on the person's participation, including a limit on the number of witnesses that the person may call, a limit to the length of testimony that the person's witness may present, a limit to the person's cross-examination of a witness, or otherwise limit the participation by the person in the litigation.

(e) If the attorney general or the inspector general elects not to intervene in the action, the person who initially filed the complaint has the right to prosecute the action. Upon request, the attorney general or the inspector general shall be served with copies of all documents filed in the action and may obtain a copy of depositions and other transcripts at the state's expense.

(f) If the attorney general and the inspector general have elected not to intervene in an action in accordance with section 4 of this chapter, upon a showing of good cause, a court may permit either the attorney general or the inspector general to intervene at a later time. The attorney general may move to intervene at any time. If the attorney general has not moved to intervene, the inspector general may move to intervene by providing written notice to the attorney general of the inspector general's intent to intervene. If the attorney general does not move to intervene earlier than fifteen (15) days after receipt of the notice of intent to intervene, the inspector general may move to intervene. If the attorney general or the inspector general intervenes under this subsection, the attorney general or the inspector general is responsible for prosecuting the action as if the attorney general or the inspector general had intervened in accordance with section 4 of this chapter.

(g) If the attorney general or inspector general shows that a specific discovery action by the person who initially filed the complaint will interfere with the investigation or prosecution of a civil or criminal matter arising out of the same facts, the court may, following a hearing in camera, stay discovery for not more than sixty (60) days. After the court has granted a sixty (60) day stay, the court may extend the stay, following a hearing in camera, if it determines that the state has pursued the civil or criminal investigation with reasonable diligence and that a specific discovery action by the person who initially filed the complaint will interfere with the state's investigation or prosecution of the civil or criminal matter.

(h) A court may dismiss an action brought under this chapter to permit the attorney general or the inspector general to pursue its claim through an alternative proceeding, including an administrative proceeding or a proceeding brought in another jurisdiction. The person who initially filed the complaint has the same rights in the alternative proceedings as the person would have had in the original proceedings. A finding of fact or conclusion of law made in the alternative proceeding is binding on all parties to an action under this section once the determination made in the alternative proceeding is final under the rules, regulations, statutes, or law governing the alternative proceeding, or if the time for seeking an appeal or review of the determination made in the alternative proceeding has elapsed.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-6

Entitlement for person who initially filed complaint; attorney's fees and costs; state not liable for expenses and costs

Sec. 6. (a) The person who initially filed the complaint is entitled to the following amounts if the state prevails in the action:

(1) Except as provided in subdivision (2), if the attorney general or the inspector general intervened in the action, the person is entitled to receive at least fifteen percent (15%) and not more than twenty-five percent (25%) of the proceeds of the action or settlement, plus reasonable attorney's fees and an amount to cover the expenses and costs of bringing the action.

(2) If the attorney general or the inspector general intervened in the action and the court finds that the evidence used to prosecute the action consisted primarily of specific information, other than information provided by the person bringing the action, contained in:

(A) a transcript of a criminal, a civil, or an administrative hearing;

(B) a legislative, an administrative, or another public report, hearing, audit, or investigation; or

(C) a news media report;

the person is entitled to receive not more than ten percent (10%) of the proceeds of the action or settlement, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation, plus reasonable attorney's fees and an amount to cover the expenses and costs of bringing the action.

(3) If the attorney general or the inspector general did not intervene in the action, the person is entitled to receive at least twenty-five percent (25%) and not more than thirty percent (30%) of the proceeds of the action or settlement, plus reasonable attorney's fees and an amount to cover the expenses and costs of bringing the action.

(4) If the person who initially filed the complaint:

(A) planned and initiated the violation of section 2 of this chapter; or

(B) has been convicted of a crime related to the person's violation of section 2 of this chapter;

the person is not entitled to an amount under this section.

After conducting a hearing at which the attorney general or the inspector general and the person who initially filed the complaint may be heard, the court shall determine the specific amount to be awarded under this section to the person who initially filed the complaint. The award of reasonable attorney's fees plus an amount to cover the expenses and costs of bringing the action is an additional cost assessed against the defendant and may not be paid from the proceeds of the civil action.

(b) If:

(1) the attorney general or the inspector general did not intervene in the action; and

(2) the defendant prevails;

the court may award the defendant reasonable attorney's fees plus an amount to cover the expenses and costs of defending the action, if the court finds that the action is frivolous, vexatious, or brought primarily for purposes of harassment.

(c) The state is not liable for the expenses, costs, or attorney's fees of a party to an action brought under this chapter.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-7

No court jurisdiction for actions brought by incarcerated offenders, actions brought against certain officeholders, actions subject to civil suit or criminal prosecution, or actions based on information contained in specified documents

Sec. 7. (a) This section does not apply to an action brought by:

(1) the attorney general;

(2) the inspector general;

(3) a prosecuting attorney; or

(4) a state employee in the employee's official capacity.

(b) A court does not have jurisdiction over an action brought under section 4 of this chapter if the action is brought by an incarcerated offender, including an offender incarcerated in another jurisdiction.

(c) A court does not have jurisdiction over an action brought under section 4 of this chapter against the state, a state officer, a judge (as defined in IC 33-23-11-7), a justice, a member of the general assembly, a state employee, or an employee of a political subdivision, if the action is based on information known to the state at the time the action was brought.

(d) A court does not have jurisdiction over an action brought under section 4 of this chapter if the action is based upon an act that is the subject of a civil suit, a criminal prosecution, or an administrative proceeding in which the state is a party.

(e) A court does not have jurisdiction over an action brought under section 4 of this chapter if the action is based upon information contained in:

(1) a transcript of a criminal, a civil, or an administrative hearing in which the state or the state's agent is a party;

(2) a legislative, an administrative, or another public state report, hearing, audit, or investigation; or

(3) a news media report; unless the person bringing the action either, before a public disclosure under this section voluntarily discloses to the state the information on which the

allegations or transactions in a claim are based, or has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and the person bringing the action has voluntarily provided this information to the state before an action is filed under section 4 of this chapter.

(f) In determining whether a prior public disclosure bars a court from exercising jurisdiction over an action brought under section 4 of this chapter, the court shall consider, but is not bound by, any objection brought by the attorney general or the inspector general.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-8
Entitled relief for employees, contractors, or agents; three year limitation

Sec. 8. (a) An employee, contractor, or agent who has been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others to:

(1) object to or otherwise stop an act or omission described in section 2 of this chapter; or

(2) initiate, testify, assist, or participate in an investigation, an action, or a hearing under this chapter;

is entitled to all relief necessary to make the employee, contractor, or agent whole.

(b) Relief under this section must include:

(1) reinstatement with the same seniority status the employee, contractor, or agent would have had but for the act described in subsection (a);

(2) two (2) times the amount of back pay;

(3) interest on the back pay; and

(4) compensation for any special damages sustained as a result of the act described in subsection (a), including costs and expenses of litigation and reasonable attorney's fees.

(c) An employee may bring an action for the relief provided in this section in any court with jurisdiction.

(d) A civil action under this section may not be brought more than three (3) years after the date the retaliation occurred.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-9
Subpoena; barring of civil action timing; establishment of elements of offense and damages by preponderance of the evidence; estoppels if conviction of crime involving fraud or false statements

Sec. 9. (a) A subpoena requiring the attendance of a witness at a trial or hearing conducted under this chapter may be served at any place in Indiana.

(b) A civil action under section 4 of this chapter is barred unless it is commenced:

(1) not later than six (6) years after the date on which the violation is committed; or

(2) not later than three (3) years after the date when facts material to the cause of action are known or reasonably should have been known by a state officer or employee who is responsible for addressing the false claim. However, an action is barred unless it is commenced not later than ten (10) years after the date on which the violation is committed.

(c) In a civil action brought under this chapter, the state is required to establish:

(1) the essential elements of the offense; and

(2) damages;

by a preponderance of the evidence.

(d) If a defendant has been convicted (including a plea of guilty or nolo contendere) of a crime involving fraud or a false statement, the defendant is estopped from denying the elements of the

offense in a civil action brought under section 4 of this chapter that involves the same transaction as the criminal prosecution.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-10
Issuance of civil investigative demand concerning documents and information; requirements
Sec. 10. (a) Whenever the attorney general, the inspector general, or the designee of the attorney general or the inspector general has reason to believe that a person may be in possession, custody, or control of documentary material or information relevant to an investigation under this chapter involving a false claim, the attorney general, the inspector general, or the designee of the attorney general or inspector general may, before commencing a civil proceeding under this chapter, issue and serve a civil investigative demand requiring the person to do one (1) or more of the following:

(1) Produce the documentary material for inspection and copying.
(2) Answer an interrogatory in writing concerning the documentary material or information.
(3) Give oral testimony concerning the documentary material or information.

(b) If a civil investigative demand is a specific demand for a product of discovery, the official issuing the civil investigative demand shall:

(1) serve a copy of the civil investigative demand on the person from whom the discovery was obtained; and
(2) notify the person to whom the civil investigative demand is issued of the date of service.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-11
Civil investigative demand include description of conduct constituting violation involving a false claim; requirements; return; date for oral testimony requirements
Sec. 11. (a) A civil investigative demand issued under this chapter must describe the conduct constituting a violation involving a false claim that is under investigation and the statute or rule that has been violated.

