

	School Based Health Services Provider Specific Revision Table
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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.
10/20/05	5.1	Language is being added to clarify the description of personnel authorized to provide mental health treatment services.
3/6/06	2.5.3	Revision of the time frame for completion of a progress note.
6/21/06	4.2.2.4, 4.2.3.4, 4.2.4.4, 4.2.5.4, 4.3, 7.2.2	Revision of the time frame for completion of a progress note reflected throughout the manual.
4/8/09	7.0	Clarified billing with example chart
4/16/09	7.0	Clarified the description which introduces the newly added billing example chart.
11/11/09	9.0 – Appendix B	Added code G9008 to Appendix B – Codes and Descriptions of School Based Health Services.
2/25/13	4.6.2	Update and clarification in reference to general service limitations.
2/25/13	4.6.3	Revised language to comply with CMS regulations and NCCI edits.
5/19/13	9.0	Added language for code 97150 + GT modifier as it is no longer in use after 6/30/2012. Added language for code 97150 + GP modifier to be used for services on or after 7/1/2012. Added language to codes 90810, 90812, 90814, 90810 + HT modifier, 90812 + HT modifier, and 90814 + HT modifier as these codes are no longer in use after 12/31/2012. Added language for codes 90832, 90834, 90837, 90832 + HT modifier, 90834 + HT modifier and 90837 + HT modifier to be used for services on or after 01/01/2013.
04/01/2016	All	Manual revision to include, language added to clarify signature requirements, updated policy to reflect Random Moment Time Study (RTMS) CMS compliance, and universal language change from client to member.

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Table of Contents

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 Member 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 Member 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 Random Moment Time Study

- 8.1 What is RMTS
- 8.2 Time Study Participants
- 8.3 Time Study Compliance
- 8.4 CSCRP Medicaid Cost Reconciliation Process

9.0 Appendix A - Application for Certification

10.0 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 member 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 must 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 recipients. 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 whereby 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 member 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 Member- 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.
- 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 member requesting the services.
- 1.3.9 Provider Agency (also Provider) - refers to a person or organization of individual providers who has been certified and enrolled by DHSS to provide services to members 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 dictated by current legislation. EPSDT providers are not limited to those who are qualified to provide the full range of medical, vision, and hearing services Reimbursement may only be made when providers meet the eligibility qualifications.
- 1.4.3 To receive payment for EPSDT services provided to Medicaid members, 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 participate in EPSDT must enroll for the specific screening service or combination of screening services or health services they 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 shall 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 participate as follows:

- Compliance with current licensure by the appropriate State authority for the individual provider'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 members than is charged on the usual and customary 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 member or parent/guardian for any unpaid portion of a bill.
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the 1964 Civil Rights Action, Section 504 of the Rehabilitation Act of 1973 and, if applicable Title VII of the 1964 Civil Rights Act.

1.5.2 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.

1.5.3 School Based Health Services Program requires that medical record entries for services provided/ordered be authenticated by the author. The method used must either hand written or an electronic signature. Stamp signatures are not acceptable. Patient identification, date of service, and the provider of the service must be clearly identified on the submitted documentation.

Acceptable methods of signing records/test orders and findings include:

- Handwritten
- Electronic
 - Electronic signatures usually contain date and timestamps and include printed statements (e.g., 'electronically signed by' or 'verified/reviewed by') followed by the practitioner's name and preferably a professional designation. Note that the responsibility and authorship related to the signature should be clearly defined in the record.
 - Digital signatures are an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage.

Note: Be aware that electronic and digital signatures are not the same as 'auto-authentication' or 'auto-signature' systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been 'Signed but not read' are not acceptable.

2.0 Provider Participation and Requirements

2.1 Provider Eligibility

- 2.1.1 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 IEP or in the school health program.
 - Each individual provider 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 individual provider 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 In order for a school district to become a school based health services provider, it 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/or IEPs 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 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 participate in the DMAP must also apply for enrollment as a school based health services provider. The Provider Enrollment Application is located on the DMAP website. Prospective providers should contact DMAP's fiscal agent with questions related to the enrollment application. 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), are to be submitted to the DMAP's fiscal agent.

