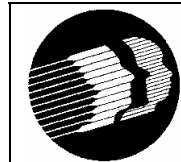




School Based Health Services
Provider Specific Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
8/30/04	9.0	Appendix B is updated to include the universal codes that providers are to use for dates of service on and after 7/1/03.
10/22/04	5.1	Language is being added to clarify the licensing requirements for pathologists/audiologists.

This page intentionally left blank



School Based Health Services

Provider Specific Policy Manual

Table Of Contents

[Main Menu](#)

1.0 Introduction

- 1.1 Legal Basis
- 1.2 Purpose and Scope of the EPSDT Program
- 1.3 Definitions
- 1.4 EPSDT Provider Enrollment
- 1.5 General Conditions for Participation

2.0 Provider Participation and Requirements

- 2.1 Provider Eligibility
- 2.2 Application for Certification and Enrollment
- 2.3 Notification of Enrollment Status
- 2.4 Provider Contract
- 2.5 Maintenance of Records and Documentation
- 2.6 Audits and Monitoring
- 2.7 Administrative Sanctions
- 2.8 Appeal Process of Adverse Actions for Providers

3.0 Client Eligibility

- 3.1 Eligibility

4.0 Services and Programs

- 4.1 Availability
- 4.2 Covered School Based Health Services
- 4.3 Service Documentation
- 4.4 Need for Service and Authorization Process
- 4.5 Medical Necessity
- 4.6 Service Limitations and Exclusions

5.0 Staff Authorized to Provide Services

- 5.1 Authorized Personnel
- 5.2 Billing for Staff Services

6.0 Quality Assurance

- 6.1 Quality Assurance Activities
- 6.2 Client Records

- 6.3 Quality Assurance Monitoring
- 6.4 Organizational Structure for Quality Assurance Monitoring
- 6.5 Program/Clinical Review
- 6.6 Fiscal Reporting Reviews
- 6.7 Monitoring Process
- 6.8 Technical Assistance

7.0 Reimbursement and Billing Procedures

- 7.1 Reimbursement
- 7.2 Billing Procedures and Claims Submission
- 7.3 Records Maintenance

8.0 Appendix A - Application for Certification

9.0 Appendix B – Codes and Descriptions of School Based Health Services

School Based Health Services Provider Specific Policy Manual

1.0 Introduction

Delaware of Health and Social Services (DHSS) enters into contracts with provider agencies for the purchase of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services furnished to eligible clients under Medicaid (Title XIX of the Social Security Act). This manual has been developed to set forth the general policies and procedures for provider participation in the EPSDT program as it relates to services provided to individuals under the age of 21 by public education organizations. For reimbursement of services by DHSS providers shall comply with the certification and enrollment requirements stated in this manual.

This manual is a reference document for provider agencies, Department program and contract administrators and staff. It contains the necessary conditions and requirements for continuing participation in and reimbursement of EPSDT services.

1.1 Legal Basis

The EPSDT program was established by Title XIX of the Social Security Act in 1967. Sections 1902(a)(43), 1905(1)(4)(B), and 1905(r) of the Act, as amended, set forth the basic requirements for the program. Delaware enacted its EPSDT program in 1967. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) by Congress expanded the scope of the EPSDT program in terms of service coverage and participating providers.

1.2 Purpose and Scope of the EPSDT Program

1.2.1 The purposes of the EPSDT program are:

- To provide for the detection of any physical and mental problems in individuals under the age of 21 as early as possible through comprehensive medical screenings in accordance with prescribed standards; and
- To provide for appropriate and timely diagnostic and/or other services to correct or ameliorate any acute or chronic conditions found before the health problems become more complex and their treatment more costly.

1.2.2 EPSDT services are available statewide to Medicaid eligible individuals under 21 years of age. The amount, duration, and scope of the services provided under the EPSDT program are not required to be provided to other Medicaid eligible clients. Some EPSDT services may be limited based on medical necessity as determined by DHSS or its representatives.

1.3 Definitions

The following is an alphabetical listing of definitions of terms frequently used in this manual.

- 1.3.1 Certification - refers to a process where by providers make application to and receive certification from DHSS that they meet standards established for EPSDT service provision and reimbursement. See Appendix A for Application for Certification.
- 1.3.2 Contract (provider) - refers to the contract between the provider and DHSS which sets forth conditions of participation and defines the services to be provided.
- 1.3.3 Covered services - refers to a service or procedure, provided by a provider or under a provider's supervision to a Medicaid eligible client for which Medicaid reimbursement is available.
- 1.3.4 Department - refers to Delaware Health and Social Services (DHSS).
- 1.3.5 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services refers to a mandatory Medicaid program service which consists of screening and diagnostic services to determine physical or mental illness, treatment, and other measures to correct or ameliorate any defects or conditions discovered in clients under the age of 21.
- 1.3.6 Eligible client - refers to a person who is entitled to receive benefits under the Delaware Medical Assistance Program (DMAP).
- 1.3.7 Individual Education Program (IEP) - refers to a formal, written plan which is developed to meet the needs of a child identified to be handicapped and requiring special education and health services pursuant to Delaware Department of Education regulation. (Non-handicapped children may also receive school based services and require a treatment plan, but not an I.E.P.).
- 1.3.8 Medically necessary - a service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the eligible client requesting the services.
- 1.3.9 Provider agency (also Provider) - refers to a person or organization of practitioners who has been certified and enrolled by DHSS to provide services to eligible clients and to be reimbursed by Medicaid for those services.
- 1.3.10 School based health services providers - refers to eligible providers who meet the certification and enrollment requirements for providing EPSDT related school based services provided in a public education environment.
- 1.3.11 State - refers to the state of Delaware.

1.4 EPSDT Provider Enrollment

- 1.4.1 One of the goals of the EPSDT program is to improve access to care by increasing the number and types of providers participating in the EPSDT program, including school systems, private physicians in individual and group practices, community health centers, Head Start agencies, and other public and private facilities providing health care to children.
- 1.4.2 Participation in the EPSDT program as a provider is entirely voluntary. EPSDT providers are not limited to those who are qualified to provide the full range of medical, vision, and hearing services.
- 1.4.3 To receive payment for EPSDT services provided to Medicaid eligible clients, a provider must enroll and be approved for participation by DHSS. An eligible EPSDT services provider is any individual or group of individuals with medical or health care related expertise in the provision of either screening, diagnostic, or treatment services.
- 1.4.4 All providers who wish to participate in EPSDT must enroll for the specific screening service or combination of screening services or health services they wish to provide.
- 1.4.5 DHSS reviews potential EPSDT services provider applicants. Prior to enrollment as an EPSDT services provider, DHSS may conduct an on-site evaluation of the provider. The site visit is made to assure compliance with standards and requirements in the following areas:
- Screening, diagnosis and treatment procedures;
 - Periodicity scheduling process;
 - Referral and follow-up process;
 - Documentation and record maintenance;
 - Billing and reporting procedures;
 - Confidentiality, informed consent, release of information, civil rights; and
 - Staff qualifications and licensure.
- 1.4.6 Depending upon the provider applicant's compliance with appropriate standards and requirements, either temporary or full approval may be granted. The provider's application may be denied if the provider fails to comply with necessary standards and requirements.

1.4.7 Local school districts may participate in the EPSDT program as school based health services providers. Participation requirements for school based health services providers are detailed in Section 2.0 of this manual.

1.5 General Conditions for Participation

1.5.1 State regulations and policy define the following general standards for providers who choose to participate as follows:

- Compliance with current licensure by the appropriate State authority for the practitioner's specialty, all applicable accrediting standards, any applicable Federal service standards, and all applicable State and Federal laws.
- Establishment of a provider agreement and enrollment with DHSS.
- Agreement to charge the Medicaid program no more for services to eligible clients than is charged on the average for similar services to others.
- Agreement to accept the amounts established by the DMAP as payment-in-full and not to seek additional payment from the client or parent/guardian for any unpaid portion of a bill.
- Agreement that all services to and materials for clients of public assistance be in compliance with Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and, if applicable Title VII of the 1964 Civil Rights Act.

1.5.2 Although this is a voluntary program, a signature on a Medicaid claim form serves as an agreement to abide by all policies and regulations of the DMAP. This agreement also certifies that, to the best of the provider's knowledge, the information contained on the Medicaid claim form is true, accurate, and complete.

2.0 Provider Participation and Requirements

2.1 Provider Eligibility

2.1.1 Participation in the DMAP is entirely voluntary. However, in order to be eligible for reimbursement of covered services, a provider must meet specific requirements and become an approved provider of Medicaid services.