(b) If a civil investigative demand is for the production of documentary material, the civil investigative demand must:

(1) describe each class of documentary material to be produced with sufficient specificity to permit the material to be fairly identified;
(2) prescribe a return date for each class of documentary material that provides a reasonable period of time to assemble and make the material available for inspection and copying; and
(3) identify the official to whom the material must be made available.

(c) If a civil investigative demand is for answers to written interrogatories, the civil investigative demand must:

(1) set forth with specificity the written interrogatories to be answered;
(2) prescribe the date by which answers to the written interrogatories must be submitted; and
(3) identify the official to whom the answers must be submitted.

(d) If a civil investigative demand requires oral testimony, the civil investigative demand must:

(1) prescribe a date, time, and place at which oral testimony will be given;
(2) identify the official who will conduct the examination and the custodian to whom the transcript of the examination will be submitted;
(3) specifically state that attendance and testimony are necessary to the conduct of the investigation;

(4) notify the person receiving the demand that the person has the right to be accompanied by an attorney and any other representative; and

(5) describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry.

(e) A civil investigative demand that is a specific demand for a product of discovery may not be returned until at least twenty-one (21) days after a copy of the civil investigative demand has been served on the person from whom the discovery was obtained.

(f) The date prescribed for the giving of oral testimony under a civil investigative demand issued under this chapter must be a date that is not less than seven (7) days after the date on which the demand is received, unless the official issuing the demand determines that exceptional circumstances are present that require an earlier date.

(g) The official who issues a civil investigative demand may not issue more than one (1) civil investigative demand for oral testimony by the same person, unless:

(1) the person requests otherwise; or

(2) the official who issues a civil investigative demand, after conducting an investigation, notifies the person in writing that an additional civil investigative demand for oral testimony is necessary.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-12
Demand limitations if disclosure is protected; civil investigative demand supercedes contrary orders, rules, provisions that prevent or restrict disclosure; does not constitute waiver of a right or privilege

Sec. 12. (a) A civil investigative demand issued under this chapter may not require the production of any documentary material, the submission of any answers to written interrogatories, or the giving of any oral testimony if the material, answers, or testimony would be protected from disclosure under the standards applicable:

(1) to a subpoena or subpoena duces tecum issued by a court to aid in a grand jury investigation; or

(2) to a discovery request under the rules of trial procedure;

to the extent that the application of these standards to a civil investigative demand is consistent with the purposes of this chapter.

(b) A civil investigative demand that is a specific demand for a product of discovery supersedes any contrary order, rule, or statutory provision, other than this section, that prevents or restricts disclosure of the product of discovery. Disclosure of a product of discovery under a specific demand does not constitute a waiver of a right or privilege that the person making the disclosure may be otherwise entitled to invoke to object to discovery of trial preparation materials.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-13
Service of investigative demand

Sec. 13. (a) A civil investigative demand issued under this chapter may be served by an investigator or by any other person authorized to serve process.

(b) A civil investigative demand shall be served in accordance with the rules of trial procedure. A court having jurisdiction over a person not located in Indiana has the same authority to enforce compliance with this chapter as the court has over a person located in Indiana.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-14
Production of documentary material, interrogatories, and examination of persons in accordance with Trial Rules

Sec. 14. (a) The production of documentary material in response to a civil investigative demand served under this chapter shall be made in accordance with Trial Rule 34.

(b) Each interrogatory in a civil investigative demand served under this chapter shall be answered in accordance with Trial Rule 33.

(c) The examination of a person under a civil investigative demand for oral testimony served under this chapter shall be conducted in accordance with Trial Rule 30.

As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-15
Issuer of civil investigative demand as custodian; transmittal and possession of documents; copies; restricted availability of documents; return of materials

Sec. 15. (a) The official who issued the civil investigative demand is the custodian of the documentary material, answers to interrogatories, and transcripts of oral testimony received under this chapter.

(b) An investigator who receives documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the official who issued the civil investigative demand. The official shall take physical possession of the material, answers, or transcripts and is responsible for the use made of them and for the return of documentary material.

(c) The official who issued the civil investigative demand may make copies of documentary material, answers to interrogatories, or transcripts of oral testimony as required for official use by the attorney general, the inspector general, or the state police. The material, answers, or transcripts may be used in connection with the taking of oral testimony under this chapter.

(d) Except as provided in subsection (e), documentary material, answers to interrogatories, or transcripts of oral testimony, while in the possession of the official who issued the civil investigative demand, may not be made available for examination to any person other than:

(1) the attorney general or designated personnel of the attorney general's office;
(2) the inspector general or designated personnel of the inspector general's office; or
(3) an officer of the state police who has been authorized by the official who issued the civil investigative demand.

(e) The restricted availability of documentary material, answers to interrogatories, or transcripts of oral testimony does not apply:

(1) if the person who provided:
(A) the documentary material, answers to interrogatories, or oral testimony; or
(B) a product of discovery that includes documentary material, answers to interrogatories, or oral testimony;
consents to disclosure;
(2) to the general assembly or a committee or subcommittee of the general assembly; or
(3) to a state agency that requires the information to carry out its statutory responsibility.

Documentary material, answers to interrogatories, or transcripts of oral testimony requested by a state agency may be disclosed only under a court order finding that the state agency has a substantial need for the use of the information in carrying out its statutory responsibility.

(f) While in the possession of the official who issued the civil investigative demand, documentary material, answers to interrogatories, or transcripts of oral testimony shall be made available to the person, or to the representative of the person who produced the material, answered the interrogatories, or gave oral testimony. The official who issued the civil investigative demand may impose reasonable conditions upon the examination or use of the documentary material, answers to interrogatories, or transcripts of oral testimony.

(g) The official who issued the civil investigative demand and any attorney employed in the same office as the official who issued the civil investigative demand may use the documentary material,

answers to interrogatories, or transcripts of oral testimony in connection with a proceeding before a grand jury, a court, or an agency. Upon the completion of the proceeding, the attorney shall return to the official who issued the civil investigative demand any documentary material, answers to interrogatories, or transcripts of oral testimony that are not under the control of the grand jury, court, or agency.

(h) Upon written request of a person who produced documentary material in response to a civil investigative demand, the official who issued the civil investigative demand shall return any documentary material in the official's possession to the person who produced documentary material, if:

(1) a proceeding before a grand jury, a court, or an agency involving the documentary material has been completed; or

(2) a proceeding before a grand jury, a court, or an agency involving the documentary material has not been commenced within a reasonable time after the completion of the investigation.

The official who issued the civil investigative demand is not required to return documentary material that is in the custody of a grand jury, a court, or an agency.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-16
Sanctions for failure to comply; protective order

Sec. 16. (a) A person who has failed to comply with a civil investigative demand is subject to sanctions under Trial Rule 37 to the same extent as a person who has failed to cooperate in discovery.

(b) A person who objects to a civil investigative demand issued under this chapter may seek a protective order in accordance with Trial Rule 26(C).
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-17
Confidentiality of material and information

Sec. 17. Documentary material, answers to written interrogatories, or oral testimony provided in response to a civil investigative demand issued under this chapter is confidential.
As added by P.L.197-2013, SEC.1.

IC 5-11-5.7-18
Proceedings governed by Indiana Rules of Trial Procedure

Sec. 18. Proceedings under this chapter are governed by the Indiana Rules of Trial Procedure, unless the Indiana Rules of Trial Procedure are inconsistent with this chapter.
As added by P.L.197-2013, SEC.1.

APPENDIX D –Indiana Medicaid Program Contact Information

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

IHCP General Information	**Provider Customer Service** 1-800-457-4584 **Member Customer Service** 1-800-457-4584 **Member Applications** 1-800-403-0864	**Member Premium Payment Services** *Package C Payment Address/Telephone* Hoosier Healthwise P.O. Box 3127 Indianapolis, IN 46206-3127 1-855-765-8672 *MED Works Payment Address/Telephone* MED Works P.O. Box 946 Indianapolis, IN 46206 1-855-765-8672	**Third Party Liability (TPL)** IHCP – TPL P.O. Box 7262 Indianapolis, IN 46207-7262 1-800-457-4584 Fax 1-866-667-6579 INXIXTPLRequests@dxc.com **TPL Casualty** INXIXTPLCasualty@dxc.com **Provider Enrollment** IHCP Provider Enrollment P.O. Box 7263 Indianapolis, IN 46207-7263 1-800-457-4584	**Fraud and Abuse Reporting** ProgramIntegrity@fssa.in.gov FSSA Program Integrity 402 W. Washington Street Room W374 Indianapolis, IN 46204-2739 IHCP Provider and Member Concerns Line 1-800-457-4515	**Long-Term Care Rate-Setting** **Long-Term Care Audits** IN/MSLC.com Myers and Stauffer 1-800-877-6927 Fax (317) 571-8481

