



KENTUCKY SCHOOL-BASED SERVICES TECHNICAL ASSISTANCE GUIDE

Effective August 1, 2022

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**Kentucky Department for Medicaid Services
in collaboration with the Kentucky Department of Education**



**CABINET FOR HEALTH
AND FAMILY SERVICES**

UPDATES

August 15, 2022	Removed CPT code 99201. This code had been removed in the January 2022 edition of the TAG and was reinserted in error.
November 18, 2022	Corrected error in Expanded Access for LMFT modifier by changing to HO.

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About this Guide

This publication takes effect August 1, 2022, and supersedes earlier Technical Assistance Guides (TAG).

The Department for Medicaid Services (DMS) means the public health insurance programs for eligible Kentucky residents. DMS is the name used in Kentucky for Medicaid, the Kentucky Children's Health Insurance Program (KCHIP), and state-only funded health care programs.

Kentucky Medicaid identifies school-based health services (SBHS) as Provider Type 21. To enroll and bill Kentucky Medicaid, a SBHS provider must be a local school district enrolled as a Medicaid health service provider for beneficiaries eligible under the Medicaid program through the Kentucky Department of Education.

Under the Medicaid SBHS program, local education agencies in Kentucky, that enroll as a Medicaid health service provider, may provide medically necessary services for all Medicaid eligible children including children who qualify under the Medicaid program and under the Individuals with Disabilities Education Improvement Act (IDEA).

DMS is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please email Erica.davis@ky.gov. For those who have hearing or speech disabilities, please call 711 for relay services.

Program Overview

The purpose of this billing guide is to provide program policy and guidance to contracted school districts in order to successfully implement and maintain the School-Based Health Care Services (SBHS) program to receive Medicaid reimbursement. The billing guide does not supersede federal Centers for Medicare and Medicaid (CMS) policy.

This manual explains the SBHS Program, including "Expanded Access" services for all Medicaid eligible children and is intended to provide technical assistance for local education agencies participating, or wishing to participate, in the programs.

The Health Care Authority (the agency) pays school districts for school-based health care services (SBHS) provided to all Medicaid eligible children and children who require special education services consistent with Sections 1905(a) and 1903 (c) of the Social Security Act. The services must do all of the following:

- Identify, treat, and manage the medically necessary or education-related disabilities (mental, emotional, and physical) of all Medicaid eligible children or a child who requires special education services
- Be prescribed or recommended by a physician or other licensed health care provider operating within the provider's scope of practice under state law
- Be medically necessary
- Be diagnostic, evaluative, habilitative, or rehabilitative in nature
- Be included in the child's current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) or be medically necessary .
- Provided in a school setting

Background

In 1975, Congress amended the Education for the Handicapped Act with Public Law 94-142 to provide protections for parents and children and assist states and local education agencies with the excess cost of educating children with disabilities. Children with disabilities must be provided a free appropriate public education (FAPE) including the special education and any related services that are necessary for the children to benefit from special education. Some children require related services that may be medically necessary and reimbursable by Medicaid.

In 1988, Congress amended the Social Security Act to allow states and local education agencies to access Medicaid federal funds to assist in their efforts to educate children with disabilities (the Medicare Catastrophic Healthcare Act, Public Law 100-360). Title XIX of the Social Security Act (the Act) is a federal-state matching entitlement program (the Medicaid program) which provides medical assistance for *certain low-income individuals*. Federal and state governments jointly fund the Medicaid program with each individual state administering the program to assist in the provision of medical care to eligible recipients. States must operate their Medicaid programs within the parameters of federal Medicaid laws and regulations.

The state and the federal governments share funding for the Medicaid program, and the amount of total federal payment to states for Medicaid has no set limit. Federal Financial Participation (FFP), which is the federal government's share for states' Medicaid program expenditures and is claimed under two categories, (1) **administration** and (2) **medical assistance payments**. The information in this guide applies to **medical assistance payments** (sometimes referred to as "*fee-for-service (FFS)*" or "*direct service*"). In Kentucky, the administrative claiming program in school districts operates as a separate program.

In 1994, the Kentucky General Assembly enacted legislation (KRS 605.115) allowing local education agencies to access Medicaid **medical assistance payments** funding if they agree to provide the **matching state funds** for the Medicaid covered services.

In 2019, Kentucky Medicaid submitted and received approval for a State Plan Amendment (SPA) to allow districts to bill for eligible services delivered to all Medicaid enrolled children. Commonly known as the Free Care Reversal rule, Kentucky's Expanded Access School Based Services Program, will address student medical and behavioral health needs by expanding access to services to address student health needs, improve care coordination between healthcare providers and school districts, and generate revenue for the schools.

Introduction

Medicaid's Role in School Health Services

The cost of school health services is covered by different funding streams. Federal, state and local sources of education funding cover most of the cost, while the Medicaid reimburses a smaller portion of the total healthcare costs.

Medicaid provides a significant amount of funding in almost every state for school health services, particularly for children with disabilities, although it's only a small proportion of Medicaid's overall expenditures.

Since 1988, Medicaid has reimbursed states for certain medically necessary services provided in a school-based setting to children with an Individualized Education Program (IEP) and in other limited situations, providing billions of dollars of federal funding to support school health services.

In 2019 CMS approved "Expanded Access" services which provides medically necessary services to all Medicaid eligible children

States are not required to participate in Medicaid, nor are they automatically eligible to receive Medicaid payment for services provided in schools. But schools are required to provide the services listed in an IEP—whether or not Medicaid funding is available. Many states and school districts rely on federal Medicaid funding to offset the expenses of providing these medically necessary services and ease the pressure on the state education budget.

Medicaid is a federal-state partnership; states must pay a certain percentage of their state's overall Medicaid costs, known as the Federal Medicaid Assistance Percentage (FMAP). The FMAP varies from state to state, but the federal government reimburses, at a minimum, 50 percent of a state's spending on eligible services provided to Medicaid enrollees. This means states are responsible for up to 50 percent of the cost of care (otherwise known as the state's match). To raise their share of the match, states rely on many different funding sources, and most states require Local Educational Agencies (LEAs) to draw from their district budget to contribute some or all of the non-federal share of school-based services.

The Centers for Medicare and Medicaid Services (CMS) reimburses states for a portion of the services that are billed, and each state passes some of the money back to schools and districts. The process for reimbursement is complicated and varies state-by-state. When a state increases the number of eligible services that are billed to Medicaid, the state gets back more money from CMS.

Not billing for otherwise eligible services that are already being provided in schools means leaving federal dollars unclaimed. When that happens, state taxpayers bear the entire cost of services. This makes Medicaid a very important source of funding for school health services—and for state health and education budgets overall.

The Role of State Medicaid Plans

Benefits and eligibility levels are outlined in each state's Medicaid state plan. This agreement between a state and the federal government describes how the state administers its Medicaid program and includes clear guidelines about *who gets covered, what services are covered and who the eligible providers are*

In general, Medicaid will pay for covered physical and behavioral health services as long as they are medically necessary; follow local, state and federal rules; are covered by the state Medicaid program; and are delivered by a Medicaid-enrolled provider. Medicaid will also pay for certain activities that are directly related to enrollment, outreach and administration of the Medicaid program.

LEAs are not required to participate in school-based Medicaid, but those that do can seek reimbursement for eligible health services delivered to Medicaid-enrolled students, thereby recouping a portion of their spending.

Restrictions

Kentucky's state plan lists the types of providers eligible to bill for services delivered in school-based settings, as well as the scope of those services. Those providers, including both LEA and contract employees, include school nurses, counselors, school psychologists, speech-language pathologists, physical therapists and occupational therapists.

The state education department credentials providers who are employed or contracted by school districts and verifies certification/licensure requirements for school-based health providers. The credential is specific to the school setting and does not allow providers to serve students in other settings. Various state licensing boards determine requirements for providers who can treat people in community settings. The state education department may accept this type of license to provide school-based services.

The Centers for Medicare & Medicaid Services (CMS) stipulates that any provider seeking reimbursement from Medicaid be recognized as a qualified provider, as defined in the state Medicaid plan. Any provider—including those who work in a school-based setting—wishing to bill services to Medicaid must meet appropriate federal and state requirements.

Effects of School Based Medicaid:

- Students and families eligible to receive health services
- Teachers whose students may have health needs that interfere with their attendance and learning potential
- Superintendents who may be able to access much-needed, available funds to expand health services
- School district legal departments that must work out consent agreements and contracts
- School-based and community-based service providers local public health departments and behavioral health centers that can help target services to meet student health needs.
- Local and state healthcare systems and provider networks State public health agencies that allocate funding and resources
- State education departments, including multiple programs that work on student health.
- State Medicaid agencies, including eligibility and benefit departments, as well as contracting and other programs

District Benefits

These questions should help guide the district in making a decision to participate.

- How many Medicaid eligible children are in the district and/or are receiving special education and related services?
- How many children currently receive services that could be reimbursed under covered Medicaid school-based health services and what is the cost?
- How many parents of Medicaid eligible children will permit the district to access Medicaid coverage?
- What staff time demands will be required to implement the program?
- How will changes in state and local funding influence district expenditures?
- Does the district have services that it is already providing that could be eligible for Medicaid reimbursement?

District Participation Requirements

A school district must apply annually and be certified by the Kentucky Department of Education (KDE) to participate as a school-based health care provider.

To be certified, a school district agrees to:

- Provide services to all Medicaid eligible children and services as required by IDEA as specified in an IEP developed by an admissions and release committee.
- Comply with the requirements for provision of services required by IDEA and Medicaid.
- Employ or contract with health care professionals who meet the specified qualifications.
- Develop and implement a quality assurance program approved by the KDE.
- Maintain records for a minimum of five (5) years plus any additional time required by law and submit to the KDE all required records and reports to ensure compliance with IDEA and the Medicaid School Based Health Services (SBHS) program.