2.1.2 To participate as a school based health services provider, the following conditions of participation in the DMAP must be met:

- The school based health services provider must meet all applicable State licensing and certification requirements.
- The school based health services provider must meet all DHSS requirements for Medicaid participation and reimbursement.
- The school based health services provider must receive approval from the Delaware Department of Education to participate in the DMAP.
- The school based health services provider must comply with State level organizational, administrative, and program standards, and with Federal requirements for the administration of Medicaid services as contained in Federal statutes, regulations and guidelines.
- The local school district must be the enrolled provider in order to be eligible for reimbursement for health-related services defined in the I.E.P. or in the school health program.
- Each practitioner who meets the specified professional and/or clinical qualifications to provide services in his or her discipline area must also apply for Medicaid enrollment if covered services rendered by the practitioner are to be billed on behalf of the school based provider to the DMAP.

2.2 Application for Certification and Enrollment

2.2.1 Prior to enrollment as a Medicaid eligible provider of school based health services, a school district must first apply for certification status. This certification status affirms that the school district is in compliance with appropriate Delaware

Department of Education and DHSS guidelines for becoming an enrolled Medicaid provider.

- 2.2.2 A school district that wants to become a school based health services provider must initially complete an application for provider status. The Certification Application format can be found in this manual as Appendix A. In addition to supplying the application information, the school district must also attach any requested documentation and narrative description which supports the certification of the school district as a school based health services provider. The narrative description, at a minimum, must include a discussion of the following:
- School district organization, including the special education and related services programs
 - Records and documentation maintenance, including reference to assessments, physician referrals, treatment plans and case/progress notes; the manner in which the records are maintained; and individuals responsible for record maintenance
 - Staff qualifications, including documentation regarding staff "competency" credentials; verification practices for assuring staff qualifications for Medicaid reimbursement; and procedures for contracting with professionals who shall provide Medicaid covered services
 - Quality assurance program implemented by the district to assure that Medicaid services are delivered and recorded in the appropriate manner, including a description of the program and assignment of oversight responsibilities associated with the program
- 2.2.3 In order to apply for Medicaid provider enrollment, a school district must meet the requirements of the certification process.
- 2.2.4 School districts who wish to participate in the DMAP must also apply for enrollment as a school based health services provider. A Provider Enrollment Application can be obtained from the DMAP's fiscal agent. All applicants must complete the provider application.
- 2.2.5 Applicants are requested to complete information regarding provider organization data, application type, licensing data, and provider specialty type. All relevant data fields must be completed on the application form. The application, along with any necessary documents (e.g. copies of professional licenses), is to be submitted to the DMAP's fiscal agent.

2.3 Notification of Enrollment Status

The applicant shall receive written notification from the fiscal agent of the new provider number. This provider number is to be used on all Medicaid reimbursement correspondence and transactions.

2.4 Provider Contract

2.4.1 Applicants who meet the requirements for enrollment with the DMAP will enter into a contract with DHSS. Providers who sign a contract with the Medicaid program are obligated to meet certain conditions in order to remain an eligible provider and receive payment for services rendered.

2.4.2 The provider must abide by the DMAP's policies and procedures, including but not limited to:

- Submit claims only for services that were actually rendered by the billing provider
- Accept final Medicaid payment disposition as payment in full for Medicaid covered services
- Keep records necessary to verify the services provided and permit Federal/State representatives access to the records
- Determine the individual was Medicaid eligible at the time of service
- Make restitution for any overpayment
- Notify the DMAP of any suspensions or exclusions from any program

2.5 Maintenance of Records and Documentation

2.5.1 All providers participating in the DMAP are required to maintain records that will disclose services rendered and billed under the program, and upon request, to make such records available to DHSS or its representatives in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all State and Federal regulations and laws.

2.5.2 In order for DHSS to fulfill its obligation to verify services provided to Medicaid eligible clients and that are paid for by Medicaid, providers must maintain auditable records that will substantiate the claim submitted to Medicaid.

2.5.3 At a minimum, the records must contain the following on each client:

- Notice of referral for physical therapy services by a licensed physician, updated annually
- Referral/authorization for services by an appropriately credentialed service provider
- Full assessment(s) in the appropriate discipline area(s) with pertinent documentation such as tests, evaluations, and diagnosis (updated at least every 3 years), and an annual reassessment documented in written format including narrative information summarizing the child's status and the continuing need for treatment
- A treatment plan prepared by the respective therapist(s) that describes the goals/objectives and level of service(s) (i.e., type and frequency of service) needed. The treatment plan is required annually. A progress note is required approximately every six months (but no earlier than 4 months, nor later than 8 months after the date of the current I.E.P./treatment plan) which delineates the continuing need for service. An I.E.P. must be developed within 30 calendar days following the determination that a student is eligible for special education and related services.
- The name and title of the professional providing services and/or supervision
- Each occurrence of the student's service, including the date, type, length, and scope of professional services provided
- Any significant contacts made in relation to the student

2.6 Audits and Monitoring

- 2.6.1 All services for which charges are made to the DMAP are subject to audit. The initiating of audit proceedings should not be construed as an indication of any wrongdoing on the part of the provider. Rather, an audit should be looked upon as an ongoing and necessary part of procedures for monitoring health care facilities and services provided that is required by State and Federal regulations.
- 2.6.2 During a review audit, the provider shall furnish to the Department or its representative, pertinent information regarding claims for payment. Should an audit reveal incorrect payments were made, or that the provider's records do not

support the payments that were made, the provider shall make appropriate restitution.

- 2.6.3 In addition to performing audits, the Department may routinely monitor a provider's performance with respect to compliance with certification and/or enrollment requirements. Both fiscal and clinical compliance shall be monitored. Should a provider be found to be non-compliant, Medicaid enrollment may be suspended or revoked, until at which time the provider can prove compliance with necessary requirements.
- 2.6.4 DHSS has also delegated authority to Children's Services Cost Recovery Project (CSCR) personnel to periodically review the ongoing operations of a school based health services provider with respect to:
- Certification requirements
 - Service documentation, including need for services, treatment plans and case/progress notes
 - Service practitioner's qualifications
 - Billing records

2.7 Administrative Sanctions

- 2.7.1 Payments made by the DMAP are subject to review by program representatives to ensure the quality, quantity, and medical need for services. Administrative sanctions may be imposed against any Medicaid provider who does not meet the State and Federal guidelines, regulations and laws.
- 2.7.2 Administrative sanction refers to any administrative action applied by DHSS, as the single state agency, against any provider of Medicaid services - which is designed to remedy inefficient and/or illegal practices that are in noncompliance with the DMAP policies and procedures, statutes, and regulations.
- 2.7.3 DHSS may impose various levels of administrative sanctions against a Medicaid provider, including the following:
- Give warning through written notice or consultation
 - Require education in program policies and billing procedures
 - Require prior authorization of services
 - Place claims on manual review before payment is made
 - Suspend or withhold payments
 - Recover money improperly or erroneously paid either by

crediting against future billings or by requiring direct payment

- Refer to the State licensing authority for review
- Refer for review by appropriate professional organizations
- Refer to Attorney General's Fraud Control Unit for fraud investigation
- Suspend certification and participation in the Medicaid program
- Refuse to allow participation in the Medicaid program

2.7.4 DHSS may impose sanctions against a provider of Medicaid services if the agency finds that the provider:

- Is not complying with Medicaid policy or rules and regulations, or with the terms and conditions prescribed in the provider agreement
- Has submitted a false or fraudulent application for provider enrollment status
- Is not properly licensed or qualified, or that the provider's professional license, certificate or other authorization has not been renewed or has been revoked, suspended or terminated
- Has failed to correct any deficiencies in its delivery of service or billing practices after having received written notice of these deficiencies from DHSS
- Has presented any false or fraudulent claim for services
- Has failed to repay or make arrangements for the repayment of any identified overpayment or erroneous payment
- Has failed to keep or make available for review, audit, or copying any information or records to substantiate payment of claims for service provision

2.8 Appeal Process of Adverse Actions for Providers

In the case of denial from participation in the Medicaid program, the provider will receive written notification from DHSS. The written notice will include the reason for denial.