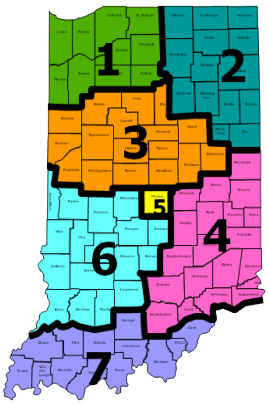
Fee-for-Service

FFS Nonpharmacy Non-NEMT Information	**Prior Authorization – FFS Medical** Cooperative Managed Care Services (CMCS) P.O. Box 56017 Indianapolis, IN 46256 cmcs-indy.com 1-800-269-5720 Fax 1-800-689-2759 **FFS IHCP Portal Claims** Provider Healthcare Portal **IHCP Portal Help Desk Technical Assistance** INXIXElectronicSolution@dxc.com 1-800-457-4584	**FFS Electronic Claim Attachments** DXC – Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259 **Electronic Data Interchange** INXIXTradingPartner@dxc.com 1-800-457-4584 **FFS *CMS-1500* Claims** *(Single/Attachment Claims, Including 590/Waiver)* DXC – *CMS-1500* P.O. Box 7269 Indianapolis, IN 46207-7269	**FFS *CMS-1500* Crossover Claims (Including 590/ Waiver)** DXC – *CMS-1500* Crossover P.O. Box 7267 Indianapolis, IN 46207-7267 **FFS Institutional Claims** *(Crossover/UB-04 Inpatient Hospital, Home Health, Outpatient, Long-Term Care)* DXC – Institutional Claims P.O. Box 7271 Indianapolis, IN 46207-7271 **FFS Dental Claims** DXC – Dental P.O. Box 7268 Indianapolis, IN 46207-7268	**FFS Adjustment Forms (No Refund Checks)** DXC – Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265 **FFS Refunds** DXC – Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303 **Uncashed FFS Check Returns** DXC – Finance Unit 950 North Meridian Street Suite 1150 Indianapolis, IN 46204-4288	**Forms Requests** DXC – Forms P.O. Box 7263 Indianapolis, IN 46207-7263 **Provider Inquiries and Administrative Review Requests** DXC – Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
FFS Nonemergency Medical Transportation (NEMT) Information	**Member Trip Reservations** Southeastrans Southeastrans.com 1-855-325-7586	**Transportation Providers** Southeastrans Southeastrans.com 1-855-325-7611	**Facility Dispatch** Southeastrans Southeastrans.com 1-888-822-6104	**Special Services (standing orders)** Southeastrans 1-855-325-7588	

Check current information online at https://www.in.gov/medicaid/providers/733.htm

INDIANA MEDICAID PROVIDER FIELD CONSULTANTS BY TERRITORY

To check for most current information visit https://www.in.gov/medicaid/providers/490.htm



Territory	Consultant	Telephone	Email	Counties Served
1	Jean Downs	(317) 488-5071	INXIXRegion1@dxc.com	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Shari Galbreath	(317) 488-5080	INXIXRegion2@dxc.com	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Crystal Woodson	(317) 488-5324	INXIXRegion3@dxc.com	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Ken Guth	(317) 488-5153	INXIXRegion4@dxc.com	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Virginia Hudson	(317) 488-5186	INXIXRegion5@dxc.com	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne
	Jenny Atkins	(317) 488-5032	Indiana Medicaid Provider Relations Team Lead	

APPENDIX E
CMS-1500 BILLING INSTRUCTIONS

Please refer to **the Indiana Health Coverage Programs (IHCP) Provider Reference Modules** for detailed instructions for completing the CMS-1500 claim form (see a copy of this form on the next page). The IHCP will return any claims not submitted on the required form. Appendix E of this Tool Kit highlights specific claim form completion details applicable to Indiana public school corporations billing Medicaid-covered IEP/IFSP services. See additional relevant information in Sections 2.5.8. through 2.5.11. and Chapters 3 through 9 of this Tool Kit.

Billing and Rendering Provider Numbers

Medicaid-participating school corporations enter the corporation's Medicaid provider number in both the Billing and Rendering Provider Number fields on the medical claim form.

Billing Provider Number (Required Field): The Billing Provider Number means the specific Medicaid provider number (National Provider Identifier) assigned to the public school corporation or state-operated school. This billing provider number is entered in Locator 33 on the CMS-1500 form or 837P electronic transaction. Reminder: the school corporation's Medicaid Provider Number can only be used to bill Medicaid for services listed in the IEPs/IFSPs of Medicaid-eligible students.

Rendering Provider Number: The school corporation's Medicaid provider number is also entered as the "rendering provider" number in Locator 24K on the CMS-1500 or 837P. Practitioners who are rendering Medicaid-covered IEP/IFSP services to Medicaid-eligible students in the school setting are not required to be separately enrolled in the Medicaid program if their services are being billed by the school corporation on its Medicaid Provider Number.

To bill Medicaid for IEP/IFSP services provided by its employed or contracted practitioners, the school corporation must ensure that the individuals delivering Medicaid services meet the criteria for Medicaid-qualified providers of the services billed. The Provider Enrollment Module of the Indiana Health Coverage Programs (IHCP) Provider Reference Modules sets out, by provider type and specialty, the criteria for Medicaid-qualified providers in Indiana. Provider Reference Modules are available online at http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

E COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary t benefits either to myself or to the party who accepts assignment

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by N ES

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER		NPI
1							NPI
2							NPI
3							NPI
4							NPI
5							NPI
6							NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Field 19: *Care Select* Certification Code is no longer required

Field 21 ICD Ind.: Enter **9** to indicate ICD-9 and **0** to indicate ICD 10. **Required**

Fields 21A-L: Enter the diagnosis codes in priority order. A total of 12 codes can be entered. **Required**

Field 24E: Enter letter A-L corresponding to the applicable diagnosis codes in fields 21A-L. A minimum of one and a maximum of four, diagnosis code references can be entered on each line. **Required**

Field 30: Balance Due is no longer required.

PROCEDURE CODE DESCRIPTIONS, ASSOCIATED MODIFIERS AND REIMBURSEMENT

The following tables contain procedure code and modifier examples for Medicaid-covered IEP/IFSP services. While not all inclusive, the following tables list codes for IEP/IFSP services commonly billed by school corporations (see also: Sections 2.5.10., 2.5.11 and Appendix I). For more details on modifiers, see the IHCP Provider Reference Modules section on modifiers. ***Please note that most codes are billed on a per service per day basis unless otherwise noted in the code description*** (for example, the code description says it can be billed per 15 minutes of service provided).

Using Current Procedural Terminology ® code definitions, coding conventions and ethical coding guidelines (AMA, 2005), and any updates thereto, school corporations must bill the most appropriate procedure code, including any appropriate modifier(s), to describe the service actually performed, irrespective of the reimbursement associated with the appropriate code. School corporations must maintain documentation to support the codes billed. Effective 1-27-2011 the Indiana Medicaid agency instituted National Correct Coding Initiative (NCCI) claims edits [see Medicaid provider bulletin #BT 201036 at www.indianamedicaid.com]. Please see Section 2.5.9. and Appendix E Tables 1-6 for details on avoiding unnecessary claims denials for similar services provided to the same individual on the same date of service. Indiana Medicaid reimbursement amounts for covered procedure codes are available in the IHCP fee schedule available at www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp.

For assistance or additional information regarding Medicaid billing, coding and payment, please contact DXC Customer Assistance at 800-577-1278. See Appendix D for contact information to get help with specific topics or to schedule an on-site consultation with the DXC Provider Field Consultant assigned to your local area.

Table 1. Behavioral Health – bill service(s) per day unless otherwise noted (e.g., per time interval)

Behavioral Health Services CPT Codes		Behavioral Health Services (BHS) Modifiers for use with BHS CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
*90791	Psychiatric diagnostic interview evaluation	AH	Clinical psychologist	Processing	Paid at 75% of allowable rate
*90832	Psychotherapy, 30 minutes face-to-face with patient and/or family member; patient must be present for all or part of service. Do not use to report service of less than 16 minutes in duration.	AJ	Clinical social worker	Processing	Paid at 75% of allowable rate
*90834	Psychotherapy, 45 minutes face-to-face with patient and/or family member; patient must be present for all or part of service. Do not use to report service of less than 38 minutes in duration.	HE	Mental Health Program	Processing	Paid at 75% of allowable rate
*90837	Psychotherapy, 60 minutes face-to-face with patient and/or family member; patient must be present for all or part of service. Do not use to report service of less than 53 minutes in duration.	HE with SA	Mental Health Services by nurse practitioner/clinical nurse specialist	Processing	Paid at 75% of allowable rate
90846	Family psychotherapy (without the patient present)	HO	Master's degree level	Informational	None-informational only
90847	Family psychotherapy (conjoint psychotherapy)(with patient present)	TM	IEP-See Table 4	Informational-required	To Identify an IEP service
90853	Group psychotherapy (other than of a multiple-family group)	59	Separate and distinct service on same date	Informational	Required to identify a therapy service that is separate and distinct from another therapy service provided to the same patient on the same date
*90792	Psychiatric diagnostic evaluation with medical services	TM	IEP-See Table 4	Informational-required	Identifies an IEP service
96101	Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.	Bill these codes only if the described services are performed by a physician (MD/DO) or Health Service Provider in Psychology (HSPP).			
96116	Neurobehavioral Status Exam: Clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.				