- Maintain records on each Medicaid eligible student who receives services reimbursed by Medicaid. Service records must show the services performed for the child and the quantity or units of service; be signed and dated by the professional who provided or supervised the service; be legible with statements written in an objective manner; and indicate progress being made, any change in treatment and response to the treatment.
- Annually apply to the KDE for Medicaid recertification as a Medicaid SBHS provider.
- Submit the required SBHS Cost Report on or before April 1 each year, with the cost reconciliation and settlement processes completed no later than July 31. The cost reported is based on expenditures for the prior fiscal year (July 1 – June 30).
- Agree to an annual review by the KDE to ensure compliance with the standards for continued participation as a Medicaid provider and have an on-site survey completed by the KDE as necessary to determine compliance with the Medicaid SBHS program.
- Take actions specified by the KDE and/or the Kentucky Department for Medicaid Services (DMS) to correct a deficiency if found to be in non-compliance with the provision Medicaid.
- Quarterly certify expenditure of state or local funds to provide covered school-based health services to Medicaid eligible children as specified in 702 KAR 3:285.
- Once the KDE determines that the school district meets criteria for enrollment in the Kentucky Medicaid Program as a provider of school-based health services, KDE notifies the DMS that a provider number shall be issued and/or activated by the school district.

Process to Change District Medicaid Application

- An amendment to the application is to be submitted to Kentucky Department of Education (KDE) by the district within 15 days of a change in any of the information on file and approved by the KDE.
- The amendment shall be uploaded to KDE via GMAP. If an effective date is not included in the amendment request, the effective date will be the date the email was received.
- Failure to submit amendments in a timely manner may result in claim denials. An amendment is needed when:
 - Practitioners are added or deleted from the approved practitioner list;
 - Practitioners change license or certification status;
 - The district needs to add or delete the services approved; or
 - Changes are necessary in the Quality Assurance Program.
- A change in a practitioner's license, certification or registration may disqualify the practitioner from providing reimbursable Medicaid services.
- The district must maintain up-to-date information on current licensure, certification, or registration and immediately remove disqualified practitioners from the practitioner list.
- Medicaid reimbursement is available only for practitioners with specified qualifications.
- Medicaid reimbursement claims may be denied and recouped for services by practitioners who do not meet the qualifications and whom the district terminated as a provider.

School District Providers

School districts must enroll licensed health care providers as servicing providers under the school district's Medicaid account before submitting claims to the agency. Failure to enroll licensed health care providers will result in denied claims.

- The school district's KDE/Medicaid Liaison enrolls each provider in SBHS.
- The Liaison generates an application ID so that the school district may track the status of a provider's application.
- For assistance in enrolling Medicaid providers, school districts can contact Medicaid Provider Enrollment at (877) 838-5085.

Provider Qualifications

- The Medicaid agency pays school districts to provide certain healthcare-related services.
- These services must be delivered by a qualified health care provider who meets federal and state licensing and certification requirements and who is enrolled with the agency and holds a current professional license.
- School districts must ensure that health care providers meet professional licensing and certification requirements.

Electronic Signatures

The school district and the person whose name is represented by the electronic signature are responsible for the authenticity of the signature. Each school district should recognize the potential for misuse or abuse when using electronic signatures and should determine, at its own risk, what standards are consistent with state and federal electronic requirements. School districts should develop policies and procedures to ensure complete, accurate, and authentic records. These policies and procedures should include:

- Security provisions to prevent the use of an electronic signature by anyone other than the licensed provider to which the electronic signature belongs.
- Procedures that follow recognized standards and laws that protect against modification.
- Protection of the privacy and integrity of the documentation.
- A list of which documents will be maintained and signed electronically.

Note: School districts are not required to submit copies of licensure and transcripts with the annual update form. However, these documents must be current and on file with the school district and available for review upon request.

Eligibility

- Kentucky Medicaid is a state and federal program authorized by Title XIX of the Social Security Act to provide health care for eligible low-income residents including children, families, pregnant women, the aged and the disabled.
- Eligibility is determined by a number of factors, including family size, income and the federal poverty level. Eligibility for Supplemental Security Income recipients, the aged, blind and disabled are based on additional requirements.
- Districts are responsible for conducting eligibility checks since student eligibility can change from one month to the next.
- Medicaid offers various programs and services directed at specific eligibility and medical needs.
- If you are a Medicaid member and need assistance, or are interested in applying for Medicaid, please visit the kynect at <https://kynect.ky.gov>
- Children ages three to 21 enrolled in or eligible for Medicaid under provision of the Individuals with Disabilities Education Act and who have an IEP are eligible for school-based health services.
- Children who require special education services must be receiving Title XIX Medicaid under a categorically needy program (CNP) or medical needy program (MNP) to be eligible for school-based health care services
- The parent/legal guardian must give consent to release records for Medicaid billing
- Parents must be advised annually that the school intends to bill Medicaid for a child's services. A parent may refuse to allow the school to bill.
- Speech therapy, occupational therapy, physical therapy and mental health services may be provided in an individual or group setting.
- When medically necessary, services may be covered through both the IEP and Expanded Access programs.
- Children who receive school-based health services are not prohibited from receiving services through the EPSDT program.

Eligibility Verification

Providers must verify that a patient has Medicaid/KCHIP coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for. Verifying eligibility is a two-step process.

Step 1. Verify the patient's eligibility via the following:

- ✓ Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- ✓ Access KYHealthNet at <https://public.kymmis.com>;

For detailed instructions on verifying a patient's eligibility for Kentucky Medicaid/KCHIP, see refer to the Kentucky Medicaid current Provider Manual.

If the patient is eligible for Kentucky Medicaid/KCHIP, proceed to Step 2.

Step 2. Verify service coverage under the Kentucky Medicaid/KCHIP client's benefit package. To determine if the requested service is a covered benefit under the Kentucky Medicaid client's benefit package, see the SBHS Covered Services Page of this document

Local Educational Agencies

- It is the responsibility of the LEA to maintain adequate records and documentation to ensure the delivery of quality care and post-payment review by the KDE or DMS.
- Each record should be legible and contain the signature and the title of the practitioner.
- Delegated services and services provided by persons under the supervision of a practitioner should include the name and title of the supervisory person.
- Insufficient documentation may result in rejection of claims, development of corrective action plans, and/or financial penalties.
- Continued noncompliance may result in removal from the Medicaid School-Based Health Services Program.
- In the absence of proper and complete records, claims may be denied, and previous payments may be recovered.
- Each LEA must maintain:
 - Verification that the services being claimed for reimbursement are listed in the student's IEP or are medically necessary.
 - Professional service logs reflect the date, type, diagnosis code, procedure code and description of the service(s) provided to the student. Progress reports are included as part of the treatment notes. These progress reports are used to measure the student's progress toward the goals defined in the IEP (Plan of Care). Any alterations to documents must be signed and dated. No white-out is permitted.
 - A minimum, the service log includes:
 - Name of the student.
 - Date the child was seen
 - The length of time spent with the child in duration of treatment.
 - The description of the service provided and result(s)
 - The procedure code
 - The diagnosis code
 - Verification of the attendance of both the child and the service provider for claims submitted.

Notice to Providers (LEA's)

Program Information:

- Provider must have an on-site inspection, upon request.
- Provider can only be an entity, not an individual.
- Provider must have a permanent physical location in Kentucky.
- Out-of-state providers may not enroll. Only Kentucky school districts.
- The Kentucky Department of Education must certify all School-Based Health Service applicants.
- New Provider Application, Revalidation and Maintenance Information:
 - All provider applications (new enrollment, revalidations, and maintenance items) are now completed using the KY Medicaid Partner Portal Application (KY MPPA website).
 - Supporting Documentation Required for New Provider Enrollment, Revalidation and Maintenance Tasks:
 - Department of Education Certification letter (must be current and reflect the requested enrollment date)
 - IRS letter of verification of FEIN or official IRS documentation stating FEIN.
 - FEIN must be pre-printed by IRS on documentation. W-9 forms will not be accepted.
 - NPI and Taxonomy Code Verification.
 - If the provider chooses to enroll in direct deposit, verification of the bank routing/accounting numbers, such as voided check or bank letter, is required

Service Records Requirements

Medicaid requires records to be maintained on each Medicaid eligible recipient (student) who receives services that are reimbursed by Medicaid. These records must:

- Substantiate the services billed to Medicaid by identifying the student, the services performed, the quantity or units of service, and the medical necessity of the services.
- Indicate progress being made, any change in treatment, and response to the treatment.
- Must be signed and dated by the professional who provided or supervised the service.
- Must be legible with statements written in an objective manner are maintained for a minimum of five (5) years plus any additional time required by law to provide a clear audit trail. However, the Kentucky Public School District Records Retention Schedule should be consulted to determine if longer retention periods are required.
- <https://kdla.ky.gov/records/retentionschedules/Documents/Local%20Records%20Schedules/PublicSchoolDistrictRecordsRetentionSchedule.pdf>,

If service logs are also being used for Due Process documentation, the log must be kept in accordance with Due Process procedures.

- Entries in a service log are required by each practitioner providing covered services billed to Medicaid.

Parental Consent for IEP and Expanded Access Services

- In addition to documenting medical necessity, it is important to have a process to obtain parental consent. Parental consent (or student consent, if the student is age 18 or older) not only confers permission to provide diagnostic and treatment services within the school, but it is also required to bill the student's health insurance plan (including Medicaid) for the services provided. Parental consent is NOT retroactive, LEA's shall only bill for services that occurred after the date of signed parental consent.
- Parental consent also facilitates the sharing of information between healthcare providers and education agencies under state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and the Kentucky Family Educational Rights and Privacy Act at KRS 160.700 et. seq
- LEAs may use the consent form in this manual at IEP or other health plan meetings. During the meeting, the LEA can ask if parents/guardians are willing to complete a form for each child in the family.
- LEAs may include the new consent form with other required information sent home with students pursuant to Title I, information about free and/or reduced lunch applications or other similar communication.
- LEAs may include the consent form in annual "back to school" packets.
- Parental permission for a "Release of Information" is a onetime event.
- If the parent denies access and later allows access, a new consent to release information is required. The parent must be given annual written notice by the school district of the district's intent to bill all medically necessary services for all Medicaid children and services in their child's IEP. Parental consent is obtained per district and is valid as long as the student is continuously enrolled in that district, or until consent is revoked by the parent. Once the student is unenrolled, parental consent is end dated.
- Parent permission (i.e., consent) is needed to confer permission to provide diagnostic and treatment services within the school and allows student information to be submitted to the Department of Medicaid Services (DMS) in a claim for reimbursement pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and the Kentucky Family Educational Rights and Privacy Act at KRS 160.700 et. seq. In addition, parental consent is required to bill the student's health insurance plan (including Medicaid) for the services provided. Parental consent is NOT retroactive, LEA's shall only bill for services that occurred after the date of signed parental consent.
- The district can be selective in their notification, but they cannot submit claims for reimbursement for students whose parents were not notified. Also, the parent must have a way to deny district access to Medicaid reimbursement. The parent may refuse to allow the district access to Medicaid at any time. However, all IEP services must still be provided as specified by the Admissions and Release Committee (ARC).