2.3 Notification of Enrollment Status

The applicant and/or designee will receive written notification from the fiscal agent of the acceptance of the 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; and
- 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 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 members 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 member:

- 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 update/summary documented in written format including narrative information summarizing the child's status and the continuing need for treatment;
- A treatment plan and/or IEP 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 and/or IEP is required annually. A progress note is required approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. An IEP must be developed within 60 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; and
- Parental consent to release information and to access public benefits or insurance for special education and related services.

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 is required to 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 is required to 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 will be monitored. Should a provider be found to be non-compliant, Medicaid enrollment may be suspended or terminated, 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 (CSCRP) 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/or IEPs and case/progress notes
- Individual provider's Service 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 and reduce fraud waste and abuse. 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; and
 - 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; and
- 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.

2.9

Refer to Appendix A – Appeal Procedures of the General Policy Manual for Appeal Procedures for adverse actions for providers under the State of Delaware Medical Assistance Program.

3.0**Member 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 members 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 member , but for whom eligibility cannot be established should be considered ineligible until proven otherwise.

4.0 Services and Programs

4.1 Availability

School based health services are 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 member 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:
 - Medically necessary;
 - Appropriate and effective for the medical needs of the individual;
 - Meet quality and timeliness standards; and
 - Most cost-effective health service available for the medical needs of the individual.
- Represent an effective and appropriate use of DMAP funds
- Within the service limits specified by the DMAP
- 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; and
 - Periodontal problems.

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 and or IEP Requirements
Treatment plans and/or IEPs for assessment services are not required. Rather, documentation is required if the member 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 and be included as a related service in the IEP/Treatment Plan:

- 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 an individual 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 and/or IEP Requirements

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

A progress note is required approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. The progress note must:

- Indicate where the student is in relation to the treatment plan and/or IEP goals
- Indicate if the treatment plan and/or IEP 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: 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.

Occupational Therapy 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 and be included as a related service in the IEP/Treatment Plan:

- 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.

The type and level of treatment services are a direct outcome of the assessment.

Service options may include:

Direct Service

Frequent contact with the student to help the student effectively meet demands within current and anticipated educational environments. This may include but not limited to: self-care, physical, social, emotional, academic.

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 an individual 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 assessment
- 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 and/or IEP Requirements

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

A progress note is required approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. The progress note must:

- Indicate where the student is in relation to the treatment plan and/or IEP goals
- Indicate if the treatment plan and/or IEP 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 and be included as a related service in the IEP/Treatment Plan:

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

Physical Therapy 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 an individual 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 and/or IEP Requirements

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

A progress note is required approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. The progress note must:

- Indicate where the student is in relation to the treatment plan and/or IEP goals
- Indicate if the treatment plan and/or IEP 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. The services must be included as a related service in the IEP/Treatment Plan:

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 and/or IEP Requirements

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

A progress note is required approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. The progress note must:

- Indicate where the student is in relation to the treatment plan and/or IEP goals
- Indicate if the treatment plan and/or IEP 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

4.2.6.1 The school-based health nursing service(s) (with the exception of Nursing Assessment services) provided to the child must be included in the child's treatment plan and/or IEP.

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 or caregiver and the location where school based health services are provided to children with special needs. The locations are 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 and/or IEP Requirements**

Both the school-based health service(s) provided to the child and the special transportation service must be included in the child's treatment plan and/or 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 treatment plan and/or IEP documenting the need for the specific therapy, treatment or transportation service and nursing services (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 an individual provider 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 member specific, date specific format.