*New codes effective January 1, 2013. For full details see Medicaid bulletin BT 201253 and "Outpatient Mental Health" under IHCP Provider Reference Modules. Both publications are accessible online from the Indiana Medicaid Provider home page at http://provider.indianamedicaid.com/.

Table 2. Physical and Occupational Therapy – bill service(s) per day unless otherwise noted

Physical Therapy/Occupational Therapy Services CPT Codes		Physical Therapy/Occupational Therapy Modifiers for use with PT/OT CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Medicaid reimbursement policy**
97001* 97161 97162 97163	Physical therapy eval, *code replaced PT eval low complexity 20 min, effective 1/1/17 PT eval mod complexity 30 min, eff 1/1/17 PT eval high complexity 45 min, eff 1/1/17	GP	Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.	Informational--required for services provided pursuant to an outpatient PT plan of care	Paid at 100% of allowable rate (modifier does not affect reimbursement). Physical therapy services must be performed by a licensed PT or PTA under direct supervision of a licensed PT. PTAs may not perform/interpret tests, conduct assessments or develop treatment plans. Please refer to IHCP provider bulletin BT200611.
97002* 97164	Physical therapy re-eval, *code replaced PT Re-eval est plan of care, eff 1/1/17				
97003* 97165 97166 97167	Occupational therapy eval, *code replaced OT eval low complexity 30 min, effective 1/1/17 OT eval mod complexity 45 min, eff 1/1/17 OT eval high complexity 60 min, eff 1/1/17	GO	Service delivered personally by an OT or under an outpatient OT plan of care.	Informational--required for services provided pursuant to an outpatient OT plan of care	Paid at 100% of allowable rate (modifier does not affect reimbursement). "Occupational therapy service must be performed by a licensed occupational therapist or occupational therapy assistant under the supervision of a licensed occupational therapist."
97004 97168	Occupational therapy re-eval, *code replaced OT Re-eval est plan of care, eff 1/1/17				
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	GP, GO or HM	HM - Service delivered personally by a certified physical or occupational therapy assistant	HM - Processing-required for services provided pursuant to an outpatient plan of care. (See IHCP Provider Bulletin BT200611.)	HM - Paid at 75% of allowable rate. Service must be performed by a certified PTA under the direct supervision of a licensed physical therapist or by an OTA under the direct supervision of a licensed occupational therapist. The PTA and OTA may not perform/interpret tests, conduct assessments, or develop treatment plans and must consult with the supervising therapist daily to review treatment. See IHCP provider bulletin BT200611 and BT201627.
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	TM	IEP-See Table 4, General Modifiers; include TM (IEP) for all IEP services		
		59	Informational Modifier required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date		
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)				
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)				

Table 2 continued. Physical Therapy/Occupational Therapy – bill per day unless otherwise noted				
Physical Therapy/Occupational Therapy Services CPT Codes		**Physical Therapy/Occupational Therapy Modifiers for use with PT/OT CPT Codes**		
97150	Therapeutic procedure(s), group (2 or more individuals).	GP, GO or HM		
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	TM	IEP-See Table 4	
		59	Informational	Required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.	GP and GO		
		TM	IEP-See Table 4	
97542	Wheelchair management/propulsion training, each 15 minutes.	59	Informational	Required to identify a therapy service that is a separate and distinct service from another therapy service provided to the same patient on the same date

For more details see the Indiana Health Coverage Programs Therapy Code Set for a list of services that Indiana Medicaid will cover when performed by a Physical Therapy Assistant (PTA) http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Therapy_Services_Codes.pdf

Table 3. Speech/Language/Hearing – bill service(s) per day unless otherwise noted

Speech/Language/Hearing Disorders Services CPT Codes		Modifiers for use with Speech/Language/Hearing Disorders Services CPT Codes			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
92521	Evaluation of speech fluency (eg, stuttering, cluttering)				
92522	Eval of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)				
92523	Eval of speech sound production; w/eval of language comprehension & expression (eg, recptve/expressve)				
92524	Behavioral & qualitative analysis of voice and resonance				
92507	Treatment of speech , language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation) – Individual	GN	Services delivered under an outpatient speech-language plan of care.	Informational-required	Qualified SLP services paid at 100% of allowable rate See 405 IAC 5-22-9
92508	Treatment of speech , language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation) -- Group, two or more individuals	HM	Service delivered personally by a qualified practitioner under required supervision of a licensed, certified SLP	Processing-required for services provided per an outpatient plan of care	Paid at 75% of allowable rate
92551	Screening test, pure tone—air only	59	Required to identify a therapy service that is a separate & distinct service from another therapy service provided to the same patient on the same date	Informational (often used incorrectly-see IHCP Provider Bulletin BT200907)	
92552	Pure tone audiometry threshold—air only				
92553	Pure tone audiometry threshold—air and bone				
92555	Speech audiometry threshold				
92556	Speech audiometry, threshold; w/spch recognition				
92557	Comprehensive audiometry threshold eval and speech recognition (92553 and 92556 combined)				
92567	Tympanometry (Impedance testing)	TM	To identify an IEP service	Informational-required	None
92592	Hearing aid check—one ear monaural				
92593	Hearing aid check—both ears binaural	*Please see additional details on Page 2-5-5 of this Tool Kit.*			

Table 4. General Modifiers for Billing All IEP-Required Services

Use these **and** modifiers in Tables 1-8 to include required information about IEP-required services billed.

Code up to 4 modifiers per CPT code billed on the CMS 1500 claim form or electronic transaction.

Modifier	Modifier Description	Modifier Type	Impact on reimbursement
TL	Early Intervention/**IFSP** services	TL, TM & TR are informational	None
TM	**IEP Services**	**TM must be used to identify an IEP service**	
TR	IEP/IFSP health related services provided outside the district in which the student is enrolled.		

Table 5. Nursing Services Provided by an R.N. – bill in 15-minute increments unless otherwise noted

Nursing Services CPT and HCPCS Codes		Modifiers for use with Nursing Services CPT Codes			
CPT Code	Description	Modifier	Modifier Description	Modifier Type	Impact on reimbursement
99600*	Indiana Medicaid is defining this code as "IEP Related Nursing Services." The standardized code book description for the code with TD modifier is an R.N. Visit Not Otherwise Specified [TM = IEP service]	***Required***			
		TD	Service provided by an R.N.	Informational-required	Paid at 100% of allowable rate
		TM	Indicates service is in an IEP	Informational-required	None
		*	*See important note below*		
G0108 U6	Diabetes outpatient self-management training services, individual, per 15 minutes	***Required***			
		U6	Denotes "per 15 minutes."	Informational-required	Paid at 100% of allowable rate
G0109 U6	Diabetes outpatient self-management training services, group session (2 or more), per 15 minutes	TM	Indicates service is in an IEP	Informational-required	None
			See also Table 4 General Modifiers; **include TM (IEP) for all IEP services**.		

*** IMPORTANT NOTE: 99600 TD TM is used for *all* IEP nursing services *except* DSMT, as described above. When billing 99600 TD TM for IEP Nursing Services other than DSMT, *please note that the order of the modifiers is critical* for appropriate reimbursement. See also: Medicaid bulletin #BT201108 at Appendix C.**

Table 6. Special Education Transportation – bill service(s) per trip unless otherwise noted

Type	Code & Modifiers	Service Description
CAS	A0425 U3 TM	Ground mileage, per statute mile; Commercial or Common Ambulatory Services; IEP Related
CAS	T2001 TM	Non-emergency transportation, patient attendant/escort
CAS	T2003 TM	Non-emergency transportation, encounter/trip Commercial or Common Ambulatory Services; IEP Related
CAS	T2004 TM	Non-emergency transportation, commercial carrier, multiple passengers
CAS	T2007 U3 TM	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
NAS	A0425 U5 TM	Ground mileage, per statute mile; Non-Ambulatory Services; IEP Related
NAS	A0130 TM	Non-emergency transportation, wheel chair van base rate; IEP Related
NAS	A0130 TK TM	Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance
NAS	A0130 TT TM	Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting

See also: information and transportation billing codes in BT#201108 in Appendix C and transportation-related IHCP Provider Reference Modules and banners/bulletins. When billing IEP transportation services, school corporations must attach the TM modifier to the end of all appropriate transportation billing codes to identify the services as IEP related. It is anticipated that the most frequently billed IEP related transportation codes will be those for common ambulatory services (CAS) and non-ambulatory services (NAS). Common ambulatory services (CAS) may be provided to a student who is able to walk. Claims for ambulatory students transported in a vehicle equipped to transport non-ambulatory students must be billed according to the CAS level of service and rate, and, thus, not billed according to the vehicle type. Non-ambulatory services (NAS) are transportation services provided to non-ambulatory students who must travel in a wheelchair to or from a covered service.

Table 7. Applied Behavior Analysis (ABA) Therapy – bill modifier & code noted per service description in Table 7		
Applied Behavior Analysis (ABA) Assessment CPT Codes		**Applied Behavior Analysis Therapy Modifiers for use with ABA CPT Codes**
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional*, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	TM IEP-See Table 4
97152	Behavior identification supporting assessment, administered by one** Technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes	
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized to the patient's behavior.	

* Qualified Healthcare Professional (QHP) is defined as a Board Certified Behavior Analyst Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), psychologist, or other credentialed professional whose scope of practice, training, and competence includes behavior.