- 2.8.1 Deputy Director's Review
- 2.8.1.1 Any provider wishing to appeal an adverse action (e.g. denial from participation) must notify the Department in writing within 60 days and request a review by the Deputy Director of the Department or his/her designee. If the provider does not file within 60 days of notice of adverse action, the appeal shall be dismissed.
- 2.8.1.2 The Deputy Director or his/her designee will schedule a review date and place convenient for all parties. If all parties agree the Deputy Director's review may be waived. Confirmation of this agreement will be made through certified mail to the provider by the Deputy Director or his/her designee and will constitute the initiation of the time frames for the Director's review.
- 2.8.1.3 The provider may submit any documentation and written argument as desired to the Deputy Director or his/her designee. Such documentation must be delivered to the Department at least seven (7) days prior to the scheduled review. Submission of additional documentation may eliminate the need for a face-to-face meeting.
- 2.8.1.4 Based on the materials submitted by the provider, the Deputy Director or his/her designee may rule in favor of the provider and, thereby, eliminate the need for the provider to attend the meeting. The provider will be notified prior to the scheduled meeting if the meeting becomes 2.8.1.5 unnecessary.
- 2.8.1.5 If a provider fails to appear at a scheduled Deputy Director's review meeting, the Deputy Director or his/her designee may immediately dismiss the appeal and issue a decision against the provider. The Deputy Director or his/her designee may, alternatively, at his/her discretion, reschedule the meeting if it is so warranted. If the appeal is dismissed due to failure to appear of the provider, the provider forfeits any rights to appeal further even if the adverse action would normally entitle the provider to the additional level of appeal.
- 2.8.1.6 After the review, the Deputy Director or his/her designee will forward a written decision to the provider. This decision will affirm, deny or modify the terms of the adverse action and is final except as noted below.
- 2.8.2 Director's Review
- 2.8.2.1 The only cases which may be appealed to the Director are those which involve denial, termination or non-renewal of provider agreement, limitation(s) on participation, and any monetary adverse actions of \$1,000 or greater.
- 2.8.2.2 The provider may submit any documentation and written argument as desired to the Director or his/her designee. Such material must be delivered to the Department at least seven (7) days prior to the scheduled meeting. Submission of additional documentation may eliminate the need for a face-to-face meeting.

- 2.8.2.3 Based on the material submitted by the provider, the Director or his/her designee may rule in favor of the provider, and thereby, eliminate the need for the provider to attend the meeting. The provider will be notified prior to the scheduled meeting if the meeting becomes unnecessary.
- 2.8.2.4 The Director or his/her designee will schedule a time and place for the hearing convenient to all parties. The provider has the opportunity to review the documentation upon which the initial adverse action and previous level decisions were based either prior to or at the Deputy Director's review. The hearing must, at a minimum, include an opportunity for the provider to:
- Review documentation
 - Appear before an impartial decision maker to refute the basis for the decision
 - Be represented by counsel or another representative
 - Be heard in person, to call witness, and to present documentary evidence
 - Cross-examine witnesses
- 2.8.2.5 If a provider fails to appear at the scheduled hearing, the Director or his/her designee may immediately dismiss the appeal and issue a decision against the provider. The hearing may be rescheduled if the failure to appear was for good cause as determined by the Director or his/her designee.
- 2.8.2.6 The Director or his/her designee will notify the provider in writing of the decision. The decision is final and no further appeals are afforded by the Medicaid program. The provider may be held responsible for all costs incurred in holding the Director's review.

3.0 Client Eligibility

3.1 Eligibility

- 3.1.1 Payment for school based health services under the EPSDT program is available for all individuals under the age of 21 eligible for Medicaid, subject to the conditions and limitations that apply to these services.
- 3.1.2 Payment can be made by the DMAP only for services provided to individuals who are eligible clients on the date services are actually provided. It is the responsibility of the provider to verify an individual's eligibility for medical assistance prior to providing services by requesting the individual (or parent/guardian) to present evidence of his/her eligibility at the time of service provision. The local cost recovery specialist, acting on behalf of an enrolled school-based health services provider, may also verify Medicaid eligibility through the Medicaid Managed Information System (MMIS).
- 3.1.3 An individual who claims to be a Medicaid eligible client, but for whom eligibility cannot be established should be considered ineligible until proven otherwise.

This page intentionally left blank.

4.0 Services and Programs

4.1 Availability

Payment for school based health services is available for all individuals under the age of 21 who are eligible for Medicaid subject to the conditions and limitations which apply to these services.

4.2 Covered School Based Health Services

The DMAP shall pay for a covered service provided to an eligible Medicaid client or to a person who is later found to be eligible at the time he or she received the service. To be eligible for payment, a school based health service must:

- Be determined by prevailing community standards or customary practice and usage to:
 - Be medically necessary
 - Be appropriate and effective for the medical needs of the individual
 - Meet quality and timeliness standards
 - Be the most cost-effective health service available for the medical needs of the individual
- Represent an effective and appropriate use of DMAP funds
- Be within the service limits specified by the DMAP
- Be personally furnished by personnel who meet the necessary requirements and credentials described in this manual

The school based health services which are covered under the DMAP are described below.

4.2.1 EPSDT Assessment Services

4.2.1.1 The following EPSDT assessment services are included in this service category and should be used to document service provision for reimbursement purposes:

- EPSDT Partial Assessment: Health Education - includes one-to-one teaching and health counseling
- EPSDT Partial Assessment: Immunization - includes immunization review
- EPSDT Hearing Assessment - includes hearing screening

- EPSDT Vision Assessment - includes vision screening
- EPSDT Partial Assessment: Developmental/Orthopedic - includes orthopedic screening
- EPSDT Dental Assessment - includes a dental oral exam using a mouth mirror and explorer. The screening identifies any caries and/or any other abnormalities that would be present, including but not limited to:
 - Abscess
 - Growth or lesion
 - Traumatic fracture or injury
 - Rampant caries
 - Orthodontic problems
 - Necessary prophylaxis treatment
 - Periodontal problems
- EPSDT Dental Health Education - includes one-to-one teaching of awareness, prevention and education. Teaching of dental health education is age appropriate. The following is included in dental health education: awareness of teeth, elimination of fear and other barriers to dental care, dental hygiene techniques, prevention, plaque control, brushing and flossing techniques, and how dental health is related to psychological and physical health.

4.2.1.2 As necessary, families are notified and referred to private or public service providers. The referral process may include identification of available service providers and assistance in access to service.

4.2.1.3 EPSDT Assessment Services: Treatment Plan Requirements
Treatment plans for assessment services are not required. Rather, documentation is required if the eligible client is to be referred for evaluation and/or treatment services which have been identified as a result of the assessment service(s). A referral status should be documented for each assessment service when a referral for additional service is determined appropriate and/or necessary.

4.2.2 Speech, Language and Hearing Services

4.2.2.1 Speech, Language and Hearing: Assessment

Assessment refers to the process of determining the need, nature, frequency and duration of treatment; deciding the needed coordination with others involved; and documenting these activities.

The speech, language, and hearing evaluation includes the assessment of articulation and language (receptive, expressive; form, content, and use) as measured by a standardized/norm-based instrument (i.e., criterion referenced measures including clinical observations). The evaluation may also include an assessment of oral motor functioning (oro-pharyngeal function), voice quality and speech fluency.

Results of the evaluation may identify a significant delay or disorder in one or more of the following areas:

- Articulation skills
- Speech fluency
- Oral motor/feeding
- Voice quality
- Hearing
- Language

4.2.2.2 Speech, Language, and Hearing Treatment

The type and level of treatment services are a direct outcome of the assessment. Service options include:

Direct Service

- **Articulation:** Treatment, support and rehabilitation services to ameliorate articulation disorders (misarticulated phonemes) with stimulability of at least two phonemes and decreased intelligibility of conversational speech.
- **Fluency:** Treatment, support and rehabilitation services to ameliorate speech dysfluencies, and to ameliorate a child's struggle with behavior and concerns about his/her dysfluencies.
- **Voice:** Treatment, support and rehabilitation services to ameliorate voice pathology and/or abnormality of vocal quality, pitch or volume.
- **Language:** Treatment, support and rehabilitation services to improve a child's language skills which fall outside average ranges, and exhibit significant weakness in a single area such as auditory memory or vocabulary.

- Auditory Training: sound discrimination tasks (in quiet noise), sound awareness, sound localization, support services for hearing aid use/wear.
- Audiology Treatment: support and rehabilitation services to hearing impaired children and their families, including ongoing assessment of hearing aid function, adjustment/modification of hearing aids, repair of hearing aids, recommendation for new hearing aids, counseling to child and parents regarding proper care and use of amplification.

Case Consultation

(Reimbursable as a treatment service for the time of the therapist only and pertain specifically and completely to an individual student.)