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 individual provider performing the service
- Record including the name(s) of the individual provider(s) actually providing the service(s)
- The treatment services are part of the student's written treatment plan and/or IEP on file with the participating local school district. Exceptions to this include emergency mental health treatment services. The treatment plan and/or IEP, as developed by the respective therapist(s), are subject to review by authorized DMAP personnel. The treatment plan and/or IEP 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
 - o 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 and/or IEP must be maintained in the eligible individual's record(s) 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 will 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 must be determined medically necessary based upon the assessments and evaluations conducted and the prescribed care as found in the student's treatment plan and/or IEP. The treatment plan and/or IEP will be developed by a multi-disciplinary team, or by an authorized therapist or other authorized medical professional and signed by treatment team and/or IEP members. The treatment plan and/or IEP should address the medical necessity for the identified service(s).
- 4.5.3 Although a physician signature is not required on the treatment plan and/or IEP, evidence of annual physician referral is required for physical therapy treatment 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 apply:

- Treatment services are generally limited to a maximum of one session per day of the same type per child, Reimbursement may be provided for covered services until a member 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 - 1 unit per occurrence
 - EPSDT Partial Assessment, Immunization - 2 units per year
EPSDT Hearing Assessment - 1 unit per day/2 units per year
 - EPSDT Vision Assessment -1 unit per day/2 units per year
 - EPSDT Partial Assessment, Developmental/Orthopedic - 2 units per year
 - EPSDT Dental Assessment - 2 units per year
 - Speech, Language, and Hearing Assessment - 1 unit per day
 - Individual Speech/Language Therapy - 1 unit per day
 - Individual Hearing Therapy - 1 unit per day
 - Group Speech/Language Therapy - 1 unit per day
 - Individual Speech/Language Co-Treatment Therapy - 1 unit per day
 - Individual Hearing Co-Treatment Therapy - 1 unit per day
 - Group Speech/Language Co-Treatment Therapy - 1 unit per day
 - Occupational Therapy Assessment - 1 unit per day
 - Individual Occupational Therapy Treatment - maximum 6 units per day
 - Group Occupational Therapy Treatment -1 unit per day
 - Physical Therapy Assessment - 1 unit per day
 - Individual Physical Therapy Treatment - maximum 6 units per day
 - Group Physical Therapy Treatment - 1 unit per day
 - Mental Health Treatment Assessment – 1 unit per complete assessment
 - Individual Mental Health Treatment Therapy - 1 unit per day
 - Group Mental Health Treatment Therapy - 1 unit per day

- Family Mental Health Treatment Therapy - 1 unit per day
- Individual Mental Health Co-Treatment Therapy - 1 unit per day
- Group Mental Health Co-Treatment Therapy - 1 unit per day
- Family Mental Health Co-Treatment Therapy - 1 unit per day
- Mental Health Case Consultation - 1 unit per day
- Individual Nursing Treatment - 4 units per day
- Transportation Services - 1 round trip per day

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

4.6.4 The following services will not be covered:

- Physical therapy services provided without physician referral.
- Services provided but not documented in the individual's treatment plan and/or IEP or student record. An exception to this is the provision of 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 licensed registered or practical nurse
- EPSDT hearing assessment when provided by a State licensed registered or practical nurse, State of Delaware licensed speech-language pathologist, or a State of Delaware 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 State of Delaware Certified Occupational Therapy Assistant (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 (PTA) 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 Delaware licensed 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 licensed registered nurse, a State of Delaware licensed professional counselor of mental health, or a State of Delaware licensed clinical social worker. Mental health treatment services may also be provided by a masters of social work, a masters of clinical psychology or a masters of counseling when these providers are practicing under the supervision of a licensed psychologist, a licensed clinical social worker, or a Delaware certified school psychologist.
- Nursing services when provided by a State Licensed registered nurse or Licensed 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
 - 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 as a Medicaid School Based Health Services provider will 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 must reflect the overall approach to ensuring that the required documentation in support of service provision is available.
- 6.1.3 Each provider will 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 will be provided to Medicaid members
 - 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 and/or IEP are developed for special needs children determined to be in need of school based health services
 - Verification that treatment plans and/or IEP 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 will 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 are designated to 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 Member 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 must be consistent with the DMAP's laws and regulations governing confidentiality of member information.