** Technician is defined as a Board Certified Assistant Behavior Analyst (BCaBA), or Registered Behavior Technician (RBT). A QHP may substitute for the technician.

Table 7 continued. Applied Behavior Analysis – bill modifier & code noted per service description in Table 7			
Applied Behavior Analysis (ABA) Treatment CPT Codes		**Applied Behavior Analysis Therapy Modifiers for use with ABA CPT Codes**	
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional*, face-to-face with one patient, each 15 minutes	TM	IEP-See Table 4
97155[1]	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes		[1] 97155 may be billed concurrently with technician delivered services for code 97153 when the patient is present, one or more protocols have been modified, and the QHP is directing the technician
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized, to the patient's behavior.		

* Qualified Healthcare Professional (QHP) is defined as a Board Certified Behavior Analyst Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), psychologist, or other credentialed professional whose scope of practice, training, and competence includes behavior.

** Technician is defined as a Board Certified Assistant Behavior Analyst (BCaBA), or Registered Behavior Technician (RBT). A QHP may substitute for the technician.

Table 7 continued. Applied Behavior Analysis – bill modifier & code noted per service description in Table 7		
Applied Behavior Analysis (ABA) GROUP CPT Codes		**Applied Behavior Analysis Therapy Modifiers for use with ABA CPT Codes**
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes	TM IEP-See Table 4
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes	
Applied Behavior Analysis (ABA) FAMILY CPT Codes		
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	

* Qualified Healthcare Professional (QHP) is defined as a Board Certified Behavior Analyst Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), psychologist, or other credentialed professional whose scope of practice, training, and competence includes behavior.

** Technician is defined as a Board Certified Assistant Behavior Analyst (BCaBA), or Registered Behavior Technician (RBT). A QHP may substitute for the technician.

Table 8. Modifiers for Billing IEP Services Delivered as Telemedicine Services

Telemedicine Service HCPCS Code		Required modifiers for use with Telemedicine Service Code			
CPT Code	**Description**	**Modifier**	**Modifier Description**	**Modifier Type**	**Impact on reimbursement**
Q3014	telemedicine originating site facility fee (pays for technology costs & supervision on the client side)	GT	Via interactive audio and video telecommunications system; must be used to denote telemedicine services	Informational	Payment amount for telemedicine service is equal to the current Professional Fee Schedule amount for the procedure code billed
		95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Informational	None

APPENDIX F – SAMPLE FORMS

The sample forms offered in this appendix are examples of potential means for streamlining business operations and maintaining required documentation at the local level. Use and customization of these sample forms is left to the discretion of the local educational agency based on local processes, policies and procedures as well as the applicable state and federal requirements. See Appendix I for additional resources that offer form examples used by Medicaid-participating schools in other states.

Sample Forms included in Appendix F	**Page #**
Sample Prior Written Notice and Request for Parental Consent to Bill Medicaid-English	*F2*
Sample Prior Written Notice and Request for Parental Consent to Bill Medicaid-Spanish	*F2S*
Link to Sample Annual Written Notice concerning Medicaid Consent incorporated into IDOE Sample Notice of Procedural Safeguards	*F3*
Sample Form to Document Physician/HSPP Review and Student Need for IEP Behavioral Health Services	*F4*
Sample Form to Document Referral or Order for IEP Nursing or Physical Therapy	*F5*
Sample Form to Document Referral or Order for IEP Speech or Occupational Therapy	*F6*
Sample Form to Document Referral or Order for IEP Hearing Service	*F7*
Sample Form to Document Criteria for a Health-Related Need for Special Education Transportation Services	*F8*
Sample IEP Transportation Service Trip Log for Off-site Medical Service	*F10*
Sample IEP Transportation Service Trip Log for To/From School	*F11*
Sample Two-Sided Nursing Services Documentation Form	*F12*
Sample Form/Report to Transfer IIEP Service Log Data to a Medicaid Billing Agent	*F14*

PRIOR WRITTEN NOTICE & PARENTAL CONSENT TO BILL MEDICAID FOR SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM

Written notice before requesting your consent

Before the school corporation asks for your consent to bill Medicaid (public benefits) for services in your child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), the school must give you this written notice about your rights and protections under federal law. And, before the school may disclose your child's health-related educational service records to the State Medicaid agency for claiming purposes, the school must have your written consent.

Federal Special Education funds cover some but not all of the costs for services that the school is required to provide at no cost to you. Public benefits such as Medicaid may also be used to help fund these costs, but only if you choose to give your consent.

Your Rights and Protections

- If you choose not to give consent or later withdraw your consent, the school must continue to provide your child all required IEP or IFSP services at no cost to you.
- If you give consent, you have the right to withdraw that consent at any time.
- The school may not require you to enroll in Medicaid or other public health coverage program as a condition of providing IEP or IFSP services that it is required to provide at no cost to you.
- The school may not use your public benefits (Medicaid) if doing so would:
  - exhaust the plan benefit limitations (for example, decrease the number of covered visits or cause you to pay for services outside of school that would otherwise be covered);
  - cause you to pay a deductible, co-payment or other out-of-pocket expense;
  - increase your premium or lead to cancellation of benefits; or
  - jeopardize your child's eligibility for Medicaid home and community based waiver services.

Written Consent to Bill Medicaid

Your signature on this form allows the school corporation to bill Medicaid for health-related educational services provided to this student. ***Medicaid reimbursement helps fund state and local costs for providing Special Education and related services, specialized equipment and training.***

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

I give consent for < fill in school corp name > to bill Medicaid for covered services in this student's education program. My signature authorizes the school to release health-related educational services records to Medicaid as necessary for eligibility verification, billing and auditing.

I understand that:

- Giving, refusing or withdrawing consent will not impact my child's/my Medicaid eligibility or benefits.
- I have the right to withdraw my consent at any time.
- The school corporation must provide required IEP or IFSP services even if I refuse or withdraw consent.
- Services in the IEP or IFSP must be provided at no cost to me even if I refuse or withdraw consent.
- Upon request, I may receive copies of any records the school disclosed to Medicaid.
- The school must give me written notice of my rights and protections under federal law one time each year.

Signature of Parent/Guardian or Student who is 18 years old or older with no legal guardian:

_____ _____

Name **[please print]** ***Signature*** ***Date***

This completed form must be retained and available for audit purposes.

SPANISH TRANSLATION OF PRIOR WRITTEN NOTICE/MEDICAID CONSENT

Notificación escrita antes de solicitar su consentimiento

Antes de que la corporación escolar pida su consentimiento para facturar al Medicaid (los beneficios públicos) para los servicios del Programa de Educación Individualizada (IEP) o Plan Individualizado de Servicios para la Familia (IFSP), la escuela tiene que darle a usted esta notificación por escrito sobre sus derechos y protecciones bajo la ley federal. Y, antes de que la escuela pueda revelar los registros de los servicios educativos relacionados con la salud de su hijo al agencia de Medicaid del Estado para el propósito de reclamar, la escuela tiene que obtener su consentimiento escrito.

Los fondos federales para educación especial cubre algunos pero no todos los costos de servicios que la escuela tiene que proveer sin costo a usted. Los beneficios públicos como Medicaid puede también ser usados para ayudar a financiar estos costos, pero sólo si usted elige dar su consentimiento.

Sus Derechos y Protecciones

- Si usted elige no dar su consentimiento o después retirar su consentimiento, la escuela tiene que seguir proporcionando a su hijo todos los servicios requeridos del IEP o IFSP sin costo para usted.
- Si usted da su consentimiento, usted tiene el derecho de retirar su consentimiento en cualquier momento.
- La escuela puede no requerir que usted se inscriba en Medicaid u otro programa de cobertura pública de salud como condición de proporcionar los servicios de IEP o IFSP que es requerida proporcionar sin costo a usted.
- La escuela no puede usar los beneficios públicos de usted (Medicaid) si al hacerlo:
  - agotaría las limitaciones de los beneficios del plan (por ejemplo, disminuir el número visitas cubiertas o causarle a usted pagar por los servicios fuera de la escuela que de lo contrario sería cubiertos);
  - causaría a usted pagar un deducible, co-pago u otro gasto de bolsillo;
  - aumentaría su prima de seguro o conducir a cancelación de los beneficios; o
  - pondría en peligro la elegibilidad de su hijo para los servicios de exención basados en el hogar y la comunidad de Medicaid.

Consentimiento Escrito para Facturar al Medicaid

Su firma en esta forma permite que la corporación escolar al Medicaid para los servicios educativos relacionados con la salud proporcionados a este estudiante. ***El reimboso de Medicaid ayudan financiar los costos para proporcionar educación especial y servicios relacionados, equipo y entrenamiento especializado.***

Nombre del Estudiante: _____ **Fecha de Nacimiento:** _____

Doy mi consentimiento para <rellenar con nombre de corporación escolar> para facturar al Medicaid para los servicios cubiertos en el programa educacional de este estudiante. Mi firma autoriza que la escuela libere registros de los servicios educativos relacionados con la salud a Medicaid según sea necesario para la verificación de la elegibilidad, facturar y revisar la contabilidad.