IEP and Expanded Access Parental Consent Letter

Kentucky Parental Notice for One Time Consent to Allow the School District to Access Kentucky Medicaid Benefits

School District Name: **[Insert School District Name]**

School/District Contact: **[Insert name and contact information]**

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission to release information needed to recover costs from Medicaid for eligible school-based services. Local education agencies in Kentucky have been approved to receive partial reimbursement from Kentucky's Department for Medicaid Services (DMS) for the costs of certain health-related services provided by the district to your child (or children).

With your permission, the school district will be able to seek partial reimbursement for medically necessary services to Medicaid recipients in accordance with an Individualized Education Program (IEP), an Individual Family Service Plan (IFSP), or are otherwise medically necessary.

The school district will need to share the following types of information about your child: name, date of birth, gender, social security number, IEP, Service records and any relevant information. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child without your permission. When you give permission, please be advised of the following:

1. *This will allow the release of information, for the sole purpose of billing Medicaid services or auditing, to the following agencies: DMS, Kentucky Department of Education (KDE), Kentucky Department for Public Health, Centers for Medicare and Medicaid Services (CMS), any agency commissioned to audit this program and contractual third-party billing agents.*
2. *The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.*
3. *This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in anyway limit your own family's use of benefits outside of school. This will not affect your child's special education services or IEP rights; and it will not lead to any risk of losing eligibility for other Medicaid or DMS funded programs.*
4. *You have the right to change your mind and withdraw your permission at any time.*

I give permission to the school district to share with DMS information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our school seek partial reimbursement of DMS covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name: _____ Child's Date of Birth: _____

Child's Medicaid Number: _____

Kentucky Parental Notice for One Time Consent to Allow the School District to Access Kentucky Medicaid Benefits

School District Name: **[Insert School District Name]**

School/District Contact: **[Insert name and contact information]**

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission to release information needed to recover costs from Medicaid for eligible school-based services. Local education agencies in Kentucky have been approved to receive partial reimbursement from Kentucky's Department for Medicaid Services (DMS) for the costs of certain health-related services provided by the district to your child (or children).

With your permission, the school district will be able to seek partial reimbursement for medically necessary services to Medicaid recipients in accordance with an Individualized Education Program (IEP), an Individual Family Service Plan (IFSP), or are otherwise medically necessary.

The school district will need to share following types of information about your child: name, date of birth; gender; social security number, Individual Education Plan, Service records and any relevant information. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child without your permission. When you give permission, please be advised of the following:

1. This will allow the release of information, for the sole purpose of billing Medicaid services or auditing, to the following agencies: DMS, Kentucky Department of Education (KDE), Kentucky Department for Public Health, Centers for Medicare and Medicaid Services (CMS), any agency commissioned to audit this program and contractual third-party billing agents.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.
3. This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of benefits outside of school. This will not affect your child's special education services or IEP rights.; and it will not lead to any risk of losing eligibility for other Medicaid or DMS funded programs.

4. You have the right to change your mind and withdraw your permission at any time.

I give permission to the school district to share with DMS information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our school seek partial reimbursement of DMS covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name: _____

Child's Date of Birth: _____

Child's Medicaid Number: _____

Medicaid Annual Parent Notification Letter

Today's Date: _____

Student's Name: _____ Current School: _____

Dear _____ *(parent's name)*,

As of August 1, 2019 _____, the _____ *(name)* School District is pleased to provide your child with special education and related services as stated in his or her Individual Education Program (IEP), 504 and ISPF Plan as well as any medically necessary service for any Medicaid eligible child. Your child is entitled to a free appropriate public education, which means at no cost to you.

State and federal laws allow school districts to be Medicaid service providers for Medicaid eligible children. This means that our school district can bill the Department of Medicaid for any medically necessary service.

Our school district is approved by the Department for Medicaid Services to take part in the Medicaid School-Based Health Services Program. School claims for Medicaid payment for IEP services will not affect your child's receipt of health services from your family physician or other health providers in any way.

Our school district cannot submit claims to Medicaid for your child's services if you do not want us to do so. Our district's billing Medicaid for these services will not change your child's IEP services or your right to receive Medicaid services as long as your son or daughter continues to be eligible for Medicaid services.

If you wish to deny the district's access to reimbursement from Medicaid for health services, you should do so in writing. Our school district will continue to bill Medicaid for medically necessary services unless you notify us in writing that you wish us to stop. We will remind you once a year. If you wish to stop the district from submitting claims to Medicaid for your child, send a written statement to the district's Medicaid Liaison.

If you have any questions or concerns about your child's Medicaid coverage, please contact _____ *(name)* _____ at _____ *(phone number)*.

If we do not hear from you, we will begin or continue to submit claims to Medicaid for your child's medically necessary health services. I want to thank you for your support of our efforts.

Sincerely,

(Name)

Medicaid Liaison

(Phone number)

File copy of notice maintained in student folder

Billing

Interim Claims

- School-based health services (SBHS) are reimbursable by Medicaid if provided by specific practitioners acting within their scope of practice as defined by state law.
- Interim claims (final reimbursement amount determined by annual cost settlement) must be submitted for all services for which LEAs seek reimbursement.
- This means that every time a Medicaid qualified practitioner provides a Medicaid Reimbursable Service to a Kentucky Medicaid enrolled student, an interim claim must be submitted.
- Only claims submitted with billable procedure codes provided to eligible enrolled members will pass through MMIS.
- LEAs are expected to submit interim bills consistent with the rules specified below:
 - Claims must be submitted in electronic format in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines using the CMS 1500 claim format or through third party contracted Vendor Direct Data Entry.
 - Interim claims must include the appropriate Procedure Code and a clinically appropriate ICD-10 Diagnosis code.
 - Claims must be received by Medicaid no later than twelve (12) months from the date of service. 42 CFR 447.45(d)(1). Received is defined in 42 CFR 447.45(d)(5) as "the date the agency receives the claim, as indicated by its date stamp on the claim."
 - All claims are subject to audit. LEAs are responsible for ensuring the appropriate documentation can be produced in the event of an audit or other request by Kentucky Medicaid or other state or federal compliance agency.
 - Further discussion of school based medical services can be found in a guidance document issued by Centers for Medicare and Medicaid Services (formally the HCFA) entitled, "Medicaid and School Health: A Technical Assistance Guide," August 1997 [Medicaid and School Health - A Technical Assistance Guide | Guidance Portal \(hhs.gov\)](#)

Electronic Claim Submission

Instructions on how to bill Direct Data Entry (DDE) claims can be found in the Agency's Provider Billing Manual web page.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, contact Gainwell Technologies at 502-209-3000.

The following claim instructions relate to school-based health care services providers.

Name	Action
Place of Service	Enter applicable code: School: 03 Telehealth: 02 Home: 12
Diagnosis Code	As applicable
Charges	If billing for more than one unit, enter the total charge of the units being billed.
FREECARE99	Must be in the header, not the detail, for <u>Expanded Access claims</u> or the claim will deny

How do I review my remittance advice (RA) and why is this important?

The remittance advice (RA) provides needed information for school districts to check the status of claims. It is important for school districts to review their RAs weekly to determine if claims were paid, determine if any claims were denied and review the explanation for the denial. School districts should contact the agency's SBHS Program Specialist, Provider Relations Unit, or their billing agent with questions about denied claims. Instructions on how to review the RA are available on the KY MMIS website.

Provider Documentation

Providers must document all school-based health care services (SBHS) as specified in this billing guide. Sufficient documentation to justify billed claims must be maintained for at least 5 years from the date of service.

Maintaining records in an electronic format is acceptable. Each school district is responsible for determining what standards are consistent with state and federal electronic record requirements.

Records for each student must include:

- A referral or prescription for services by a physician or licensed health care professional.
- Professional assessment reports completed by a licensed professional. Evaluation and reevaluation reports.
- A comprehensive individualized education program (IEP) or individualized family service plan (IFSP)
- Attendance records for each student receiving services.
- All required documentation and treatment notes for each date of service require the licensed provider's printed name, handwritten or electronic signature, and title.
- All records must be easily and readily available to the agency upon request.

Treatment notes must include:

- ✓ Child's name.
- ✓ Child's date of birth.
- ✓ Child's Medicaid client ID.
- ✓ Date of service, and for each date of service:
 - Time-in.
 - Time-out.
 - A corresponding procedure code(s) and number of billed units for each service provided.
 - A description of each service provided.
 - The child's progress related to each service.
 - Whether the treatment described in the note was individual or group therapy.
- ✓ All required documentation and treatment notes for each date of service require the licensed provider's printed name, handwritten or electronic signature, and title.
- ✓ All records must be easily and readily available to the agency upon request.
- ✓ Whether the treatment described in the note was individual or group therapy.

The provider's signature on all records and treatment notes verifies the services have been accurately and fully documented, reviewed, and authenticated. It confirms the provider has certified the medical necessity and reasonableness for the service(s) provided.

To be valid, handwritten and electronic signatures must be legible. Legible stamped signatures are permitted only in the case of an author with a physical disability who can provide proof of an inability to sign.