6.2.2 The provider is required to 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 must 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 codes)
- An Individual Education Plan, if the student is determined

to need special education and/or related services

- A current treatment plan and/or IEP 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 school district is 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 must 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 school district is responsible to 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 must 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 will 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.
 - 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 monitor the program/clinical review for the school based health services program. They periodically review Medicaid member records, treatment plan and/or IEP documentation, and service record documentation to determine the appropriate and effective utilization of Medicaid services. Determinations regarding the medical necessity of services are 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 member.

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 and/or IEP 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.

6.6.3

A semi-annual progress note is required approximately 6 months or at a reasonable interval after the meeting date of the IEP/Treatment Plan to document the student's progress. The progress note must summarize progress or lack thereof and document the continued need for service. 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 are performed on a monthly basis with a representative sample of Medicaid claims verified.

- 6.6.4 It is 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 also provides 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 member and service records, or a more formal review of the treatment plans and/or IEPs, 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 will be a function of the findings and outcomes of the earlier monitoring reviews.
- 6.7.4 It is 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 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 will 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, individual provider 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 will 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 is based upon the individual needs of the school, individual provider, 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 will adjudicate claims for a covered service provided to a Medicaid member 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 and/or IEP. Provision of services must be consistent with information contained in the individual's treatment plan and/or IEP, as appropriate. Services not specified in the treatment plan and/or IEP will not be reimbursed unless the services are emergency in nature (Mental Health) or are specific nursing services which do not require a plan of care (e.g., EPSDT screen). 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.

7.1.2

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. Providers may bill for any of the allowed services listed in Appendix B for eligible members. Refer to the General Policy Manual and the General Billing Policy Manual for requirements related to billing and claims submission.
- 7.2.2 Providers are encouraged to submit claims for reimbursement promptly and on a regular basis. Billing must be suspended for any service for which a progress note is not submitted approximately six months after the date of the IEP/Treatment Plan or at a reasonable interval to document the student's progress and the continuing need for service. 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 Medicaid member:
- 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 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 money received from the program for such non-substantiated service.

8.0 Random Moment Time Study (RMTS)

8.1 What is RMTS

The random moment time study (RMTS) methodology measures the work effort of the entire group of approved staff involved in the school district medical and health-related services program by sampling and analyzing the work efforts of a cross-section of the group. RMTS methods employ a technique of polling employees at random moments over a given time period and tallying the results of the polling. The method provides a statistically valid means of determining what portion of the selected group of staff's workload is spent performing activities that are reimbursable by Medicaid under the FFS (Fee-For-Service) and MAC (Medicaid Administrative Claiming) program.

The process is designed to be as quick and unobtrusive to the district selected participants as possible. Each calendar quarter, a portion of the statewide pool of selected employees and contractors will be identified to participate in the RMTS time study. For each employee selected, one or more moments will be generated indicating the specific date and time that the employee is to be surveyed, or "sampled". Selected employees may be sampled more than once during a given quarter. Moments will be distributed to each participant via e-mail along with a username and password to the web-based RMTS system. At the specified date and time, the employee will be expected to complete the RMTS questions. The answers will then be categorized by the RMTS vendor once the quarter is complete.

8.2 Time Study Participants

The purpose of the State of Delaware school-based services time study is to identify allowable Medicaid direct service and administrative costs within a given LEA by having staff members who spend their time performing those activities participate in a quarterly time study. This information will be used to enable the State of Delaware to conduct a cost settlement at the end of the fiscal year.

Only certain LEA staff and contractors may be included in the RMTS. In order to optimize the effectiveness and accuracy of the time study it is important that all appropriate staff are selected to participate and that inappropriate staff are omitted. Review the following guidelines carefully to select your district's participants:

1. Time study participants may be any direct employees of the school district, contract employees, part time employees, temporary employees and any other category of individuals receiving pay from the school district. This does not include individuals such as parents or other volunteers who receive no compensation for their work or in-kind contributions.