The role of consultation is monitoring, supervising, teaching and training professionals, paraprofessionals, parents and students in the educational environment, home and/or community environment. Case consultation includes:

- Providing general information about a specific student's handicapping condition
- Teaching special skills necessary for proper care of specific student's hearing aid
- Development/maintenance/demonstrating use and care of adaptive/assistive devices for a specific student
- Recommendations for enhancing a specific student's performance in education environments

4.2.2.3 Speech, Language, and Hearing Services: Service Procedures

The following service procedures are included in the speech, language, and hearing services category and should be used to document service provision for reimbursement purposes:

- Speech, language, and hearing assessment
- Individual speech/language therapy - one therapist to one student
- Individual hearing therapy - one therapist to one student
- Group speech/language therapy - one therapist to five or less students
- Individual speech/language co-treatment therapy - two

therapists to one student

- Individual hearing co-treatment therapy - two therapists to one student
- Group speech/language co-treatment therapy - two therapists to five or less students

4.2.2.4 Speech, Language, and Hearing Services: Treatment Plan Requirements

An assessment and treatment plan are required annually. The treatment plan must be based on an evaluation by the speech, language, hearing and/or audiology therapist. Further, the treatment plan must indicate goals/objectives and level of service (type and frequency of service).

A progress note is required approximately every six months (but no earlier than 4 months nor later than 8 months after the date of the current I.E.P./treatment plan) which delineates the need for ongoing treatment. The progress note must:

- Indicate where the student is in relation to the treatment plan goals
- Indicate if the treatment plan requires changes in the goals and/or objectives and
- Indicate if the type or frequency of the treatment requires modification.

4.2.3 Occupational Therapy Services

4.2.3.1 Occupational Therapy: Evaluation

Evaluation refers to the process of determining the need, nature, frequency and duration of treatment; deciding the needed coordination with others involved; and documenting these activities. This evaluation addresses the varying degrees of developmental delay, neurological deficits, and/or neuromuscular disorders:

- Sensory motor skills, such as sensory awareness, sensory processing, and perceptual skills
- Neuromuscular functioning, such as range of motion, muscle tone, and endurance as related to daily living skills, school/work activities, play and leisure skills, and vocational skills
- Motor skills, especially fine motor coordination/dexterity, visual -motor integration, and oral - motor control
- Cognitive components, such as arousal, attention span, sequencing, problem solving, and generalization of learning

- Psychosocial/psychological components, such as interest, self-concept, social conduct, self-expression, time management, and self-control

When appropriate, standardized tests should be used. Standardized tests are those whose scores are based on accompanying normative data, which may reflect age ranges, sex, ethnic groups, geographic regions, and socio-economic status. If standardized tests are not available or appropriate, the results shall be expressed in a descriptive report.

4.2.3.2 Occupational Therapy: Treatment

This service includes the provision of intervention activities, procedures, and environmental modifications necessary to implement the goals and objectives of the IEP and the occupational therapy intervention plan.

Direct Therapy

In direct therapy, the occupational therapist has frequent contact with the student to help the student effectively meet demands (self-care, physical, social, emotional, academic) within current and anticipated educational environments.

Monitoring

(Reimbursable as a treatment service for the time of the therapist only.) - In monitoring, the occupational therapist develops the intervention plan to enhance IEP goals, but instructs others (teachers, aides, paraprofessionals, volunteers, parents) to carry out the procedures. The selection of monitoring interventions should be based on consideration of both the health and safety of the student, and the appropriate procedural precautions.

Case Consultation

(Reimbursable as a treatment service for the time of the therapist only and must pertain specifically and completely to an individual student.) The purpose is to develop the most effective educational environment for the individual with special needs. This service is frequently provided when a student shifts from a self-contained special education classroom to a regular classroom with resource room help. Case consultation might be used to alter the style of presenting materials, to develop remediation materials for the student to use in the classroom or to adjust the demands for specifically required tasks.

4.2.3.3 Occupational Therapy Services: Service Procedures

The following services are included in the occupational therapy services category and should be used to document service provision for the purpose of reimbursement:

- Occupational therapy evaluation
- Occupational therapy: Individual treatment - one therapist to one student

- Occupational therapy: Group treatment - one therapist to five or less students.

4.2.3.4 Occupational Therapy Services: Treatment Plan Requirements

An assessment and treatment plan are required annually. The treatment plan must be based on an evaluation by an occupational therapist. Further, the treatment plan must indicate goals/objectives and level of service (type and frequency of service).

A progress note is required approximately every six months (but no earlier than 4 months nor later than 8 months after the date of the current I.E.P./treatment plan) which delineates the need for ongoing treatment. The progress note must:

- Indicate where the student is in relation to the treatment plan goals
- Indicate if the treatment plan requires changes in the goals and/or objectives and
- Indicate if the type or frequency of the treatment requires modification.

4.2.4 Physical Therapy Services

4.2.4.1 Physical Therapy: Assessment

Assessment refers to the process of determining the need, nature, frequency and duration of treatment; deciding the needed coordination with others involved; and documenting these activities.

Screening is the process of surveying an individual in order to identify previously undetected problems and reviewing written or verbal information concerning a handicapped individual in order to determine the need for physical therapy services. Screening may include:

- Review of written material
- Direct observation by a physical therapist, other professionals, and parents
- Discussion of information, history and current concerns between the physical therapist and parents and/or other professionals on the multi-disciplinary team

Evaluation refers to the process of obtaining and interpreting data necessary for service delivery. The nature of evaluation will be determined by the student's handicapping condition and how it impacts the educational program. The physical therapist should be a member of the multi-disciplinary team and the IEP team, where appropriate, in order to:

- Provide the participants at the multi-disciplinary team meeting with the physical therapy evaluation and

information necessary to determine eligibility for physical therapy services

- Determine the student's physical therapy needs and/or related services; to recommend goals and objectives, procedures, materials, environments and any other considerations necessary for meeting those needs

Categories of Physical Therapy Evaluation Services may include, but not be limited to:

- Standardized tests
- Non-standardized tests, such as:
 - Adaptive devices and equipment utilization
 - Classroom positioning
 - Analysis of postural control and/or deviations
 - Developmental testing
 - Environmental accessibility
 - Functional motor skills
 - Gait analysis
 - Manual muscle testing
 - Mobility skills
 - Postural responses (reflexes and automatic reactions)

4.2.4.2 Physical Therapy: Treatment

The type and level of treatment services are a direct outcome of the ongoing reassessment of therapy services. Service options include:

Direct Service

- Normalization of postural tone in preparation for function using neurophysiological techniques
- Therapeutic exercise (strength, endurance, coordination)
- Range of motion (ROM) exercise
- Functional mobility (wheelchair, automobile, bike, trike, access to public transportation)
- Functional motor skills

- Postural control, symmetry and stability
- Gait training
- Positioning and body mechanics in classroom programming
- Modalities - hot/cold packs, whirlpool, electrical stimulation, biofeedback, infrared
- Development, maintenance, training for adaptive equipment and devices
- Stimulation of cardiovascular and respiratory function
- Self-management training
- Disability awareness training

Case Consultation

(Reimbursable as a treatment service for the time of the therapist only and must pertain specifically and completely to an individual student.). The role of consultation is monitoring, supervising, teaching and training of professionals, parents and student in the educational environment, home and/or community environment. This may include:

- Providing general information about a specific student's handicapping condition
- Teaching special skills necessary for proper handling, lifting and positioning for a specific student
- Development/maintenance/demonstrating use and care of adaptive/assistive devices for a specific student
- Recommendations for enhancing a specific student's performance in education environments

4.2.4.3 Physical Therapy Services: Service Procedures

The following services are included in the Physical therapy services category and should be used to document service provision for the purpose of reimbursement:

- Physical therapy assessment
- Physical therapy: Individual treatment - one therapist to one student
- Physical therapy: Group treatment - one therapist to five or less students.

4.2.4.4 Physical Therapy Services: Treatment Plan Requirements

An assessment and treatment plan are required annually. The treatment plan must be based on an evaluation by a physical therapist. Further, the treatment plan must indicate goals/objectives and level of service (type and frequency of service).

A progress note is required approximately every six months (but no earlier than 4 months nor later than 8 months after the date of the current I.E.P./treatment plan) which delineates the need for ongoing treatment. The progress note must:

- Indicate where the student is in relation to the treatment plan goals
- Indicate if the treatment plan requires changes in the goals and/or objectives and
- Indicate if the type or frequency of the treatment requires modification.

4.2.5 Mental Health Treatment Services

4.2.5.1 Mental Health Treatment Assessment

Assessment refers to the process of determining the need, nature, frequency and duration of treatment; deciding the needed coordination with others; and documenting these activities.