School districts must maintain and are responsible for the accuracy of a signature log. The log does not need to be provided to the agency, but must be kept at the school and made available for all monitoring activities and must include the provider's:

- Printed name
- Handwritten signature
- Initials
- Credentials
- License number

Note: If a school district contracts with a billing agent, the agency does not require the servicing provider to sign for each date of service on the service log. One signature per page is acceptable only if the service log is used as backup documentation to the treatment notes.

Note: If a provider has various signatures, all versions of the provider's signature must be included on the signature log.

Reimbursement

To receive payment from the agency for providing school-based health care services (SBHS) to eligible children, a school district must:

1. Have a current, signed, and executed interagency agreement with the agency.
2. Meet and comply with the applicable requirements in accordance with 907 KAR 1:715
3. Enroll providers as a servicing provider under the district's Medicaid account.
4. Comply with the agency's current Medicaid Billing and Technical Assistance Guide.
5. Bill according to the SBHS Billing Guide and the CPE-Certified Public Expenditure process. After school districts receive their invoice from the agency, they have 120 days to provide the agency with their local match.
6. Provide only health care-related services that are medically necessary or identified in a current individualized education program (IEP) or individualized family service plan (IFSP).
7. Use only qualified health care professionals, as described in this billing guide, who are acting within the scope of their license or certification according to Provider Qualifications.
8. Meet the documentation requirements in this billing guide

Duplication of Service

The department will not reimburse for a service provided to a beneficiary by more than one provider of any program in which the service is covered during the same time period with the exception of IEP incidental interpreter services which are essential for the provision of medically related services.

Procedure codes

The agency uses the following types of procedure codes within this billing guide:

- Current Procedure Terminology (CPT)
- Level II Healthcare Common Procedure Coding System (HCPCS)

Services performed must match the description and guidelines from the most current CPT or HCPCS manual for all covered SBHS.

Final Reimbursement

Final reimbursement is based on the certified reports that are submitted using the methodology allowed under the Kentucky School-Based Cost Report reviewed by the Centers for Medicare and Medicaid Services (CMS).

To determine the Medicaid-allowable costs of providing school-based services to Kentucky Medicaid members, the following steps are performed:

1. Direct costs of providing school-based services include payroll costs and other costs that can be directly charged to school-based services, including costs that are integral to school-based services.
2. Direct costs are recorded on a modified accrual basis consistent with the Kentucky Department of Education chart of accounts, and the source data is the school-based service providers' accounting and payroll systems.
3. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school-based services providers under EPSDT.

4. Direct costs do not include salaries for staff who do not meet the qualifications required under item 4.bEPSDT in Supplement to Attachment 3.1-A/B.
5. Other direct costs include costs directly attributed to activities performed by the personnel who are approved to deliver school-based services, such as, travel, materials and supplies. Additional direct costs include purchased services. These direct costs are accumulated on the annual CMS-approved Kentucky School-Based Cost Report.
6. Direct costs do not include room and board.
7. Direct costs for school-based services are reduced by any federal payments for those costs, resulting in adjusted direct costs for school-based services.
8. Adjusted direct costs above are then allocated to identify Medicaid-reimbursable costs for school-based services according to the Random Moment in Time Study (RMTS) results that are identified according to the process described in the Kentucky RMTS Implementation Plan, approved by CMS.
9. Indirect costs are calculated using the unrestricted indirect cost rate set by the Kentucky Department of Education as the cognizant agency or other allowable rates per OMB 2 CFR Part 225: Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87).
10. Indirect costs are equal to adjusted direct costs multiplied by the unrestricted indirect costs rate. These indirect costs are the added to the adjusted direct costs to determine the total direct costs.

Interim Rate

The school-based services Providers' specific interim rate is the rate for a specific service that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period. This rate is for direct medical services, per unit of service, on a per visit basis. Claims filed by School-Based Services Providers to Medicaid Management Information System (MMIS) as part of this process are to be used for interim rates and cost settlement purposes only.

IEP, IFSP and Expanded Access Medicaid Services are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an IEP or IFSP or are otherwise medically necessary. Covered services are the following:

1. Audiology
2. Occupational Therapy
3. Physical Therapy
4. Behavioral Health Services
5. Speech
6. Nursing Services
7. Respiratory Therapy
8. Transportation (IEP only)

IEP interim payments for the above services will continue as in previous years. The Expanded Access program transitioned to a cost-based settlement program where rates are based on the district's cost to provide the services using staff salary information and unit rates in order to facilitate accurate cost settlements.

The cost-based methodology will apply to all LEAS's and will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Cost Reimbursement Methodology

Medicaid-allowable costs are identified by applying the applicable Medicaid Enrollment Ratio (MER) to the total direct costs. For those costs allocated by the RMTS as being covered services, the quarterly Medicaid Enrollment Ratio is the number of Medicaid eligible children, ages 5-18, per county. Kentucky uses calculations to determine the MER for each participating school district using the following reports:

- A countywide report of all Medicaid-eligible children ages 5-18 provided by the Department of Medicaid.
- A master detail listing of all Medicaid enrollees ages 5-18 residing in each county of the participating school district. This report includes the name, date of birth, and social security number of each enrollee.
- A school district report of all enrolled students between the ages of 5-18. This report is generated by the statewide enrollment reporting database. The report lists the student's name, date of birth, and social security number.
- An end of the school year enrollment report submitted by each individual school district.

The MER is determined by dividing the applicable number of Medicaid enrollees ages 5-18 by the school district's year-end total enrollment.

Covered Services

Covered services may include evaluation and treatment components if certain conditions are met.

In Kentucky, the following services are covered for Medicaid reimbursement when provided to an eligible child:

- Assistive Technology (IEP only)
- Audiology
- Evaluation Services
- Incidental Interpreter (IEP Only)
- Behavioral Health
- Nursing Services
- Occupational Therapy
- Orientation and Mobility (O&M)
- Physical Therapy
- Respiratory Therapy (Nursing Services)
- Speech-Language Therapy
- Specialized Transportation (IEP only)

Note: All covered services under this section may also be provided through telehealth as described in Telehealth.

Non-Covered Services

It is the responsibility of the school district to contact the SBHS Program Specialist for questions regarding covered and non-covered services. Non-covered services include, but are not limited to the following:

- Attending meetings
- Charting
- Equipment Preparation
- Evaluations that do not result in an IEP or IFSP
- Instructional assistant contact
- Parent consultation
- Parent contact
- Planning

Expanded Access/IEP Services

Medicaid school-based health services under the Expanded Access program are medically necessary health services that are provided to children who are eligible under Medicaid and offered to all students at no cost to the students.

IEP services are medically necessary health services that are provided to children who are eligible under both Medicaid and the Individual with Disabilities Education Act (IDEA). Medicaid requires services provided to eligible recipients to be medically necessary health services. The IDEA requires that related services must be necessary for the eligible child to benefit from special education. To meet the requirements for each program, the SBHS Medicaid program regulations have been written in such a way that medical necessity is established by the ARC, stating the service in the IEP.

Documentation for medical necessity for Expanded Access and IEP services may include clinical evaluations, physician evaluations, consultations, progress notes, physician's records, records from other healthcare professionals and test reports. It is maintained by the physician and/or provider.

Telehealth

Telehealth is when a qualified health care provider uses HIPAA-compliant, interactive, real-time audio and/or video telecommunications (including web-based applications) to deliver covered services that are within the provider's scope of practice to a client at a site other than the site where the provider is located.

The agency covers telehealth when it is used to substitute for an in-person encounter for only those services specifically listed in this guide. The provider furnishing services via telehealth must be enrolled as a servicing provider under the school district's billing national provider identifier (NPI).

An originating site is the physical location of the client at the time the service is provided by a licensed professional through telehealth. For the SBHS program, the approved originating site is the school.

Distant site is the physical location of the qualified health care provider providing the service to a client through telehealth.

When the originating site is a school and the provider at the distant site is enrolled as a provider with the school district, the school district submits a claim on behalf of both the originating and distant site. The school district bills for the telehealth facility fee as well as the CPT code for the service provided. Providers are required to use the "02" modifier as the place of service so that the claim will be adjudicated a Telehealth claim. The payment amount for the service provided is equal to the current cost settlement amount.

Therapy

Treatment services are provided with the expectation that the student's condition will improve significantly in a reasonable (and generally predictable) period, or the services are necessary to maintain a safe and effective maintenance program. These services are at a level of complexity and sophistication, or the condition of the student is such that the health service can only be provided by a licensed or certified practitioner, or by a trained person under the supervision of a licensed or certified practitioner.

During treatment, the areas of speech-language, occupational therapy, physical therapy and behavioral health may have services delivered either in an individual or group setting.

Individual therapy is defined by the DMS as "therapeutic intervention provided by a qualified practitioner for the purpose of reducing or eliminating the presenting problem of the student." Individual services are provided in a in-person or via telehealth, one-on-one encounter between the student and the qualified practitioner.

Group therapy services are defined by the DMS as "therapeutic intervention provided by qualified practitioners to a group of students. Only services provided to a group of six or less are billable. Group treatment is rehabilitation services, which offer activities in a therapeutic environment that focus on the development and restoration of the skills of daily living.

Group therapy reimbursement is limited to the following services and must be listed in the student's IEP unless billing for expanded access services:

- Behavioral health
- Occupational therapy
- Speech therapy
- Physical therapy
- The service log documentation would then describe the service delivery and the student's response to the services provided.

Assistive Technology (IEP Only)

Note: Assistive Technology devices are not covered under expanded access. Only Medicaid reimbursable under an IEP and when provided with another covered service.

An assistive technology device is an item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of a child with a disability and is medically necessary to implement the health services in the child's individualized education program.

Schools may procure assistive technology devices in bulk but must ensure that the DOS (the date that the child is issued the device) and the invoice date be within the same state fiscal year (July 1 to June 30th) as the IEP/school year date.

The cost of the evaluation to establish medical necessity (e.g., related to an identified medical or behavioral disability, and appropriateness of the device, item or system prior to purchase or rental) is included in the assistive device or item's overall cost. Evaluations may be provided by an occupational therapist, a physical therapist, or a speech therapist. Other appropriate professionals also may provide evaluations with prior approval by DMS. An assistive device or item cannot be covered without an evaluation by the appropriate professional.