2. Generally, school district employees or contract staff with, but not limited to, the job titles listed below may be included in time studies. Clerical staff, supervisory staff, educational instructors (general education and special education), and administrators who provide direct support exclusively to time study participants usually do not participate in time studies

Direct Service Cost Pool

- Audiologists / Assistants
- Behavioral Health Providers /
- Occupational Therapists / Assistants
- Physical Therapists / Assistants
- Psychologists and Interns
- Speech-Language Pathologists / Assistants
- Counselors / Social Workers

Nursing Cost Pool

- Nurses / School Health Staff

Administrative Service Providers Cost Pool

These providers may perform administrative claiming activities only.

- School Administrators – Principals and Assistant Principals.
- State Certified Counselor
- Non-certified Psychologist/Psychologist Interns
- Non-certified Social Worker
- Psychologist Intern
- Special Education Administrator
- School Bilingual Assistant
- Speech Language Pathologist (Non-Masters Level and Non-Licensed)
- Program Specialist
- Other groups/individuals that may be identified by the LEA

3. LEAs should only include vacant positions if they are confident that the position will be filled before the commencement of the quarter. The same holds true for contracted employees obtained through an agency. For example, during the summer quarter, if your district uses a speech therapist from a contractor, but you do not have the individuals name by the time the roster is due, you can put the name of the agency in the first name cell. If the position is vacant, the word "vacant" will go in the first name cell. If you do not believe the position will be filled before the quarter commences, you should not include the individual on the roster.

8.3**Time Study Compliance**

DEDOE will assure a response rate for the time study survey of at least eighty-five percent (85%). To assist in reaching the goal of eighty-five percent (85%) compliance, DEDOE will monitor the providers to ensure they are properly returning sample moments.

DEDOE will gather as much information as possible from the CSCR Program RMTS Coordinators or time study participants to explain the reasons the non-returned moments were unanswered. Both entities will then analyze this data to ensure that the non-returns are reflective of the time study results. This data will not be included in the claiming process but will be used only to ensure that providers are not purposely withholding non-Medicaid related moments.

8.4**CSCR Medicaid Cost Reconciliation Process**

CSCR participating providers will submit fee for service claims on an interim basis to DMMA for medical services rendered, according to the guidelines in the DMAP School Based Health Services Provider Specific Policy Manual. At the end of each year, each provider will submit a cost report that uses actual annual costs, time study results, and the IEP Ratio in order to perform a reconciliation of claims to cost and to complete the cost settlement process as outlined in Attachment 4.19-B Other EPSDT Services of the State of Delaware Medicaid State Plan.

The CSCR Medicaid cost reconciliation process will use an IEP Ratio as one of the steps in determining total allowable costs, as described in Section 4.19-B of the State of Delaware Medicaid State Plan. The IEP Ratio will be determined for each participating district (i.e. Medicaid Provider). When applied, this IEP Ratio will discount the direct service cost pool by the percentage of IEP Medicaid students. The names and birthdates of students with a health related IEP will be matched to the children identified as Medicaid eligible. The numerator of the rate will be the students with an IEP that are eligible for Medicaid and the denominator will be the total number of students with an IEP.

A special procedure will be used for the cost reconciliation and cost settlement applicable to SFYs 2009 and 2010. Within 60 days after the end of the second quarter of time study implementation, DEDOE will derive results from two quarters of the CMS approved time study and apply these results to the FY2009 and 2010 cost report data to determine the final reconciled costs allowable for FYs 2009 and 2010. Final cost settlement of the 2009 and 2010 cost reports will be completed within 120 days from the receipt of the time study results.



Application for Certification

9.0

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 individual providers

**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 years.

SECTION III**INDIVIDUAL PROVIDER CREDENTIALS****A. Individual Provider License**

List of the names, license numbers and school assignment for individual providers 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

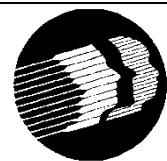
PROVIDER**NAME****TITLE**

DATE**c. Approval – Department of Health and Social Services**

Medicaid Certification #

EPSDT ADMINISTRATOR**NAME**

DATE



Codes and Descriptions of School Based Health Services

10.0 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 Medicaid members ages 0 through 20.