Screening

Mental Health screen has four primary components:

- Child study team meetings - a meeting of staff who have knowledge of a referred student to discuss the referral problem for the purpose of determining the next step in the screening process.
- Observations - a period of time spent observing a referred student in a natural setting for the purpose of determining student's academic and/or interpersonal behaviors.
- Group testing - Psychologist's or psychiatrist's participation in administration of tests for the purpose of obtaining specific information about a student or group of students.
- Records review - Information gathering on a designated student by way of examining academic, health, behavioral and any other related records for the purpose of providing data relevant to concerns.

Evaluation

Evaluation includes a "Psycho-educational Assessment". This assessment includes psychological and/or educational testing, typically for intellectual, personality, and/or educational evaluation of referred student, for diagnostic purposes resulting in the generation of a report. The psychological component of the assessment evaluates the intellectual, academic, perceptual motor skills, social and emotional adjustment, and readiness for learning.

4.2.5.2 Mental Health Treatment Services

Mental health treatment services includes the following therapeutic and related services:

- Individual Therapy - This service consists of supportive, interpretive, insight oriented and occasionally directive interventions.
- Group therapy - This service is designed to enhance socialization skills, peer interaction, consensual validation, expression of feelings, etc.
- Family Therapy - This service consists of sessions with one or more family members, for purposes of effecting changes within the family structure, communication, clarification of roles, etc.
- Case Consultation (Reimbursable for the time of the mental health professional only and must pertain specifically and completely to an individual student.) The role of consultation is monitoring, supervision, teaching and training of professionals, paraprofessionals, parents and student in the educational environment, home and/or community environment. Case consultation includes:
 - Providing general information about a specific student's handicapping condition
 - Teaching special coping and intervention techniques necessary for the specific student's interpersonal skills
 - Recommendations for enhancing a specific student's performance in educational environments

4.2.5.3 Mental Health Treatment Services: Service Procedures

The following services are included in the mental health treatment services category and should be used to document service provision for the purpose of reimbursement:

- Mental health treatment assessment
- Individual therapy - one therapist to one student
- Group therapy - one therapist to six or less students.
- Family therapy - one therapist to one or more family members of the student's family
- Individual co-treatment therapy - two therapists to one student
- Group co-treatment therapy - two therapists to six or less students
- Family co-treatment therapy - two therapists to one or more family members of the student's family
- Case consultation

4.2.5.4 Mental Health Treatment Services: Treatment Plan Requirements

An assessment and treatment plan are required annually. This treatment plan must be based on an evaluation by a qualified mental health treatment provider. Further, the treatment plan must indicate goals/objectives and level of service (type and frequency of service).

A progress note is required approximately every six months (but no earlier than 4 months nor later than 8 months after the date of the current I.E.P./treatment plan) which delineates the need for ongoing treatment. The progress note must:

- Indicate where the student is in relation to the treatment plan goals
- Indicate if the treatment plan requires changes in the goals and/or objectives and
- Indicate if the type or frequency of the treatment requires modification.

4.2.6 Nursing Services

The following service procedures are included in the Nursing Services category and should be used to document service provision for reimbursement purposes:

Individual nursing treatment - includes one or more of the following:

- Personal care, which is medically necessary and requires nurse intervention
- Nursing evaluation
- Naso-gastric feedings--Bolus/drip

- Gastrostomy feedings--Bolus/drip
- Change of gastrostomy tube
- Catheterization
- Tracheal suctioning
- Tracheal care--Decanulation
- Tracheal ventilation--Ambu bag
- Medications--Administration and monitoring
- Diabetic care--Monitoring and/or medication administration
- Wound care--First aid
- Wound care--ongoing
- Cast care
- Postural drainage
- Chest percussion
- Suctioning
- Special diet considerations--Modification and monitoring
- Feeding of children with oral motor deficits (Speech/O.T.)
- Collateral contacts for updating medical information--community agencies, doctor, staff, family
- Physician prescribed medical treatments
- Care of the sick
- Oxygen administration
- Nebulizing/humidifying

4.2.7 Special Transportation Services

Services are for transportation to and from the individual's place of residence and the location where school based health services are provided to children with special needs. The locations are special schools which include, but not limited to, autistic, deaf/blind and orthopedic schools, among others. Because of the seriousness of the medical conditions, either transportation aides are required to assure that the children are safely transported, and/or specialized buses, capable of handling wheelchairs and other medical equipment that results from medical conditions, are required. Special Transportation is only covered on days when a Medicaid-covered health service (other than transportation) is also provided.

4.2.7.1 Special Transportation Services: Treatment Plan Requirements

Both the school-based health service(s) provided to the child and the special transportation service must be included in the child's I.E.P.

4.3 Service Documentation

School based health services providers must make all records of services provided to students with special health needs available to Medicaid program personnel or its representatives for monitoring and auditing purposes. These providers must maintain the following information for at least five years on all individuals for whom claims have been submitted:

- Dates and results of all evaluations/assessments provided in the interest of establishing or modifying an IEP, including specific tests performed and copies of evaluation and diagnostic assessment reports
- Copies of the IEP/treatment plan documenting the need for the specific therapy, treatment or transportation service (updated annually)
- Documentation of the provision of service in the student's record by individual therapists and individuals providing service, including:
 - The date of service
 - Signature of the therapist rendering the service
 - Duration of the service
- Documentation of case notes, at a minimum of once a month, by the individual therapist or the individual providing the service. The definition of case note is a descriptive summary of service provided with identification of any isolated or recurring problems. If a practitioner chooses to document session notes, there is no need to document monthly case notes. Session notes must contain some written narrative.
- The provision of special transportation services will be documented by the responsible schools in a client specific, date specific format.
- Progress notes delineating the continuing need for service are required approximately every 6 months (but no earlier than 4 months nor later than 8 months after the date of the current IEP/Treatment Plan)

4.4 Need for Service and Authorization Process

- 4.4.1 Any Medicaid eligible individual requiring school based health services may receive these services from the local school district provided that:
- All school based health services relate to a medical diagnosis
 - The service provided is within the scope of the profession of the practitioner performing the service
 - Record including the name(s) of the practitioner(s) actually providing the service(s)
 - The treatment services are part of the student's written treatment plan on file with the participating local school district. Exceptions to this include emergency or unplanned nursing or mental health treatment services. The treatment plan, as developed by the respective therapist(s), shall be subject to review by authorized DMAP personnel. The treatment plan must include:
 - An indication of the applicable medical diagnosis and other conditions and anticipated rehabilitation goals/objectives
 - A description of the type, amount, frequency and duration of the services to be provided
 - Signature by the appropriate school-based health personnel substantiating that the treatment services are necessary because the child requires skilled health services
 - Evidence of annual physician referral for physical therapy services
- 4.4.2 Prior authorization by the DMAP is not required for reimbursement of covered school based health services except as noted below. A referral for service(s) and a documented need for the service(s), however, is required.
- 4.4.3 Evidence of referral for services and the documented treatment plan must be maintained in the eligible individual's health care record or other approved location which is readily accessible should verification of service need be necessary.
- 4.4.4 If during periodic monitoring reviews or DMAP audits it is found that the need for service(s) is not sufficiently documented for an individual, the Department may

determine prior authorization of services shall be necessary in order to obtain Medicaid reimbursement for services.

- 4.4.5 The DMAP shall notify the school-based health services provider should prior authorization for reimbursement of covered services become necessary.

4.5 Medical Necessity

- 4.5.1 Medical necessity will be determined by judging what is reasonable and necessary with reference to accepted standards of medical practice and treatment of the individual's illness.
- 4.5.2 School based health services shall be determined medically necessary based upon the assessments and evaluations conducted and the prescribed care as found in the student's treatment plan. The treatment plan shall be developed by a multi-disciplinary team, or by an authorized therapist or other authorized medical professional and signed by treatment team members. The treatment plan should address the medical necessity for the identified service(s).
- 4.5.3 Although a physician signature is not required on the treatment plan, evidence of annual physician referral is required for physical therapy services.

4.6 Service Limitations and Exclusions

- 4.6.1 Except for limitations and exclusions listed below, Medicaid will reimburse for school based health services which conform to accepted methods of screening, assessment, diagnosis and treatment.
- 4.6.2 The following general service limitations shall apply:
- Treatment services are generally limited to a maximum of one session per day of the same type per child, with the exception of certain nursing services that may require repetitive sessions during the course of the day.
 - Reimbursement may be provided for covered services until a client attains age 21.
 - Covered services are generally limited to the types and amounts listed below: NOTE: One unit is equal to 15 minutes for all services except transportation. The unit of service for transportation is a round trip.
 - EPSDT Partial Assessment--Health Education - 4 units per year.