Entiendo que:

- Dar, rechazar o retirar el consentimiento no afectaría la elegibilidad o los beneficios de Medicaid para mi hijo.
- Tengo el derecho de retirar mi consentimiento en cualquier momento.
- La corporación escolar tiene que proveer los servicios requeridos del IEP o IFSP aunque yo rechazo o retiro mi consentimiento.
- Los servicios en el IEP o IFSP tienen que ser proporcionados sin costo a mi aunque yo rechazo or retiro mi consentimiento.
- A petición, es posible que yo reciba copias de los registros de la escuela revelada a Medicaid.
- La escuela tiene que darme notificación escrita de mis derechos y protecciones bajo la ley federal una vez cada año.

La firma del Padre/Guardián o del Estudiante quien tiene 18 años o más sin guardían legal:

_____ _____

Nombre **[favor de imprimir]** ***Firma*** ***La Fecha***

This completed form must be retained and available for audit purposes.
[Esta forma completada debe ser guardada y disponible para los propósitos de revisiones.]

ANNUAL NOTICE REGARDING CONSENT TO BILL MEDICAID FOR SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM

Federal regulations at 34 CFR 300.154[d][2][iv], et seq., require school corporations to provide parents with prior and annual written notice regarding consent to bill Medicaid for services in a student's IEP. For school corporations that choose to incorporate this required **annual** written notice into their Notice of Procedural Safeguards ("NOPS"), the Office of Special Education offers sample notices, in English and Spanish, under Procedural Safeguards and Parent Rights on IDOE's web site at http://www.doe.in.gov/specialed/laws-rules-and-interpretations.

Behavioral Health Services

To be completed by a licensed physician or psychologist endorsed as a health service provider in psychology (HSPP).

Student Name: _____ Date of Birth: _____

Therapist/Medicaid-qualified Mid-Level Practitioner: _____

____I certify that I or a qualified mid-level practitioner conducted an initial intake/evaluation of the above named student within the past seven (7) days, that the student meets the criteria for behavioral health services to be delivered as specified in the student's *Individualized Education Program* (IEP).

____I certify that, within ninety (90) days of intake or the most recent medical records review, I have reviewed the above-named student's medical information and the student continues to meet the criteria for behavioral health services as specified in the student's IEP.

Authorized Signature: _____

Print Name/Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

To find out if a referring physician/practitioner has an NPI:
Visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do and enter the applicable search criteria for the individual practitioner.

Nursing / Physical Therapy Services

For R.N.: to be completed by a licensed physician (M.D. or D.O.)
For PT: to be completed by an M.D., D.O. or referral practitioner identified in the PT practice act, Indiana Code § 25-27-1-2(b).

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Physical Therapy: ____ Evaluation
____ Treatment Services: _____
_____
_____
____ Other: _____

Nursing Service: ____ Assessment
____ Treatment Services: _____
_____
_____
____ Other: _____

Precautions: _____

Additional Comments:

_____

Authorized Signature: _____

Print Name & Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

To find out if a referring physician/practitioner has an NPI:
Visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do and enter the applicable search criteria for the individual practitioner.

Speech-Language / Occupational Therapy Services

To be completed by a licensed Physician (M.D. or D.O.) or other licensed Practitioner of the Healing Arts, in accordance with 42 CRF 440.110 (See Tool Kit Section 2.8.1.b.)

Student Name: _____ Date of Birth: _____

Speech-Language: ____ Evaluation
____ Treatment Services: _____

_____

____ Other: _____

Occupational Therapy: ____ Evaluation
____ Treatment Services: _____

_____

____ Other: _____

Precautions:

_____

Additional Comments:

_____

Authorized Signature: _____

Print Name & Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

To find out if a referring physician/practitioner has an NPI:
Visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do and enter the applicable search criteria for the individual practitioner.

Hearing Services

To be completed by a licensed physician (M.D. or D.O.).

Student Name: _____ Date of Birth: _____

Physician certification of need for audiological assessment or evaluation:
_____ Evaluation
_____ Treatment Services: _____

Precautions:

_____

_____

Additional Comments:

_____

_____

_____

Authorized Signature: _____

Print Name & Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

To find out if a referring physician/practitioner has an NPI:
Visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do and enter the applicable search criteria for the individual practitioner.

Sample Criteria for Determining a Health-Related Need for Special Education Transportation Services

Includes considerations for special accommodations to meet the student's identified need(s)

To Bill Medicaid for Special Education Transportation:
the IEP must describe the specialized transportation need, and the service must be provided on a day when the student receives a Medicaid-covered IEP service other than transportation.

The IEP must identify/document the specific need to provide Special Ed Transportation:

☐ **Orthopedic/Physical Impairment:**
- non-ambulatory
- wheelchair bound
- needs assistive devices to maintain a sitting position
- needs assistance walking and going up and down stairs
- extremely brittle bones

☐ **Behavior Impairment:**
- unusually problematic responses to sensory experiences
- self-abusive
- runs away

☐ **Communication Impairment:**
- deaf
- hard of hearing
- nonverbal
- impaired in processing linguistic information through hearing
- other communication disorder

☐ **Visual Impairment:**
- partial sight
- blindness

☐ **Health needs:**
- seizures
- extreme fatigue
- requires oxygen or other breathing equipment
- high risk of a medical emergency requiring immediate emergency medical procedures
- traumatic brain injury-related cognitive, sensory, perceptual, motor, problem-solving, reasoning, attention, judgment, information processing or abstract thinking impairment

Potential additional considerations to meet the identified need. After identifying the need the case conference committee may also consider accommodations to meet the need, e.g.:

☐ **Accommodations for specialized vehicle, equipment, etc:**
- brace, car seat, seat belt, safety vest
- manual or power wheelchair lift
- accompanying service animal

- medical equipment
- assistive technology device
- adapted bus, e.g., ramp, kneeling capability

☐ **Adult supervision, medical monitoring or other services required:**
- specialized bus driver training
- bus attendant
- specialized bus attendant training
- one-on-one bus attendant for a designated purpose described in IEP
- nursing services
- special monitoring
- interpreter

☐ **Type of transportation or specialized accommodation:**
- door-to-door pick up and drop off
- a small bus with few students
- individual transportation
- air conditioned vehicle

☐ **Other accommodations:**
- permission to carry/use personal electronic devices or other such items

Sample Special Education Transportation Trip Log – for off-site medical service

[for to/from school trip log sample see next page]

DAILY TRIP LOG: IEP-Required Special Needs Transportation to off-site medical service

Trip Date: _____ (mm/dd/yy)

Student's First & Last Name *Office to add Medicaid ID #*	Adult Escort's Name & Signature* (if applicable) **Escort must sign log*	Off-site Destination: (name & address of off-site medical service provider)	Trip *Start* Location Address	Trip *Return* Location Address	Total Mileage* (round to nearest mile)	Total Wait Time (round to nearest minute)
	*_____					
	*_____					
	*_____					
	*_____					
	*_____					
Driver Printed Name			Driver Signature and Date			

* Record round trip mileage for each round trip. ***For one-way trips, record the mileage and note "one-way" in the "Return Location" column.***

Sample Special Education Transportation Trip Log – to/from School

[for off-site medical service trip log sample see previous page]

DAILY TRIP LOG: IEP-Required Special Needs Transportation between School and Home

Trip Date: _____ (mm/dd/yy)

Student's First & Last Name *Office to add Medicaid ID #*	Adult Escort's Name & Signature* (if applicable) **Escort must sign log*	Destination: *School Building Name*	Trip *Start* Location Address	Trip *Return* Location Address (enter "same" if same as Start Location)	Total Mileage* (round to nearest mile)	Student Rode Today? Yes or No
	*_____					
	*_____					
	*_____					
	*_____					
	*_____					
Driver Printed Name			Driver Signature and Date			

* Record round trip mileage for each round trip. ***For one-way trips, record the mileage and note "one-way" in the "Return Location" column.***

Sample Nursing Services Documentation Form to Adapt for Local Use

[see the back of this 2-sided form on next page]

NURSING SERVICES DOCUMENTATION

Student Name _____ DOB _____ Schl Corp/Bldg _____

Check *ONE* if applicable: This student has an Individualized Education Program (IEP) □ -OR- a Section 504 Plan □

				PROCEDURES: ENTER # MINUTES SPENT ON EACH								
				Assessment								
Date of Service (DOS)	Start Time	Stop Time	Total Service Time (minutes)	develop / revise IHP	v physical / mental status	cathe-teriza-tion	respira tory care	spclz feed ing	hlth supp syst othr	meds admn	DSMT	Nurse's Notes & Initials

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

Back of 2-Sided Sample Nursing Documentation Form [see the front side of this 2-sided form on next page]

EXAMPLES OF MEDICAID-COVERED IEP NURSING SERVICES PROVIDED BY A REGISTERED NURSE (R.N.)