DMS requires that the device becomes the property of the student once the district receives Medicaid reimbursement for the assistive device. Should the student outgrow the device or the student's needs require a change in devices, the old device remains the property of the student and is only released to the custodial parent. A parent may, however, donate the item. There are no limitations as to the frequency of purchasing assistive devices, as long as an evaluation to determine the need for a different device has been conducted and the type of device is documented in the student's IEP.

Audiology

Audiology services must be medically necessary. They are professional services involving the evaluation and treatment of impaired hearing that cannot be improved by medication or surgical treatment.

Audiology services include:

- Assessing hearing loss
- Determining the range, nature, and degree of hearing loss; and including the referral for medical and other professional attention for restoration or rehabilitation due to hearing disorders
- Providing rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determining the need for individual amplification

Assessment services may include testing or clinical observation as appropriate for chronological or mental age for one or more of the following areas of functioning, and shall yield a written report:

- Auditory acuity (including pure tone air and bone conduction)
- Speech detection
- Speech reception threshold
- Auditory discrimination in quiet and noise
- Impedance audiometry, including tympanometry and acoustic reflex
- Hearing aid evaluation
- Central auditory function
- Auditory brainstem evoked response

Treatment may be provided individually or in groups as appropriate. Examples of treatment include:

- Auditory training
- Speech reading
- Aural rehabilitation
- Augmentative communication

Behavioral Health

Medicaid school-based health services are medically necessary health services that are provided to children who are eligible under Medicaid and offered to all students at no cost to the students.

Assessment services may include the following:

- Testing obtaining information from the parents or home behavior, social and developmental history and parents' perceptions of the problems may be included in the assessment
- Clinical evaluation, observation and interviews as appropriate for chronological or mental age including, but not limited to, the following areas of functioning:
 - Cognitive
 - Emotional or personality development
 - Adaptive behavior
 - Behavior
 - Perceptual or visual motor
 - Developmental
 - Psycho-social
 - Psycho-educational
 - Psycho-neurological

Treatment services may include the following as appropriate:

- Individual therapy or counseling
- Group therapy or counseling. Examples of group therapy topics are building and maintaining healthy relationships, personal goal setting, etc. The topic of each group session shall be relative to all children participating.

Evaluations

1. Medicaid school-based health services are medically necessary health services that are provided to children who are eligible under Medicaid and offered to all students at no cost to the students.
2. Evaluations are procedures used to determine what services a child may need, such as medical or behavioral treatments, therapy, special education, and the nature and extent of these and related services. Evaluation includes assessments, tests and related activities performed under state and federal requirements in KAR chapter 1 and IDEA. The ARC determines the evaluation or assessments necessary for each individual student and only assessment of covered components is reimbursable by Medicaid. No academic assessments are reimbursable.
3. A medical diagnostic code is needed to bill for Medicaid services. Therefore, assessment needs to provide information sufficient for a medical diagnosis and reasons for providing a specific related health service. Qualified practitioners provide appropriate diagnosis information and diagnostic codes within their scope of practice. The practitioners determine the diagnosis and diagnostic code based on the evaluation information that is completed for initial or continued eligibility for IDEA. Medical diagnostic codes are found in the international classification of diseases (ICD-10) manual. (See appendix page 41)
4. If assessment of more than one Medicaid covered service is conducted, the costs for each Medicaid covered assessment are billable if the conditions are met. For example, the ARC requires assessments in the areas of speech-language, behavioral health and physical therapy. The ARC reviews the completed evaluation and determines the student needs services only in the area of speech-language. The ARC includes the speech-language services in the IEP based upon the evaluation information. The district may submit claims for all three areas evaluated, including the time spent by each practitioner analyzing and writing the evaluation reports.
5. Assessment results are documented in a report. The ARC uses evaluation reports to determine the student's disability and need for special education and related services, including medically necessary health related services. Following evaluation, if the Medicaid eligible student is determined eligible for IDEA services and at least one Medicaid covered service is included in the student's IEP, the associated costs of the evaluation services (including report-writing time) is Medicaid reimbursable. The district may be reimbursed for the time approved practitioners spend conducting assessments and the amount of time required to analyze and write the evaluation reports (please note, dictating the report for clerical transcription is not a billable service).
6. Medicaid will allow therapists to use snow days, district professional development days and planning and flex days to be used for writing evaluations and analyzing the evaluation data. This does not include after school regular hours and holidays or weekends.
7. In the instance where the behavioral health practitioner contacts the parent or guardian by telephone to collect evaluation information, such as the social-developmental history of the student, the time spent on the telephone collecting the information may be billed as part of the evaluation if service log documentation supports the claim.
8. Re-evaluations conducted in response to an ARC's decision to determine the student's continued eligibility for IDEA services are billable services. The current IEP and ARC decision to re-evaluate a student allows the district to seek reimbursement of the covered evaluations. The Medicaid covered evaluations are billable even if the results determine the student is no longer eligible or requires the covered services.
9. Mass screenings done for the purpose of determining disabilities are not billable; however mass screenings are billable under Expanded Services if they are age appropriate and listed in the

preventative/EPSTD services. Individual screenings conducted by covered practitioners as part of the individual evaluation requested by an ARC may be billed.

Incidental Interpreter Services (IEP Only)

Note: Interpreter services are not covered under expanded access. Only Medicaid reimbursable under an IEP and when provided with another covered service.

Interpreter services are services for a child who is deaf, hard of hearing, or who requires special communication techniques in order to communicate. Incidental interpreter services are interpreter services that are necessary to allow the child to benefit from other covered school-based health services. These services must be stated in the student's IEP and cannot be the only covered service needed.

Interpreters must be licensed by the Kentucky board of interpreters as required by KRS 309.300 to 309.319.

Example 1: an interpreter might be required as an incidental service for the school psychologist to administer a portion or all of a behavioral health assessment to a child who is hearing impaired or understands a different language.

Example 2: an incidental interpreter may be needed during the ARC meeting where a parent needs an interpreter in order to understand and participate in the meeting. There must be at least one Medicaid covered service stated in the IEP for the interpreting services provided to a parent during an ARC meeting to be Medicaid reimbursable.

Nursing Services

A Medicaid school-based health service is a medically necessary health service that is within the scope of licensure of the appropriate ordering supervising provider and is provided to children who are eligible under Medicaid and offered to all students at no cost to the students.

Direct nursing services shall be provided in-person or via telehealth and on a one-to-one basis. Extended nursing care for a technology-dependent child who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital level nursing care to avert death or further disability shall be limited to services provided during normal school hours.

Examples of covered nursing services include, but are not limited to:

- Assessments, reassessments, and treatment services, including referrals based on results
Note: Assessment includes monitoring of eligible students with chronic medical illnesses in order to assure that medical needs are being appropriately identified and addressed.
- Suctioning
- Emergency interventions
- Individual health counseling and instructions
- Medication administration and management including observation for adverse reactions, response or lack of response to medication
- Oxygen administration via tracheostomy and ventilator care
- Positioning
- Gastrostomy tube feeding
- Glucose monitoring
- Ileostomy and colostomy care
- Respirator dependent
- Catheterization and management and care of specialized medical equipment such as colostomy bags, nasal gastric tubes, and tracheotomy tubes
- Supervision of the health aide by the delegating nurse
- Examples of health aid services:
 - Handling and positioning
 - Wheelchair care and monitoring
 - Bowel care
 - Skin care and monitoring
 - Gastrostomy tube feeding
 - Shunt monitoring, catheterization and postural drainage; and
 - Changing tracheotomy ties, oxygen supplementation.
 - Certain emergency services may be provided on an as needed basis. The practitioner's documentation must explain the treatment provided. An example of an emergency service is the administration of an inhalation treatment to a child who is having an asthma attack.
 - Treatment services, considered observation or standby in nature, are not covered.

Qualified providers of nursing services are:

- an advanced registered nurse practitioner with a current license from the Kentucky Board of Nursing; or
- a registered nurse with a current license from the Kentucky Board of Nursing; or
- a licensed practical nurse with a current license issued by the Kentucky Board of Nursing, under appropriate supervision and delegated authority; or

- A health aide if:
 - the aide is under the supervision of a specific registered nurse or advanced registered nurse practitioner; or
 - a registered nurse or advanced registered nurse practitioner has trained the aide for the specific nursing service for the specific recipient; and
 - a supervising registered nurse or advanced registered nurse practitioner has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

The following are examples of health aide services:

- Handling and positioning
- Wheelchair care and monitoring
- Bowel care
- Skin care and monitoring
- Gastrostomy tube feeding
- Shunt monitoring, catheterization and postural drainage; and
- Changing tracheotomy ties, oxygen supplementation.
- Certain emergency services may be provided on an as needed basis.

Note: treatment services, considered observation or standby in nature, are not covered.

Occupational Therapy

Occupational therapy services are services to develop, improve, or restore functional abilities related to performance of self-help skills, adaptive behavior and sensory, motor, postural and emotional development. Services involve the use of purposeful activity, interventions, and adaptations to enhance functional performance.

Occupational therapy services include:

- Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation.
- Improving ability to perform tasks for independent functioning when functions are lost or impaired preventing initial or further impairment or loss of function through early intervention.
- Assessment: assessment services include testing or clinical observation as appropriate for chronological or mental age for one or more of the following:
 - Activities of daily living
 - Sensory or perceptual motor development
 - Neuromotor function (e.g., Balance, coordination, muscle tone, postural control, reflexes, and developmental stages)
 - Musculo-skeletal function (e.g., Muscle strength, joint range of motion, endurance)
 - Gross and fine motor function
 - Adaptive equipment assessment
- Treatment services may include one or more of the following and be provided individually or in a group as appropriate:
 - Activities of daily living
 - Sensory or perceptual motor skills
 - Neuromotor function
 - Musculo-skeletal function
 - Gross and fine motor skills
 - Feeding or oral motor skills
 - Adaptive equipment needs (design, selection, fabrication, use)
- Occupational therapy service providers must meet the applicable requirements of 42 CFR 440.110. Service providers must also meet the following requirements:
 - be an occupational therapist with a current license from the Kentucky board of licensure for occupational therapy; or
 - be an occupational therapy assistant who is licensed by the Kentucky board of licensure for occupational therapy to assist in the practice of occupational therapy and Under the supervision of an occupational therapist; or
 - be an unlicensed occupational therapy aide who provides supportive services to occupational therapists and occupational therapy assistants and is under the direct supervision of a licensed occupational therapist.