- EPSDT Partial Assessment--Immunization one unit per year.
- EPSDT Hearing Assessment--one unit per day/2 units per year.
- EPSDT Vision Assessment--one unit per day/2 units per year.
- EPSDT Partial Assessment--Developmental/orthopedic-one unit per year.
- EPSDT Dental Assessment--two units per year.
- EPSDT Dental Health Education--two units per year.
- Speech, Language, and Hearing Assessment--24 units per month.
- Individual Speech/Language Therapy--20 units per week.
- Individual Hearing Therapy--20 units per week.
- Group Speech/Language Therapy--20 units per week.
- Individual Speech/Language Co-Treatment Therapy--20 units per week.
- Individual Hearing Co-Treatment Therapy--20 units per week.
- Group Speech/Language Co-Treatment Therapy--20 units per week.
- Occupational Therapy Evaluation--12 units per six months.
- Individual Occupational Therapy Treatment--6 units per day.
- Group Occupational Therapy Treatment--6 units per day.
- Physical Therapy Assessment--12 units per six months.
- Individual Physical Therapy Treatment--6 units per day.
- Group Physical Therapy Treatment--6 units per day.
- Mental Health Treatment Assessment--25 units per year.
- Individual Mental Health Treatment Therapy--4 units per day/80 units per month.
- Group Mental Health Treatment Therapy--4 units per day/80 units per month.
- Family Mental Health Treatment Therapy--4 units per day/80 units per month.

- Individual Mental Health Co-Treatment Therapy--4 units per day/80 units per month.
- Group Mental Health Co-Treatment Therapy--4 units per day/80 units per month.
- Family Mental Health Co-Treatment Therapy--4 units per day/80 units per month.
- Mental Health Case Consultation--4 units per day/80 units per month.
- Individual Nursing Treatment--16 units per day.
- Transportation Services--one round trip per day.

4.6.3 Services billed that exceed these general limitations shall be "pending" until medical necessity is determined. Pending services shall not be reimbursed and shall be subject to review by representatives of the DMAP. If determined medically necessary, these services shall be reimbursed according to the established fee schedule.

4.6.4 The following services shall not be covered:

- Physical therapy services provided without physician referral.
- Services provided but not documented in the individual's treatment plan or student record. An exception to this is the provision of nursing and psychological services that are unplanned or emergency in nature.
- Services rendered which are not provided directly to the eligible individual or family member, or on behalf of the individual. Indirect services such as attendance at staff meetings, staff supervision, etc. are non-covered services.
- Canceled visits or appointments not kept.
- Services that are solely educational, vocational, or career oriented.
- Services which are solely recreational in nature.

5.0 Staff Authorized to Provide Services

5.1 Authorized Personnel

Covered services may be reimbursed only when the services are provided by appropriately qualified personnel in their respective discipline. The following covered services may be reimbursed:

- EPSDT screening services when provided by a State of Delaware licensed registered or practical nurse
- EPSDT hearing assessment when provided by a State of Delaware licensed registered or practical nurse, licensed speech-language pathologist, or a licensed audiologist
- EPSDT dental assessment when provided by a State of Delaware licensed dental hygienist
- EPSDT dental health education when provided by a State of Delaware licensed dental hygienist
- Speech, language, and hearing services when provided by a State of Delaware licensed audiologist holding a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), a State of Delaware licensed speech-language pathologist holding a CCC-SLP, or a State of Delaware licensed speech-language pathologist holding a temporary CCC-SLP under the supervision of a State of Delaware licensed speech-language pathologist holding a CCC-SLP.
- Occupational therapy services when provided by a State of Delaware licensed occupational therapist or a certified occupational therapist associate (COTA) under the supervision of a State of Delaware licensed occupational therapist
- Physical therapy services when provided by a State of Delaware licensed physical therapist or a State of Delaware licensed Physical Therapy Assistant under the supervision of a state of Delaware licensed physical therapist
- Mental health treatment assessment when provided by a State of Delaware licensed psychiatrist or psychologist, or a Delaware certified school psychologist

- Mental health treatment services when provided by a State of Delaware licensed psychiatrist or psychologist, a Delaware certified school psychologist, a State of Delaware licensed registered nurse or practical nurse, a State of Delaware licensed professional counselor of mental health, a State of Delaware licensed clinical social worker, or a masters of social work under the supervision of a licensed clinical social worker
- Nursing services when provided by a State of Delaware Licensed registered or practical nurse.
- Special transportation services when rendered by qualified providers according to the Department of Education's rules and regulations governing the transportation of school age children, and in particular children with special needs. Appropriate policies and procedures ensure the health, safety and welfare of children by addressing:
 - Insurance requirements
 - Licensing of individuals engaged in transporting children safety equipment
 - Vehicle condition and maintenance
 - Emergency procedures
 - Use of additional staff to accompany children with medical and/or behavioral conditions which could interfere with the safe transport of the passengers.

5.2 Billing for Staff Services

- 5.2.1 Billing is allowed only for services provided by staff who are professionally or clinically qualified to render services in their respective areas. Billing for services rendered by professional or clinical staff who do not meet the above credentials is not permitted.
- 5.2.2 Billing for professional or clinical personnel who are under contract is allowed providing the local school district assumes responsibility for the submission of claims and provides appropriate supervision of the contracted personnel.
- 5.2.3 Services may be billed for reimbursement only when provided by qualified professionals as described above.

6.0 Quality Assurance

6.1 Quality Assurance Activities

- 6.1.1 Each school district that participates as a Medicaid School Based Health Services provider shall conduct ongoing quality assurance activities. The purpose of the quality assurance activities is to ensure the fiscal integrity of the Medicaid School Based Health Services program.
- 6.1.2 The quality assurance activities shall reflect the overall approach to ensuring that the required documentation in support of service provision is available.
- 6.1.3 Each provider shall have the flexibility to develop quality assurance activities that meet the specific needs and expectations of the individual provider. However, the quality assurance activities, at a minimum, should address policies and procedures for the following:
- Assurance that health related and special education services are provided to any individual who is determined to be in need of services regardless of the student's or parent's financial status or Medicaid eligibility to pay for such services
 - Identification of Medicaid covered services that are provided by professional and/or clinical staff in the school district and identification of the manner in which these services shall be provided to Medicaid eligible individuals
 - Verification that required professional credentials and licensure of staff providing Medicaid covered services to Medicaid eligible individuals is in place
 - Verification that assessments and evaluations are generally rendered to students to determine type and level of need for services
 - Verification that treatment plans (IEP's) are developed for special needs children determined to be in need of school based health services
 - Verification that treatment plans are authorized by appropriately credentialed personnel and verification that referral for services by physicians exists, when necessary
 - Verification that services are appropriate and medically necessary, as defined by the DMAP.

- Verification that service provision is properly documented, including service records and case notes/progress notes, and the maintenance of service documentation
- Verification that provider personnel who do not meet State licensure requirements are "under the supervision" of qualified personnel
- Periodic reviews shall be conducted by the Education Associate—Cost Recovery Project to ensure that guidelines and requirements set forth in the quality assurance activities are followed
- The Local Cost Recovery Specialists shall be the individuals with primary responsibility for the administration of the quality assurance program

6.1.4 The provider may wish to seek assistance or advice from the State's Education Associate - Cost Recovery Project to ensure that the quality assurance plan developed by the provider meets the requirements for certification and participation in the Medicaid school based health services program.

6.2 Client Records

6.2.1 The provider's record keeping policies and procedures as they pertain to Medicaid eligibility and the provision and reimbursement of covered services shall be consistent with the DMAP's laws and regulations governing confidentiality of client information.

6.2.2 The provider shall have a continuing system for collecting and recording accurate data describing the individuals being served, and the services being provided, permitting easy retrieval and utilization of data for financial billing, utilization review, program evaluation, and State and Federal audit review.