Catheterization:

- Education and monitoring self catheterization
- Intermittent urinary catheterization
- Indwelling catheter irrigation, reinsertion, and care

Health Support Systems Care / "Other" (incl Specimen Collection):

- Apnea assessment, monitoring, and care
- Central line care, dressing change, emergency care
- Dressing and treatment
- Dialysis monitoring and care
- Shunt monitoring and care
- Ventilator monitoring, care, and emergency plan
- Wound and skin integrity assessment, monitoring, and care
- Ostomy care, dressing, and monitoring
- Ostomy irrigation, insertion, removal, and care
- Specimen collection: blood, sputum, stool or urine

Medications Administration:

- Administration of medications by injection (intra-venous, intramuscular, subcutaneous), rectal or bladder instillation, ostomy, tube, or, only under certain circumstances by mouth
- Nebulizer treatment if child not able to self-administer

Specialized Feeding:

- Ostomy feeding
- Parenteral nutrition (intravenous)
- Specialized feeding procedures
- Stoma care and dressing changes

Respiratory care:

- Oxygen monitoring and care
- Postural drainage and percussion treatments
- Suctioning
- Tracheostomy tube replacement
- Tracheostomy monitoring and care
- Ventilator care

TRANSFERRING IIEP SERVICE LOG DATA TO A MEDICAID BILLING AGENT

For school corporations that choose to use the state's electronic IEP ("IndianaIEP" or "IIEP"), the Standard Reports options include a "Service Log" report which can be used for routine data transfers to the school corporation's Medicaid billing agent. The school corporation can select which data to include as well as the date parameters for this report. This section includes a snapshot of the IIEP Standard Report screen, followed by a snapshot of the IIEP screen used to select the fields the district will include when it generates this standard IIEP service log report.

School corporations are encouraged to consult their Medicaid billing agent to determine how best to format, store and transfer IIEP service log data extracted through this standard IIEP reporting mechanism. Establishing a regular interval for generating this report will help ensure that the billing agent has complete data with no missing dates of service. For example, the report could be run on the first day of each month for the preceding month, or it could be generated for the preceding quarter on the first day after the close of that quarter.

How to set the report parameters is a local decision based on the specific needs of the district and the district's billing agent. For example, the school corporation can opt to report service log data based on the date the service was provided ("date of service") or on the date when the service was logged in the IIEP. Note: consistency in pulling data by the date logged can help ensure that late service log entries and revisions to records logged in a prior month are captured without gaps in the data. Complete data is important for the billing agent to identify when Medicaid claims adjustments, resubmissions or retroactive billings are appropriate.

Once the fields and parameters are selected, the aforementioned standard IIEP Service Log Report can be saved in a variety of formats (including Excel and Access), which permit organization of the reported data in whatever manner is compatible with the billing agent's system or business process. *Please note: because the IIEP Service Log Report contains protected student-specific information, school corporations and their Medicaid billing agents must ensure that privacy safeguards are in place to maintain confidentiality when sharing data.* Potential possibilities include transferring the Service Log Report data via encrypted e-mail, a secured e-mail site (requiring a logon ID and password to post/obtain messages), or copying the report onto a password-protected CD mailed to or picked up by the billing agent (who is given and keeps the confidential password separately from the CD containing the report). It is also technically feasible for a district to grant a billing agent IIEP access and an administrator role that allows the agent to run the Service Log Report; however, concerns about potential privacy issues may make this a less attractive option. The district's billing agent may offer other secure file transfer options to effect and protect routine data transfers for Medicaid claiming purposes.

Beginning August 28, 2012: The Advanced Reporting function in IIEP includes a customizable Medical Service Log Sample Report that districts may use to report any data recorded in the IIEP, filtered or sorted to suit school or billing agent needs. To customize this sample report:

Once in IndianaIEP site:

- Click on School System
- Click on Reports
- Select Advanced Reporting button

- Once the window opens and you select the universe, click on Document List
- Click on the Public Folder
- Under the folder called "in<***districtname***> Reports" you will see the "Medical Service Log Sample Report"
- Double click on the report to open it
- Click "Refresh Data" and enter the date range of services for the report
- After the standard report data is displayed for the desired date range, the user may add or delete from the report format any of the data elements available in IIEP and apply sort or filter criteria to create a local customized version of the standard report [this step can be performed prior to clicking "Refresh Data," according to user preference]

To save the results:

- Click on "Document" and select "Save to my computer as"
- Options are Excel, PDF, or CSV (CSV format recommended for billing purposes)

School System | System Info | Reports | Assign Schools | Inactive Students | User Types | External Systems
Summary | Lists | Assign Teachers | Inactive Users | User Type Assign | Transfer Student

Standard Reports

Student Reports	User Reports
(None Available)	(None Available)
Service Reports	**Service Log Reports**
(None Available)	Services Documentation Report

Scheduled Reports

Active Student Listing (PDF)	Service Log
Active Student Lists (txt)	Student Missing Data
Caseloads Report	Teacher Report
Inactive Student List (pdf)	User Missing Data
Inactive Student List (txt)	Caseload List by Provider (pdf)
Logged Related Services Summary	Printable Service Report
Mailing Labels	Recent Logins (pdf)
Parental Consent to Bill Medicaid Report	Hours Logged per User (txt)

Percent of providers logging services	Hours Logged by Student/Service (txt)
Percent of students receiving services	Accommodations Report (pdf)
Prescribed vs Delivered Services	Address Labels - To the Parents (pdf)
Projected Eligibility Meetings (txt)	Address Labels - Parents
Projected Eligibility Meetings(PDF)	Indicators 11 and 12
Projected IEP Meetings (txt)	Indicators 11 and 12 (pdf)
Projected IEP Meetings(PDF)	Message Board Report

Log Out | **Main Menu** | Students | My Docs | My Reports | Wizards | Schools | School System | Users | Super User | | PCG

School System | System Info | Reports | Assign Schools | Inactive Students | User Types | External Systems
Summary | Lists | Assign Teachers | Inactive Users | User Type Assign | Transfer Student

Reports - Service Log New Mail!

Include services that were served on or after: and before:

Include services that were logged (signed) on or after: and before:

Only include services logged for Related Service: -all-

Only include services logged by user with User Code:

Only include services logged for student with Student ID:

Include these fields:

- [ ] Date Signed
- [ ] Date/Time Signed
- [x] Student Full Name
- [ ] Student First Name
- [ ] Student Last Name
- [ ] Student Code
- [ ] Student Social Security Number
- [ ] Student Gender
- [x] Service
- [ ] Related Service ID
- [x] Date of Service
- [ ] Student Middle Name
- [ ] Student Suffix
- [ ] Type of Service
- [ ] Type of Service ID
- [x] Minutes
- [ ] Student Date of Birth
- [ ] School Code
- [x] Provider
- [ ] District Code
- [ ] Provider Code
- [ ] Start Time
- [ ] Comments
- [ ] Group Size
- [ ] Status
- [ ] Number of Areas Covered/Assessed
- [ ] District Name
- [ ] Areas Covered/Assessed (please don't select this unless you really need it)
- [ ] End Time

Generate Report ?

APPENDIX G
FEDERAL GUIDANCE: MEDICAID CONSENT, FERPA, HIPAA AND IDEA

Medicaid Consent

To view the U.S. Department of Education's one-page summary on IDEA Part B Final Regulations Related to Parental Consent to Access Public Benefits or Insurance (e.g., Medicaid) and non-regulatory guidance in a Question-and-Answer (Q&A) format, visit the U.S. DOE web site at: http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html. See a copy of Indiana's rule at Appendix C; see also Indiana's sample of a combined consent and initial notice form as well as an annual notice example at Appendix F, pages *F2 – F3*.

FERPA and HIPAA

See 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* for information regarding health care provider disclosure of a student's Protected Health Information ("PHI") to school nurses, physicians, or other health care providers for treatment purposes, without the authorization of the student or student's parent.

FERPA and IDEA

The Office of Special Education and Rehabilitative Services (OSERS) and Family Policy Compliance Office (FPCO) side-by-side comparison of the primary legal provisions and definitions in IDEA Part B, IDEA Part C and FERPA regarding the requirement to safeguard personally identifiable information of children served under the IDEA is available online at http://www2.ed.gov/policy/gen/guid/ptac/pdf/idea-ferpa.pdf.

APPENDIX H

Medical Clearance and Audiometric Test Form (continued on Page *H2*)
https://www.in.gov/medicaid/files/medicalclearance_pha.pdf

MEDICAL CLEARANCE AND AUDIOMETRIC TEST FORM

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

PART I Member History

Member's Name	RID	Age
If Institution, Admission Date	Previous Institution	

If unable to independently maintain the member's hearing aid, are there resources available to assist in maintenance?
◯ Yes ◯ No
Explain:

Medical Diagnosis	Hearing Diagnosis

Has this member worn a hearing aid previously? ◯ Yes ◯ No	If so, purchase dates	IHCP Purchased?

If member owns and/or wears or previously owned and/or wore amplification, indicate where the hearing aid is or was worn; include the model and status of the instrument and settings.

PART II Medical Clearance
(to be completed by physician)

A hearing aid will not be approved for a patient prior to that patient's having had a medical examination. Preferably, this examination should be conducted by an otolaryngologist, if available and accessible, but a basic medical survey as indicated in this section can be performed by a licensed physician. All children under 15 years of age must be seen by an otolaryngologist before the hearing aid is fitted. The following minimal assessment is required before the fitting of any hearing aid:

1. Is there any evidence of infection or drainage from either ear?	◯ Yes ◯ No
2. Is there any significant headache, vertigo, dizziness, nausea, or vomiting?	◯ Yes ◯ No
3. Has the hearing loss been sudden in onset?	◯ Yes ◯ No
4. Is the patient able to hear and understand speech at conversational level?	◯ Yes ◯ No
5. Presence of pus in the eardrum?	◯ Yes ◯ No
6. Perforation of the eardrum?	◯ Yes ◯ No
7. Impacted cerumen?	◯ Yes ◯ No
8. Presence of external ear canal infection?	◯ Yes ◯ No
9. The possibility of the complete closure of the ear canal?	◯ Yes ◯ No

Remarks:

I certify that I have examined the patient mentioned above and to my knowledge there is no medical or surgical contraindication to wearing a hearing aid.