Orientation and Mobility (IEP Only)

Note: Orientation and mobility services are not covered under expanded access.

Orientation and mobility services include assessment and instruction services to correct or alleviate movement deficiencies created by a loss or lack of vision.

Assessments may include the following:

- visual functioning
- sensory awareness
- gross or fine motor skills
- concept development
- pre-cane and cane skills
- protective and navigational techniques
- sighted guide techniques
- community awareness
- public transportation
- vocational training

Treatment services include:

- using cognitive and physical skills enabling a child to establish his/her position and relationship in the environment in a safe, efficient and purposeful manner.
- Treatment services may be provided individually or in a group as appropriate.

Orientation and mobility services shall be provided by an orientation and mobility specialist certified by the:

- Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or
- National Blindness Professional Certification Board (NBPCB).

Physical Therapy

Physical therapy services are services to prevent, alleviate, or compensate for movement dysfunction and related functional problems. Services involve the use of physical agents and methods and mechanical means for remedial treatment and restoration of normal bodily function.

Assessment services may include testing or clinical observation as appropriate for the chronological or mental age for one or more of the following areas of functioning, and shall yield a written report:

- Neuromotor function (e.g., balance, coordination, muscle tone, postural control, reflexes, and developmental stages)
- Musculo-skeletal function (e.g., muscle strength, posture, joint range of motion, endurance, mobility assessment, gait and wheelchair use)
- Cardio-pulmonary function
- Activities of daily living
- Feeding or oral motor function
- Adaptive equipment assessment
- Gross and fine motor function
- Soft tissue assessment
- Pain assessment
- Cranial Nerve assessment
- Clinical electromyography assessment
- Latency and velocity assessment

Treatment services may include one or more of the following and may be provided individually or in a group as appropriate:

- Manual Therapy techniques
- Therapeutic exercise
- Functional Training
- Facilitation of motor milestones
- Sensory motor training
- Cardiac training
- Neuromotor function
- Musculo-skeletal function
- Mobility training
- Cardio-pulmonary function
- Activities of daily living
- Feeding or oral motor assessment
- Adaptive equipment skills (includes design, selection, fabrication, use)
- Gross and fine motor development
- Hydrotherapy

Physical therapy services must be provided by providers who meet the applicable requirements of 42 CFR 440.110 and:

- A physical therapist with a current license from the state Board of Physical Therapy; or
- A physical therapist assistant with a current license from the state Board of Physical Therapy under the supervision of a licensed physical therapist; or
- A physical therapist with a temporary permit issued by the state Board of Physical Therapy under the supervision of a licensed physical therapist; or
- A student of physical therapy under the supervision of a licensed physical therapist; or
- A physical therapy aide under the direct on-site supervision of a licensed physical therapist or a licensed physical therapist assistant in accordance with the provisions of 201 KAR 22:053, Section 5.

Speech-Language

Speech-language services must be medically necessary or appear in the child's IEP. These are professional services involving the assessment and treatment of speech and language disorders that are not amendable to medication or surgical treatment.

Assessment services may include formal or informal testing, medical history interviews, or clinical observation, as appropriate for chronological or mental age for all the following areas of functioning, and shall yield a formal evaluation report. Examples assessment services include but are not limited to:

- Assessing speech and language disorders
- Diagnosing and appraising speech and language disorders
- Providing speech or language services to prevent communicative disorders
- Referring to medical and other professionals necessary for rehabilitation of speech and language disorders
- Receptive and expressive language
- Auditory processing, discrimination,
- Perception, and memory
- Augmentative communication
- Vocal quality
- Resonance patterns
- Speech sound production and use (phonetic and phonologic)
- Pragmatic language
- Rhythm or fluency
- Oral mechanism
- Swallowing assessment
- Hearing screening
- Feeding assessment

Note: Reimbursement is not allowed for routine or group screenings.

Treatment services may include one or more of the following areas as appropriate and may be provided individually or in a group as appropriate:

- Articulation therapy
- Language therapy
- Receptive and expressive language
- Augmentative communication treatment or instruction
- Auditory processing dysfunction
- Disorders of fluency
- Voice therapy
- Oral motor dysfunction; swallowing therapy

Transportation (IEP Only)

Transportation costs incurred by the district to provide special transportation for a child to receive a Medicaid covered related service may be billed to Medicaid if the following criteria are met. Special transportation includes special arrangements, special equipment or a special vehicle.

- Transportation must be prior approved by KDE as a service to be provided.
- The child must be Medicaid eligible.
- The child qualifies for special education, related services and special transportation.
- The ARC qualifies the child's need for special transportation and determines what transportation is appropriate for the child's disability. The need and type of special transportation must be identified in the child's IEP.
- The child must receive at least one Medicaid reimbursable related service on the day transportation is billed.
- Only one round trip per day may be billed even if the child receives several billable related services. If the child is transported to a different location to receive a second billable service on.
- Detailed transportation logs (attendance logs) are maintained and signed by the bus driver.
- The transportation must meet the specifications established by KRS 156.153, 702 KAR 5:060, and 702 KAR 5:130.
- Transportation cost originally paid from *federal* funds such as IDEA cannot be billed to Medicaid.
- Group billing cannot be used to determine mileage. If more than one child is transported at the same time, the exact mileage for each child must be calculated. Specially adapted vehicles may have riders who are not eligible for Medicaid or who are not eligible for school-based transportation on a given day. However, only claims that are pro-rated (see example below) for the portion of the ride allocated to the Medicaid beneficiary receiving the specialized transportation, are reimbursable by Medicaid.

Example: If one general education child rides the specially adapted vehicle with one special education/physically disabled child that has a medical service and transportation in the IEP on the date of service, the cost of the ride must be divided by the two children. If there are two general education students plus the physically disabled child, the cost must be divided by three. Additional children riding the specially adapted bus must be calculated accordingly.

- Mileage may not be claimed when a member of the child's household provides transportation if that person is not an employee of the school district.
- Mileage may be claimed:
 - From the child's residence to and from the school building where the child receives the reimbursable related service.
 - From the child's residence to and from the office of a medical provider or clinic where the child receives the reimbursable related service.
 - From the child's residence if the child is a home-bound student and receives general education services at home
 - To calculate a claim amount, use the district's actual cost per mile to transport the child times the number of miles transported round trip. The actual cost per mile for special transportation is available from the pupil transportation director at your district or you may use Map-quest, Yahoo or other online mapping service.

Expanded Access in Schools

The History of the “Free Care” Rule

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a [letter to state Medicaid directors clarifying](#) which services Medicaid can reimburse in a school-based setting. This guidance allows school districts to expand their school-based Medicaid programs to cover more students and potentially bring in additional, sustainable federal funding for schools.

Known as the “free care” policy reversal, the letter clarified CMS policy prohibiting reimbursement for services provided to Medicaid-enrolled students if those services were provided free of charge to all students. There were some exceptions: Services could be submitted for Medicaid reimbursement if they were included in a student’s Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) or delivered through the Maternal and Child Health Block grant.

Prior to August 1, 2019, Medicaid Covered Services were only reimbursable when provided pursuant to a student’s Individualized Education Plan (IEP).

Effective August 1, 2019, the program also reimburses for the provision of Medicaid Covered Services that meet Medicaid’s definition of medical necessity and all other program requirements, *without* a care plan or the IEP requirement.

Examples of these additional services include preventive services, mandated physical and behavioral health screenings, dental services, including fluoride varnish treatment, as well as all of the currently covered service types when medically necessary, ordered and provided by a Medicaid qualified practitioner acting within the scope of their clinical license and providing a service which requires the skill level and clinical expertise associated with that license.

Schools can now seek reimbursement for covered services provided to all students enrolled in Medicaid if those services are available to all students at no cost—not just those with IEPs and IFSPs. The “goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities.”

Expanded Access Provider Descriptions

DESCRIPTION and MODIFIER		CREDENTIALS
Clinical Psychologist	AH	Current license from the KY Board of Examiners of Psychology in accordance with KRS Chapter 319.
MD/OD /Dentist	AM	Doctoral level Per Practice Guidelines.
Licensed Professional Clinical Counselor (LPCC)	HO	MASTERS LEVEL-Current license from the KY Board of License Professional Counselor (KRS Chapter 335).
Licensed Professional Clinical Associate (LPCA)	U4	Working on MASTERS LEVEL/Student of LPCC, under the supervision of LPCC.
Licensed Psychological Practitioner (LPP)	U8	MASTERS LEVEL/No supervision, Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319).
Licensed Psychologist	AH	DOCTORAL LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319).
Certified Psychologist with Autonomous functioning	U8	MASTERS LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319).
Certified Psychologist	U4	MASTERS LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319).
School Psychologist	U5	MASTERS LEVEL-Current school psychologist certification, only performing services in a school setting. Provider must meet the requirements of 16 KAR 2:090.
Licensed Psychological Associate	U4	MASTERS LEVEL Under supervision of PHD Psychologist in same building/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319).
Board Certified Behavior Analyst	HO	MASTERS LEVEL/Current license from the Kentucky Applied Behavior Licensing Board (KRS Chapter 319C).
Board Certified Assistant Behavior Analyst	U4	Current license from the Kentucky Applied Behavior Licensing Board as an assistant and under the supervision of BCBA (KRS Chapter 319C).
Licensed Clinical Social Worker (LCSW)	AJ	MASTERS LEVEL/Current license from the KY Board of Social Work (KAR 201 Chapter 23).
Certified Social Worker (CSW)	U4	MASTERS LEVEL/Current license as a social worker by the Kentucky Board of Social Work (KAR 201 Chapter 23) and under the supervision of a LCSW Authorized by KRS 335.010 to 335.160 and 335.990.
Psychometrist	U9	Refer to the Board of Examiners of Psychology KRS 319.
Speech-Language Pathologist	GN	Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).
Speech-Language Pathologist -CF	GN	Interim license requirement -- Exemption for public school speech-language pathologists with teacher certification in communication disorders. Per Statute 334A.035.