6.2.3 The student's service record shall contain, but is not limited to, the following:

- Identifying data including name, address and phone number, sex, date of birth, next of kin, date of initial referral or assessment/evaluation, date of service initiation, and source of referral
- Date of most recent EPSDT screen
- Referral documentation by a physician or other health care professional
- Assessment, evaluation and testing reports

- Handicapping condition of the student and/or a diagnosis which has been determined using a recognized diagnostic system (e.g., ICD-9)
- An Individual Education Program, if the student is determined to need special education and related services
- A current treatment plan which sets forth the type, level and frequency of services provided to the student
- Progress notes and other relevant service documentation which denotes status of services and progress to identified service goals
- Documentation of each service rendered which describes the type of service(s) provided and the date the service(s) were provided
- Documentation supporting the discontinuation of services including treatment outcome(s) or referral for continued/enhanced services outside of the school based health services provider

6.3 Quality Assurance Monitoring

6.3.1 Each participating school district shall be responsible for implementing a quality assurance program consistent with the guidelines described in the Quality Assurance Activities section of this manual. The quality assurance program shall ensure that Medicaid reimbursable services are provided and appropriately reported in a manner consistent with the DMAP rules, procedures and laws.

6.3.2 Moreover, each participating school district shall establish a monitoring function which assures that the principles, standards and procedures applicable to Medicaid reimbursement for school based health services are followed and maintained. The monitoring process shall encompass the following objectives:

- To assess and evaluate the ongoing practices of the school based health services Medicaid reimbursement program to ensure compliance with certification and enrollment requirements
- To assist the school district in maintaining a system of accountability and reporting of school based health services
- To periodically review student records and financial billing records to ensure adequate documentation exists to

substantiate Medicaid claims

- To recommend and assist in the implementation of appropriate, necessary corrective actions so that Medicaid reimbursement will not be jeopardized
- To coordinate and report quality assurance and monitoring findings to Education Associate - Cost Recovery Project and the DMAP personnel, as appropriate

6.3.3 Each school based health services provider shall be assigned a Local Cost Recovery Specialist to assist the school district in establishing a quality assurance program and to monitor the effectiveness of the program. In addition, the Local Cost Recovery Specialist will periodically audit Medicaid required records and documentation.

6.4 Organizational Structure for Quality Assurance Monitoring

6.4.1 The responsibility for ensuring an effective school based health services quality assurance program is shared among several organizational levels. This responsibility is shared among:

- The DMAP - responsible for ensuring the overall, Statewide integrity of the school based health services program (as well as other Medicaid programs) through the establishment of policies and procedures, utilization reviews, and Medicaid audits.
- Education Associate - Cost Recovery Project - responsible for the coordination of a comprehensive, integrated quality assurance program and reporting process for all participating school based health services providers.
- Participating School Based Health Services Providers - responsible for the local level administration and functioning of the Medicaid school based health services program in each of its participating schools. Responsibility focuses on appropriate service provision rendered by qualified personnel, service documentation, and accurate billing records.
- Local Cost Recovery Specialist - responsible for the local level monitoring process of provider operating performance, service documentation and record maintenance, and billing procedures. The Specialist shall

also be responsible for the following:

- Performance auditing (e.g., service documentation, personnel qualifications, billing records)
- Quality assurance status reporting
- Corrective action recommendation and assistance
- Ongoing technical assistance to the local school based health services provider

6.4.2 It shall be the responsibility of designated personnel from the DMAP and the CSCRP to ensure that an effective statewide school based health services Medicaid program functions in Delaware. They shall also be responsible for the on-going communication with other organizational entities in support of an integrated, consistent quality assurance program.

6.5 Program/Clinical Review

Surveillance and Utilization Review System (SURS) staff of the DMAP shall monitor the program/clinical review for the school based health services program. They shall periodically review Medicaid eligible client records, treatment plan documentation, and service record documentation to determine the appropriate and effective utilization of Medicaid services. Determinations regarding the medical necessity of services shall also be performed by these Medicaid personnel.

6.6 Fiscal Reporting Reviews

6.6.1 In addition to the performance of program/clinical determinations, the quality assurance function also encompasses the accuracy of fiscal documentation and reporting. Key to this function is evidence of documentation to support a claim to Medicaid on behalf of a Medicaid eligible client.

6.6.2 In determining whether a Medicaid claim is valid, the following documents must be available for review:

- Evidence that an EPSDT assessment was performed on the child in the form of a notation in the child's health or other record and the referral for service(s), if appropriate
- If billing for an EPSDT assessment, a notation in the student's health or other record and signed by an authorized, qualified professional who performed the assessment, including the date of the service
- A treatment plan indicating the scope of service(s) to be provided, including the frequency and level of service(s),

signed by an authorized, qualified professional

- Evidence of service provision (e.g., service ticket) which notes student's name, the date of service, type of service, and number of units of service rendered, signed by a qualified professional
- At a minimum, monthly case/progress notes documenting the status of service provision, continued need for service, and impact of service on the student's health and well-being.
- A semi annual progress note, (no earlier than 4 months nor later than 8 months after the date of I.E.P/Treatment plan), which summarizes progress or lack thereof and documents the continued need for service.

6.6.3 The Local Cost Recovery Specialist may perform a fiscal review of the practices of a school based health services provider at any time. Ideally, these reviews shall be performed on a monthly basis with a representative sample of Medicaid claims verified.

6.6.4 It shall be the responsibility of the Local Cost Recovery Specialist to advise the provider of any irregularities or inappropriate practices identified during the fiscal review. The Local Cost Recovery Specialist shall also provide assistance to the provider to immediately correct any irregularities or modify provider practices so that the fiscal integrity of the program can be maintained.

6.6.5 Dependent upon the nature of the fiscal review findings, the Local Cost Recovery Specialist may also report his/her findings to the Education Associate - Cost Recovery Project and/or Medicaid program management.

6.7 Monitoring Process

6.7.1 As noted above, the Local Cost Recovery Specialist is responsible for the day-to-day monitoring of the school based health service provider practices. This monitoring process may be either an informal process with periodic spot-reviews of client and service records, or a more formal review of the treatment plans, service records, case documentation, and billing forms. Either type of review may include document review, interviews with provider personnel, and analysis of claims history data.

6.7.2 Initially, the Local Cost Recovery Specialist will review all service records for which a Medicaid claim is to be submitted. This 100% review of service records will be a prospective review (i.e., performed prior to the submission of a Medicaid claim) and will be performed on a monthly basis.

6.7.3 Based upon the recommendation of the Local Cost Recovery Specialist and agreed upon by the Education Associate - Cost Recovery Project, the sample size may be reduced and/or the review may be performed retrospectively. The degree and frequency of on-site monitoring shall be a function of the findings and outcomes of the earlier monitoring reviews.

6.7.4 It shall be the responsibility of the Local Cost Recovery Specialist to advise other pertinent organizational entities or individuals of the findings of the periodic monitoring reviews as deemed appropriate. At all times, however, the Local Cost Recovery Specialist should keep the local school district coordinator (for school based health services) advised of the monitoring activities and review results.

6.8 Technical Assistance

6.8.1 Based upon the findings of the periodic monitoring reviews performed by the Local Cost Recovery Specialist, technical assistance may be provided to the school based health services provider. The nature of the problems and/or deficiencies noted shall determine the level and type of technical assistance.

6.8.2 In all cases where formal technical assistance is determined necessary, the Local Cost Recovery Specialist shall develop a plan of action which identifies:

- The nature of the problem or the area of deficiency, including extent of the problem/deficiency
- The recommended corrective action with specific activities to improve performance in the noted area
- Personnel involved in the correction of the problem area (e.g., Local Cost Recovery Specialist, Special Education Director, occupational therapist, local school district coordinator)
- Additional resources needed to take corrective action
- Estimated timetable to complete corrective action
- Intermittent reviews necessary to assess progress of corrective action

6.8.3 The technical assistance plan shall be reviewed with the local school district coordinator for the school based health services program. As deemed necessary, the Local Cost Recovery Specialist may forward a copy of the technical assistance plan to the Education Associate - Cost Recovery Project for review.

6.8.4 In addition to formal technical assistance, the Local Cost Recovery Specialist may determine that less structured assistance regarding minor problems or

deficiencies is more appropriate. This type of technical assistance shall be based upon the individual needs of the school, practitioner, or other personnel from the school district. Informal technical assistance may include brief meetings with pertinent individuals, training sessions with a group or on a one-to-one basis, or a modification to an existing procedure.

7.0 Reimbursement and Billing Procedures

The DMAP shall adjudicate claims for a covered service provided to an eligible client or to a person who is later found to be eligible at the time he or she received the service according to timely filing and general service limitations indicated by the DMAP. To be eligible for payment, a service must:

- Be determined by prevailing community standards or customary practice and usage to:
 - Be medically necessary
 - Be appropriate and effective for the medical needs of the individual
 - Meet quality and timeliness standards
 - Be the most cost-effective health service available for the medical needs of the individual
- Represent an effective and appropriate use of DMAP funds
- Be within the service limits as specified in the Services Limitation & Exclusion section or Appendix B of this manual.
- Be personally furnished by qualified personnel types as specified in Section 5.0, Staff Authorized to Provide Services, of this manual.