Code/Description (To be used for internal billing purposes)		Code/Description (To be used for dates of service on and after 7/1/03)	
G9008	Coordinated care fee, physician coordinated care oversight services. (Used for First State School program per diem rate.)	G9008	Coordinated care fee, physician coordinated care oversight services. (Used for First State School program per diem rate.)
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 99402 99403 99404	Preventive medicine counseling and /or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes Approximately 30 minutes Approximately 45 minutes Approximately 60 minutes
WW905	Health education assessment	S9445	Patient education, not otherwise classified, non-physician provider, individual, per session

Code/Description (To be used for internal billing purposes)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW910	Individual nursing treatment	T1002	RN services, Maximum 4 units per day
WW920	Occupational therapy evaluation	97003	Occupational therapy evaluation – 1 unit per assessment date
WW921	Individual 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 –Maximum 6 units per day
WW922	Group occupational therapy treatment	97150+ GO mod.	Therapeutic procedure(s), group (2 or more individuals) – 1 unit per day
WW930	Physical therapy assessment	97001	Physical therapy evaluation – 1 unit per assessment date
WW931	Individual physical therapy treatment	97110	Therapeutic procedure, one or more areas.; therapeutic exercises to develop strength and endurance, range of motion and flexibility – Maximum 6 units per day
WW932	Group physical therapy treatment	97150 + GT mod.	Therapeutic procedure(s), group (2 or more individuals) – 1 unit per day
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 – 1 unit per full assessment

Code/Description (To be used for internal billing purposes)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW941	Individual mental health treatment therapy	90832 90834 90837	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 0-30 minutes face-to-face with the patient. Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 31-45 minutes face-to-face with the patient. Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 46+minutes face-to-face with the patient.
WW942	Group mental health treatment therapy	90853	Group psychotherapy (other than of a multiple-family group) – 1 unit per day
WW943	Family mental health treatment therapy	90847	Family psychotherapy (co-joint psychotherapy) (with patient present) - 1 unit per day

Code/Description (To be used for internal billing purposes)		Code/Description (To be used for dates of service on and after 7/1/03)	
WW944	Individual mental health co-treatment therapy	90832+ HT mod. 90834+ HT mod. 9 90837 + 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 0 to 30 minutes face-to-face with the patient. – 1 unit per day Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 31-45 minutes face-to-face with the patient. – 1 unit per day Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 46+ minutes face-to-face with the patient. – 1 unit per day
WW945	Group mental health co-treatment therapy	90853 + HT mod.	Group psychotherapy (other than of a multiple-family group) – 1 unit per day

Code/Description (To be used for internal billing purposes)		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 (co-treatment psychotherapy) (with patient present) – 1 unit per day
WW947	Mental health case consultation	H0032	Mental health service plan development by non-physician– 1 unit per day
WW948	AuClair behavioral therapy,	H2018	Psychosocial rehabilitation services, per diem
WW950A	Speech, language and hearing assessment	92521	Evaluation of speech fluency (eg, stuttering, cluttering) – 1 unit per assessment date
WW950B	Speech, language and hearing assessment	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
WW950C	Speech, language and hearing assessment	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
WW950C1	Speech, language and hearing assessment	9253-52	Evaluation of speech sound production (eg, receptive and expressive language)
WWW950D	Speech, language and hearing assessment	92524	Behavioral and qualitative analysis of voice and resonance
WW951	Individual speech/language therapy	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual– 1 unit per day
WW952	Individual hearing therapy-	V5299	Hearing service, miscellaneous– 1 unit per day
WW953	Group speech/language therapy	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group– 1 unit per day
WW954	Individual speech/language	92507 +	Treatment of speech,

	co-treatment therapy-	HT mod.	language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual– 1 unit per day
WW955	Individual hearing co-treatment therapy	V5299 + HT mod.	Hearing service, miscellaneous– 1 unit per day
WW956	Group speech/language co-treatment	92508 + HT mod.	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group– 1 unit per day
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