Occupational Therapist	GO	Current license from KY Occupational Therapy Board (KAR 201 Chapter 28).
Occupational Therapy Assistant	GO-U3	Current License from the KY Occupational Therapy Board and under the supervision of a licensed Occupational Therapist (KAR 201 Chapter 28).
Occupational Therapist Aide	GO-UA	Under the direct supervision of the KY licensed Occupational Therapist (KRS 319A. 010 (5)).
Physical Therapist	GP	Current license from the KY Board of Physical Therapy or a temporary permit issued by the KY Board of Physical Therapy (KAR 201 Chapter 22).
Physical Therapist Assistant	GP-U3	Current license from the KY Board of Physical Therapy and under supervision of a licensed Physical Therapist (KAR 201 Chapter 22).
Physical Therapist Aide	GP-UA	Under the direct on-site supervision of the KY licensed Physical Therapist or Physical Therapy Assistant (201 KAR 22:053, Section 5.)
Physical Therapy Student (Intern)	GP-HL	Student of Physical Therapy under the supervision of a KY licensed Physical Therapist (KAR 201 Chapter 22).
Advanced Registered Nurse Practitioner (ARNP)	SA	Current license from the Kentucky (KY) Board of Nursing (201 KAR 20:057).
Registered Nurse	TD	Current license from the KY Board of Nursing (201 KAR 20:057).
Licensed Practical Nurse	TE	Current license from the KY Board of Nursing under appropriate supervision and delegation (201 KAR 20).
Health Aide	U1	Under the supervision of and with training by a KY licensed ARNP or RN and being monitored by the supervising nurse in provision of the delegated and supervised nursing services (201 KAR 20:400).
Audiologist	U2	Current license from KY Board of Speech Language Pathology and Audiology (201 KAR 17:012).
Licensed Professional Art Therapist LPAT	HO	MASTERS LEVEL-Current license from the KY Board of License Professional Art Therapists (KRS Chapter 335).
Licensed Professional Art Therapist Associate- LPATA	U4	MASTERS LEVEL-Current license from the KY Board of License Professional Art Therapists (KRS Chapter 335).
Licensed Marriage and Family Therapist- LMFT	HO	MASTERS LEVEL-Current license from the respective KY Professional Board (KRS Chapter 335)
Marriage and Family Therapist Associate- MFTA	U4	MASTERS LEVEL-Permit from the respective KY Professional Board (KRS Chapter 335)
Licensed Clinical Alcohol and Drug Counselor (LCADC)	HO	MASTERS LEVEL-Current license from the KY Board of License Professional Counselor (KRS Chapter 335).
Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA)	U4	MASTERS LEVEL-Current license from the KY Board of License Professional Counselor (KRS Chapter 335) under supervision.

Expanded Access Services *USE "FREECARE99"

CPT	DESCRIPTION
BEHAVIORAL HEALTH	
90785	INTERACTIVE COMPLEXITY
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MED SERV
90832	PSYCHOTHERAPY, 30 MINUTES WITH PT AND/OR FAM MEM
90833	PSYCHOTHERAPY, 30 MIN WITH PT AND/OR FAM MEM W/E&M
90834	PSYCHOTHERAPY, 45 MIN WITH PAT AND/OR FAMILY MEMBER
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service. Use in conjunction with allowable E&M codes [99203-99205, 99213-99215]
90837	PSYCHOTHERAPY, 60 MIN WITH PATIENT AND/OR FAMILY
90838	PSYCHOTHERAPY, 60 MIN WITH PAT AND/OR FAM MEM W/E&M
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MIN
90840	EACH ADDITIONAL 30 MIN
90846	FAMILY PSYCHOTHERAPY W/O PATIENT
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)
90887	COLLATERAL THERAPY/CONSULTATION WITH FAMILY/EXPLANATION OF PSYCHIATRIC, MEDICAL EXAMS, PROCEDURES AND DATA TO OTHER THAN PATIENT
96110	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, E
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient and family member(s) or caregiver(s), when performed; first hour
96131	Each additional hour Use in conjunction with 96130
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Each additional hour Use in conjunction with 96132
96136	Psychological or Neuropsychological testing administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Each additional 30 minutes 96136, 96137 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Each additional 30 minutes 96138, 96139 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days

96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the practitioner's time in-person with patient and/or guardian(s)/caregiver(s) administering assessments and discussing finding and recommendations, and non-in-person analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification supporting assessment
97153	Adaptive behavior treatment by protocol
97154	Group adaptive behavior treatment by protocol
97155	Adaptive behavior treatment with protocol modification
97156	Family adaptive behavior treatment guidance
97157	Multiple-family group adaptive behavior treatment guidance
97158	Group adaptive behavior treatment with protocol modification
99406	Smoking & Tobacco Use Cessation counseling visit; Intermediate, greater than 3 and up to 10 minutes.
99407	Smoking & Tobacco Use Cessation counseling visit; Intensive, greater than 10 minutes.
99408	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND INTERVENTION, 15-30 MINUTES
99409	Screening, Brief Intervention, & Referral to Treatment (SBIRT)
99457	REM PHYSIOL MNTR 1ST 20 MIN
99458	REM PHYSIOL MNTR EA ADDL 20 MIN
99473	SELF-MEAS BP PT EDUCAJ/TRAIN
H0001	ALCOHOL AND/OR DRUG ASSESS
H0002	ALCOHOL AND/OR DRUG SCREENING
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude, and/or behavior)
H0031	Mental health assessment by non- physician
H0032	MH SVC PLAN DEV BY NON-MD
H0038	SELF-HELP/PEER SVC PER 15MIN
H0049	Alcohol and/or Drug Screening, & Brief Intervention, less than 15 minutes
H2011	CRISIS INTERVEN SVC, 15 MIN
H2012	BEHAV HLTH DAY TREAT, PER HR
H2015	COMP COMM SUPP SVC, 15 MIN
H2019	Therapeutic Behavioral Health services, per 15 minutes
H2021	COM WRAP-AROUND SV, 15 MIN
H2027	Psychoeducational Service, per 15 minutes
T1007	Alcohol and/or Substance Abuse Services treatment plan development and/or modification.
97535	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (AD
S9480	INTENSIVE OUTPATIENT PSYCHIA
S9484	CRISIS INTERVENTION PER HOUR

LABWORK/TEST	
87591	N.GONORRHOEAE DNA AMP PROB
87804	INFLUENZA ASSAY W/OPTIC
87880	STREP A - ASSAY W/OPTIC
THERAPY	
96372	THER/PROPH/DIAG INJ, SC/IM
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCUL
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMP
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97167	OT EVAL HIGH COMPLEX 60 MIN
97168	OT RE-EVAL EST PLAN CARE
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PRO
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMO
SPEECH-LANGUAGE-AUDIOLOGY	
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY/INDIVIDUAL
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR HEARING PROCESSING DISORDER/GROUP
92521	EVALUATION OF SPEECH FLUENCY/INDIVIDUAL
92522	EVALUATE SPEECH SOUND PRODUCTION/INDIVIDUAL
92523	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION
92524	BEHAVIORAL QUALITATIVE ANALYSIS OF VOICE AND RESONANCE
92551	AIR TONE CONDUCTION HEARING ASSESSMENT/SCREENING
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY
MEDICAL	
99421	OL DIG E/M SVC 5-10 MIN
99422	OL DIG E/M SVC 11-20 MIN
99423	OL DIG E/M SVC 21 + MIN
99382	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION AGE 1-4
99383	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION, AGE 5 - 11

99384	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION, AGE 12-17
99385	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION AGE 18-39
99392	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION, AGE 1-4
99393	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION, AGE 5-11
99394	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION, AGE 12-17
99395	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION AGE 18-39
99202	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 20 MINUTES
99203	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 30 MINUTES
99204	OFFICE/OUTPATIENT VISIT, NEW TYPICALLY 45 MINUTES
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, MODERATE TO HIGH SEVERITY (REQUIRING THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY;A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY
99211	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 5 MINUTES
99212	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 10 MINUTES
99213	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 15 MINUTES
99214	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 25 MINUTES
99215	OFFICE/OUTPATIENT VISIT, ESTABLISHED TYPICALLY 40 MINUTES
99354	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE FIRST HOUR
99355	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE EACH 30 MINUTES BEYOND FIRST HOUR
69210	REMOVAL IMPACTED CERUMEN (SEPARATE PROCEDURE), ONE OR BOTH EARS
99173	SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BILATERAL
J0696	INJ, CEFTRIAXONE SODIUM, PER 250 MG
NURSING SERVICES	
T1002	RN SERVICE UP TO 15 MINUTES
T1003	LPN/LVN SERVICE UP TO 15 MIN
T1004	NSG AIDE SERVICE UP TO 15 MIN
VACCINES	
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90471	IMMUNIZATION ADMIN
90472	IMMUNIZATION ADMIN EACH ADD
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90620	MENB PR W/OMV VACCINE
90621	MENB RLP VACCINE
90630	VACCINE FOR INFLUENZA FOR INJECTION INTO SKIN
90632	HEP A VACCINE ADULT IM