Enrolled providers of school based health services may bill Medicaid for covered services using the locally assigned HCPCS procedure codes that appear in Appendix B of this manual.

7.1 Reimbursement

- 7.1.1 All services are provided on a one to one basis unless group or family services are specified in the treatment plan. Provision of services shall be consistent with information contained in the individual's treatment plan and/or IEP, as appropriate. Services not specified in the treatment plan of care shall not be reimbursed unless the services are emergency in nature or are specific nursing services which do not require a plan of care (e.g., EPSDT screen).
- 7.1.2 The date of service entered on the claim must be the date the service was actually provided to the individual or the evaluation was completed on the individual.
- 7.1.3 It is a requirement that claims to Medicaid be submitted no later than twelve (12) months from the date of service. If the date of service is over one year old, the

claim for reimbursement will be denied. The provider should refer to the General Policy for additional information regarding claims submission and timeliness.

7.2 Billing Procedures and Claims Submission

7.2.1 School based health services providers may elect to bill Medicaid for reimbursement either manually or electronically (i.e. electronic claims submission). Providers may bill for any of the allowed services listed in Appendix B for eligible clients.

7.2.2 Providers are encouraged to submit claims for reimbursement (either manual billing forms or electronic claims submission) promptly and on a regular basis. Billing must be suspended for any service for which a progress note is not received within one month of due date. Billing must also be suspended for any service for which an annual assessment is not received within 3 months of due date. Billing may resume when documents are received.

7.3 Records Maintenance

7.3.1 As described in Section 2.0 of this manual the provider is responsible for maintaining records to substantiate a Medicaid claim. At a minimum, the records must be auditable and contain the following information on each eligible client:

- The date of service
- The individual's presenting problem (diagnosis)
- Referral and/or authorization for services
- Treatment/services rendered
- The specific amount, duration and type of service provided by a qualified professional/clinician.

7.3.2 These records should be retained for a minimum of five (5) years in order to comply with all State and Federal regulations and laws.

7.3.3 If a provider's records do not substantiate services paid for under the DMAP, as previously noted, the provider will be asked to refund to the DMAP any money received from the program for such non-substantiated service.



Application for Certification

8.0 Appendix A - Application for Certification

Cover page should include the following:

CERTIFICATION APPLICATION

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROVIDER

SCHOOL BASED HEALTH SERVICES

**NAME OF SCHOOL DISTRICT
ADDRESS
TELEPHONE NUMBER**

SECTION I SCHOOL DISTRICT ORGANIZATIONAL STRUCTURE

Provider Contract

Number of schools in district

**Student population - Total plus noting the number of students
with a defined handicapping condition or speech disorder**

**List of professionals under the Provider Contract's supervision
and description of supervision of nurses and other practitioners**

**Separate page listing alphabetically the schools, addresses and
telephone numbers**

Separate page showing District Organizational Chart

APPENDIX A**APPLICATION FOR CERTIFICATION
(Continued)****SECTION II RECORD MAINTENANCE**

- A. Nursing Services**
- B. Psychological and Counseling Services**
- C. Speech, Language and Hearing Services**
- D. Occupational Therapy**
- E. Physical Therapy**
- F. Transportation**

A through F should include student specific identifying information, amount of service, date of service and signature of provider. All records must be maintained for a period of at least five (5) years.

SECTION III PRACTITIONER CREDENTIALS**A. Practitioner License**

List of the names, license numbers and school assignment for practitioners for whom reimbursement will be sought.

SECTION IV QUALITY ASSURANCE

- A. Assurances that the “School Based Health Services Provider Certification and Policy Manual” will be followed.**
- B. Identification of subcontracted services and description of monitoring to assure that Medicaid procedures and guidelines are adhered to regarding billing and record maintenance.**

APPENDIX A

**APPLICATION FOR CERTIFICATION
(Continued)**

SECTION V APPROVAL OF SERVICES

a. Identify services for which reimbursement will be sought:

_____ **EPSDT Screens**

_____ **Dental Hygiene Services**

_____ **Nursing Services**

_____ **Occupational Therapy Services**

_____ **Physical Therapy Services**

_____ **Psychological and Counseling Services**

_____ **Speech, Language, and Hearing Services**

_____ **Transportation**

b. Signature – School District

**PROVIDER
NAME
TITLE**

DATE

c. Approval – Department of Health and Social Services

Medicaid Certification #

**EPSDT ADMINISTRATOR
NAME**

DATE

This page intentionally left blank.



Codes and Descriptions of School Based Health Services

9.0 Appendix B – Codes and Descriptions of School Based Health Services

The following codes are only used for EPSDT School Based Services for services provided for eligible Medicaid clients ages 0 through 20.

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW900	Hearing assessment	V5008	Hearing screening
WW901	Vision assessment	99173	Screening test of visual acuity, quantitative, bilateral
WW902	Immunization assessment-	S5190	Wellness assessment, performed by non-physician
WW903	Development/orthopedic assessment	T1001	Nursing assessment/evaluation
WW904	Dental assessment	99401	Preventive medicine counseling and /or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
		99402	Approximately 30 minutes
		99403	Approximately 45 minutes
		99404	Approximately 60 minutes
WW905	Health education assessment	S9445	Patient education, not otherwise classified, non-physician provider, individual, per session
WW906	Dental health education	99401	Preventive medicine counseling and /or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW910	Individual nursing treatment	T1002	RN services, up to 15 minutes
WW920	Occupational therapy evaluation	97003	Occupational therapy evaluation
WW921	Occupational therapy treatment	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
WW922	Group occupational therapy treatment	97150+ GO mod.	Therapeutic procedure(s), group (2 or more individuals)
WW930	Physical therapy assessment	97001	Physical therapy evaluation
WW931	Individual physical therapy treatment	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
WW932	Group physical therapy treatment	97150 + GT mod.	Therapeutic procedure(s), group (2 or more individuals)
WW936	ICT placement for O-O-S RTC-based behavioral therapy, Level 1	H2020 + U1 mod.	Therapeutic behavioral services, per diem
WW937	ICT placement for O-O-S RTC-based behavioral therapy, Level II	H2020 + U2 mod	Therapeutic behavioral services, per diem
WW938	ICT placement for O-O-S RTC-based behavioral therapy, Level III	H2020 + U3 mod	Therapeutic behavioral services, per diem
WW939	ICT placement for O-O-S RTC-based behavioral therapy, Level IV	H2020 + U4 mod	Therapeutic behavioral services, per diem
WW940	Mental health treatment assessment	H0031	Mental health assessment, by non-physician

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW941	Individual mental health treatment therapy	90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
		90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
		90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.
WW942	Group mental health treatment therapy	90853	Group psychotherapy (other than of a multiple-family group)
WW943	Family mental health treatment therapy	90847	Family psychotherapy (cojoint psychotherapy) (with patient present)

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW944	Individual mental health co-treatment therapy	90810 + HT mod.	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
		90812 + HT mod.	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
		90814 + HT mod.	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.
WW945	Group mental health co-treatment therapy	90853 + HT mod.	Group psychotherapy (other than of a multiple-family group)

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW946	Family mental health co-treatment therapy	90847 + HT mod.	Family psychotherapy (couo8int psychotherapy) (with patient present)
WW947	Mental health case consultation	H0032	Mental health service plan development by non-physician
WW948	AuClair behavioral therapy,	H2018	Psychosocial rehabilitation services, per diem
WW950	Speech, language and hearing assessment	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
WW951	Individual speech/language therapy	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
WW952	Individual hearing therapy-20 units per week	V5299	Hearing service, miscellaneous
WW953	Group speech/language therapy	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group
WW954	Individual speech/language co-treatment therapy-	92507 + HT mod.	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
WW955	Individual hearing co-treatment therapy	V5299 + HT mod.	Hearing service, miscellaneous

Code/Description (To be used for dates of services through 6/30/03)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW956	Group speech/language co-treatment	92508 + HT mod.	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group
WW960	Transportation-one round trip per day	T2002	Non-emergency transportation, per diem

Modifier	Definition
GO	Services delivered under an outpatient occupational therapy plan of care
GT	Via interactive audio and video telecommunication system
U1	Level I
U2	Level II
U3	Level III
U4	Level IV
HT	Multi-disciplinary team