Otologic Diagnosis:

◯ I recommend the patient to be fitted for a hearing aid. ◯ I recommend the patient be referred for future medical evaluation.	Signature of Physician	Date

Medical Clearance and Audiometric Test Form (continued from Page *H1*)
Check online for latest version at web site shown on Tool Kit Page *H1*

PART III Audiological Assessment
(to be completed by audiologist or otolaryngologist)

Member's Name	Age	RID

RE ANSI 1969

Frequency	500	1000	2000	3000	Speech	Right	Left
Left-Air					SRT		
Left-Bone					Word Recognition (WRS)	/50 dbHL	/50 dbHL
Right-Air					Word Recognition (WRS)	/MCL	/MCL
Right-Bone							

Validity of Test Results: ◯ Good ◯ Fair ◯ Poor | Special Tests:

Hearing Aid recommended for: ◯ Left ◯ Right ◯ Binaural ◯ Hearing Aid not recommended

Recommendation information:

Signature (Testing conducted by Audiologist or Otolaryngologist)	Date

If pure tone testing indicates a bone-air gap of 15 decibels (dB) or more for two adjacent frequencies on the same ear, or if speech discrimination tests indicate a score of less than 60% in either ear, or if hearing loss in one ear is greater than the other ear by 20 decibels (dB) in the pure tone average or 20% in the discrimination score, the patient must be referred for further assessment by an otolaryngologist, providing the physician has not already considered these conditions.

PART IV Hearing Aid Evaluation
(to be completed by audiologist or hearing aid dealer)

Ear	Left Aided	Right Aided	Unaided Left	Unaided Right	Binaurally Aided
Make/Model					
SRT					
MCL					
PB Quiet					
PB Noise (+5 S/N)					
PB Level					

Special Conditions:

Signature (Evaluation conducted by Audiologist or Hearing Aid Dealer)	*Date*

PART V Hearing Aid Contract
(to be completed by audiologist or hearing aid dealer)

Should there be complaints from a member, and/or other responsible persons directly interested in the member, as to the user's failure to receive satisfactory benefits from the instruments, the Indiana State Registered Hearing Aid Dealer must attempt to make satisfactory adjustment or follow the recommendation as deemed advisable by the IHCP. Failure to do so may cause payment to be withheld. If payment has been received by the Indiana State Registered Hearing Aid Dealer, the full refund will be made to the contractor.

There is to be no solicitation of IHCP patients, for the purpose of fitting hearing aids. As a general policy, there are to be no replacement hearing aid fittings for IHCP patients where the hearing aid in use is less than five years old.

"I have read the regulations and standards adopted and approved by the IHCP for the fitting and dispensing of hearing aids for IHCP cases and I have followed the procedures provided therein."

Audiologist/Hearing Aid Dealer's Signature	*Indiana License/Registration No.*	*Date*

IHCP Medical Clearance and Audiometric Test Form
Version 2.0, October 2014

Page 2 of 2

APPENDIX I
MEDICAID RESOURCES

State Laws

1. Indiana law (statute) governing the Medicaid program can be found in Title 12, Article 15 of the Indiana Code, available at www.in.gov/legislative/ic/code/title12/ar15. Select the appropriate Chapter (e.g. Chapter 2—Eligibility, Chapter 4—Application for Assistance, Chapter 5—Services, etc.).
2. To view bills for current or most recently completed session of the Indiana General Assembly, go to www.in.gov/apps/lsa/session/billwatch/billinfo. This web site provides:
   - Bills by Subject Listing (PDF)
   - Complete Information for All Bills
   - List of "Live" Information for Bills
   - Enrolled Acts Approved by Both Houses
   - Action on Vetoed Bills
   - Resolutions
   - Fiscal Impact Statements
   - Additional Bill Information
   - You may also search for bills related to a particular topic by typing in a "keyword."

   An archive of past sessions of the Indiana General Assembly is available at www.in.gov/legislative/session/archives.html.

State Rules

1. Medicaid Covered Services Rules, Title 405 of the Indiana Administrative Code, Article 5, is available at www.in.gov/legislative/iac. Select Title 405, go to Article 5 in the Table of Contents, and select the rule relevant to the topic you are searching, for example:
   a. Rule 2—Definitions
   b. Rule 4—Provider Enrollment
   c. Rule 20—Mental Health Services
   d. Rule 22—Nursing and Therapy Services
2. Changes to the Medicaid Covered Services Rule are published in the *Indiana Register* http://www.in.gov/legislative/register/irtoc.htm on the first day of the month. Click the links to daily, weekly or monthly collections for a list of publication contents to identify Notices of Intent to Adopt a Rule, Notices of Public Hearings, Proposed, Emergency and Final Rules as well as Non-Rule Policy Documents published by Indiana's Legislative Services Agency. This site also offers a User's Guide link with background information.

Federal Regulations

1. Medicaid eligibility, coverage and payment regulations, 42 CFR, Part 430, et seq., are available at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfrv3_02.html. From the index, select the relevant Part (e.g., Services: General Provisions), then choose a specific section by topic, for example: Section 440.110—Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders.
2. Proposed and Final federal regulations are published daily in the *Federal Register* http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR. Find, review and submit public comments about Federal rules online at www.regulations.gov.

Indiana Medicaid Resources

Information about the Indiana Health Coverage Programs (IHCP), which includes Medicaid and the State Children's Health Insurance Program (CHIP), is available at http://provider.indianamedicaid.com/. The following information is available at this site:

1. The IHCP Provider Reference Modules http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx
2. Forms such as Medical Clearance forms and Electronic Funds Transfer (EFT) account forms http://provider.indianamedicaid.com/general-provider-services/forms.aspx
3. Fee schedule http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp
4. IHCP Provider Communications http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx
5. A variety of information related to Provider Services, for example, HIPAA, EFT, Provider Enrollment, description of Explanation of Benefits (EOBs) indicated on the Remittance Advice (RA), how to find your field consultant, can be found by selecting the "Provider Services" drop down menu at http://provider.indianamedicaid.com.

Indiana Department of Education Resources for Medicaid-participating School Corporations

The Indiana Department of Education's School-based Medicaid web page, at http://www.doe.in.gov/specialed/school-based-medicaid, offers an online copy of this Tool Kit, other manuals, sample forms, reports, announcements and more, including:

1. Medicaid Billing Guidebook
2. IndianaMAC Time Study Participant Manual
3. Medicaid in Schools quarterly newsletters
4. Archive of School-based Medicaid related presentations
5. Semi-annual School Corporation Medicaid Reimbursements Report

Anyone with a Learning Connection account can access the Medicaid in Schools Community on IDOE's Learning Connection for additional resources, announcements, events calendar and discussion forum related to school-based Medicaid claiming in Indiana.

Other Federal Medicaid Resources

The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), which oversees state administration of the Medicaid program, maintains a web site at: http://medicaid.gov/. This site offers Medicaid and CHIP data by state, federal policy guidance, a "What's New" section, and quick links to program initiatives such as Insure Kids Now http://www.insurekidsnow.gov/. Additionally, the following key information is accessible at www.cms.hhs.gov:

1. Quarterly Provider Updates to inform the public about regulations and major policies currently under development, completed or cancelled, as well as new/revised manual instruction http://www.cms.hhs.gov/QuarterlyProviderUpdates/
2. The State Medicaid Manual is the guidance CMS publishes for State Medicaid Agencies; see Chapter 13 at https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

3. State Medicaid Director Letters (SMDL) contain guidance on specific topics such as payment for School-Based Services http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html?filterBy=SMD%23dynamic-list
4. Healthcare Common Procedure Coding System (HCPCS) codes (Level I HCPCS consists of CPT-4 procedure codes published by AMA, and Level II is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT-4 codes) https://www.cms.gov/MedHCPCSGenInfo/02_HCPCSCODINGPROCESS.asp#TopOfPage.

Procedure Code Sets

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

Code and Diagnosis Manuals

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

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

American Psychiatric Publishing, Inc.
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
Phone: 800-368-5777 or 703-907-7322
Fax: 703-907-1091
Email: appi@psych.org Website: www.appi.org and select on Customer Service

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

Coding Workshops

School corporation staff providing health-related IEP services are encouraged to become familiar with the CPT codes, definitions and parameters relevant to their specialties. Coding workshops conducted by Registered Health Information Specialists, Certified Coding Specialists, and Certified Coding Specialist Physicians are beneficial for such purposes.

National Organization

National Alliance for Medicaid in Education (NAME), Inc. http://medicaidforeducation.org/ is a non-profit organization comprising staff of Medicaid-participating local education agencies and state Medicaid and Education agencies who administer school-based Medicaid programs.