90633	HEP A VACC PED/ADOL DOSAGE-2 DOSE
90634	HEP A VACC PED/ADOL 3 DOSE
90636	HEP A/HEP B VACC ADULT IM
90644	MENINGOCCL HIB VAC 4 DOSE IM
90647	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE)
90648	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-T CONJUGATE (4 DOSE SCHEDULE)
90649	HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18 (QUADRIVALENT)
90650	VACCINE FOR HUMAN PAPILLOMA VIRUS (3 DOSE SCHEDULE) INJECTION INTO MUSCLE
90651	VACCINE FOR HUMAN PAPILLOMA VIRUS (3 DOSE SCHEDULE) INJECTION INTO MUSCLE
90653	FLU VACCINE, ADJUVANTED IM, 65 AND OLDER ONLY
90654	FLU VACCINE NO PRESERV ID
90655	FLU VAC NO PRSV 3 VAL 6-35 M
90656	FLU VACCINE NO PRESERV 3 & >
90657	FLU VACCINE, 3 YRS, IM
90658	FLU VACCINE 3 YRS & > IM
90660	FLU VACCINE, NASAL
90661	FLU VACC CELL CULT PRSV FREE
90662	FLU VACC PRSV FREE INC ANTIG
90670	PNEUMOCOCCAL VACC 13 VAL IM
90672	FLU VACCINE 4 VALENT NASAL
90673	FLU VACC RIV3 NO PRESERV
90674	CCIIV4 VAC NO PRSV 0.5 ML IM
90680	ROTOVIRUS VACC 3 DOSE ORAL
90681	ROTAVIRUS VACC 2 DOSE ORAL
90682	RIV4 VACC RECOMBINANT DNA IM
90685	FLU VAC NO PRSV 4 VAL 6-35 M
90686	FLU VAC NO PRSV 4 VAL 3 YRS+
90687	FLU VACC 4 6-35 MONTHS IM
90688	FLU VACC 4 VAL 3 YRS PLUS IM
90689	VACC IIV4 NO PRSRV 0.25ML IM
90696	DTAP-IPV VACC 4-6 YR IM
90697	VACCINE DTaP-IPV-Hib-HepB FOR INTRAMUSCULAR USE
90698	DTAP-HIB-IP VACCINE, IM
90700	DTAP VACCINE, < 7 YRS, IM
90702	DT VACCINE < 7 YRS IM
90707	MMR VACCINE, SC
90710	MMRV VACCINE, SC

90713	POLIOVIRUS, IPV, SC/IM
90714	TD VACCINE NO PRSRV 7/> IM
90715	TDAP VACCINE 7 YRS/> IM
90716	CHICKEN POX VACCINE SC
90723	DTAP-HEP B-IPV VACCINE, IM
90732	PNEUMOCOCCAL VACCINE 23 VAL IM
90733	MENINGOCOCCAL VACCINE, SC
90734	MENINGOCOCCAL VACCINE IM
90736	ZOSTER VACC, SC
90739	HEPB VACC 2 DOSE ADULT IM
90740	HEPB VACC ILL PAT 3 DOSE IM
90743	HEP B VACC, ADOL, 2 DOSE, IM
90744	HEP B VACC PED/ADOL 3 DOSE IM
90746	HEP B VACC ADULT 3 DOSE IM
90747	HEP B VACC ILL PAT 4 DOSE IM
90748	HEP B/HIB VACCINE IM
90750	HZV VACC RECOMBINANT IM NJX
90756	CCIIV4 VACC ABX IM

Note: VACCINES CODES (90620-90756) REQUIRE THE USE OF AN "SL" MODIFIER IF VACCINE IS FROM THE VACCINES FOR CHILDREN (VFC) PROGRAM. PLEASE REFER TO GAINWELL TECHNOLOGIES FOR FURTHER PROVIDER BILLING INSTRUCTIONS.

Individualized Education Program (IEP)

Plan of Care

The IEP becomes the Plan of Care for the provision of Medicaid-covered services and the student's IEP governs the health services provided to the student in the educational setting. The ARC develops an IEP consistent with requirements of the IDEA and state regulations in 707 KAR Chapter 1. The IEP and accompanying documents (i.e., evaluation reports, ARC meeting records, tests, physician reports, and other documents) support the inclusion of a health service in the IEP and document the medical necessity of the service. The IEP must contain sufficient information to determine the type of services provided and the location, amount, anticipated frequency and duration of services.

The IDEA provides some federal financial assistance to states and local school districts for special education and related services provided to children through a child's IEP. For those children identified and determined to be disabled, in accordance with the requirements of the IDEA, an IEP must be developed by a team of individuals as defined in state and federal regulations. The IEP is statutorily defined and requires specific elements.

Not all of the special education and related services required by the IDEA and included in a child's IEP are within the scope of the Medicaid program. Only those **medically necessary** IDEA services that are described in the federal definition of "medical assistance" can be covered as Medicaid services when furnished by qualified participating Medicaid providers.

In Kentucky, the following services are covered if provided to address a medical or developmental disability and assist the eligible student in benefiting from special education programming if it is included and provided in accordance with the child's IEP:

- a) Nursing;
- b) Audiology;
- c) Speech and language;
- d) Occupational therapy;
- e) Physical therapy;
- f) Behavioral health;
- g) Incidental interpreter services provided in conjunction with another covered service;
- h) Orientation and mobility services;
- i) Respiratory therapy
- j) Assistive technology devices and appropriate related evaluations; if the device is purchased by the Medicaid Program, the device becomes the property of the recipient to be used at school and at home
- k) Transportation with limitations.

Medicaid covers services included in an IEP under the following conditions:

- The services are medically necessary, and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- The services must be listed in the child's IEP;
- The services must meet the coverage provisions and requirements of [907 KAR 1:715](#) and all other federal and state Medicaid regulations, including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and
- The services are included in the state's plan or available under Early & Periodic Screening, Diagnostic and Testing.

IEP Therapy

Approved, qualified practitioners provide treatment and therapy services in accordance with the student's IEP (Plan of Care). Treatment services are provided with the expectation that the student's condition will improve significantly in a reasonable (and generally predictable) period, or the services are necessary to maintain a safe and effective maintenance program. These services are at a level of complexity and sophistication or the condition of the student is such that the health service can only be provided by a licensed or certified practitioner, or by a trained person under the supervision of a licensed or certified practitioner.

During the course of treatment, the areas of Speech-Language, Occupational Therapy, Physical Therapy and Behavioral Health may have services delivered either in an individual or group setting.

- **Individual** therapy is defined by the DMS as a "therapeutic intervention provided by a qualified practitioner for the purpose of reducing or eliminating the presenting problem of the student." Individual services are provided in a in-person or via telehealth, one-on-one encounter between the student and the qualified practitioner.
- **Group therapy** services are defined by the DMS as "therapeutic intervention provided by qualified practitioners to a group of students. **Only services provided to a group of six or less are billable.** Group treatment is rehabilitation services, which offer activities in a therapeutic environment that focus on the development and restoration of the skills of daily living." For IEP services, group therapy must be identified in the IEP in order to bill for this service. It is permissible to state "Individual or Small Group Therapy".

Group therapy reimbursement is limited to the following services:

- Behavioral Health
- Occupational Therapy
- Speech Therapy
- Physical Therapy

A therapist's time providing Community Based Instruction may be reimbursed if the therapist's role is specified in the IEP. The service log documentation would then describe the service delivery and the student's response to the services provided.

When a therapist exceeds service, delivery specified in the IEP for any given week, a notation must be made in the Progress Notes of the service log if the additional services are make-up sessions. The practitioner will complete the service log showing the required information. However, the practitioner must also include the statement, for example, "Make-up session for 1/11/04." The only time a session has to be made up is when the therapist is unavailable to perform the service. Therapists cannot "makeup" future sessions.

IEP Provider Descriptions and Modifiers

DESCRIPTION	CREDENTIALS	MOD1	MOD2
Clinical Psychologist	Current license from the KY Board of Examiners of Psychology in accordance with KRS Chapter 319	AH	
MD	Doctoral level Per Practice Guidelines	HP	
Licensed Professional Clinical Counselor (LPCC)	MASTERS LEVEL-Current license from the KY Board of License Professional Counselor (KRS Chapter 335)	HO	
Licensed Professional Counselor Associate/Intern (LPCA)	Working on MASTERS LEVEL/Student of LPCC under the supervision of LPCC (KRS 335)	HO	HL
Licensed Psychological Practitioner (LPP)	MASTERS LEVEL/No supervision, Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)	U4	
Licensed Psychologist	DOCTORAL LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)	U4	HP
Certified Psychologist with Autonomous functioning	MASTERS LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)	U5	
Certified Psychologist	MASTERS LEVEL/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)	U5	HO
School Psychologist	MASTERS LEVEL-Current school psychologist certification, only performing services in a school setting. Provider must meet the requirements of 16 KAR 2:090	U5	
Licensed Psychological Associate	MASTERS LEVEL Under supervision of PHD Psychologist in same building/Current license to practice by the KY Board of Examiners of Psychology (KRS Chapter 319)	U4	HO
Board Certified Behavior Analyst	MASTERS LEVEL/Current license from the Kentucky Applied Behavior Licensing Board (KRS Chapter 319C)	U8	
Board Certified Assistant Behavior Analyst	Current license from the Kentucky Applied Behavior Licensing Board as an assistant and under the supervision of BCBA (KRS Chapter 319C)	U8	U3
Licensed Clinical Social Worker (LCSW)	MASTERS LEVEL/Current license from the KY Board of Social Work (KAR 201 Chapter 23)	AJ	
Certified Social Worker (CSW)	MASTERS Current license as a social worker by the Kentucky Board of Social Work (KAR 201 Chapter 23) and under the supervision of a LCSW. Authorized by KRS 335.010 to 335.160 and 335.990.	U7	
Psychometrist	Refer to the Board of Examiners of Psychology KRS 319.	U9	

Speech-Language Pathologist	Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).	GN	
Speech-Language Pathologist-CF	Interim license requirement -- Exemption for public school speech-language pathologists with teacher certification in communication disorders. Per Statute 334A.035	GN	
Occupational Therapist	Current license from KY Occupational Therapy Board (KAR 201 Chapter 28)	GO	
Occupational Therapy Assistant	Current license from the KY Occupational Therapy Board and under the supervision of a licensed Occupational Therapist (KAR 201 Chapter 28)	GO	U3
Occupational Therapist Aide	Under the direct supervision of the KY licensed Occupational Therapist (KRS 319A. 010 (5))	GO	UA
Physical Therapist	Current license from the KY Board of Physical Therapy or a temporary permit issued by the KY Board of Physical Therapy (KAR 201 Chapter 22)	GP	
Physical Therapist Assistant	Current license from the KY Board of Physical Therapy and under supervision of a licensed Physical Therapist (KAR 201 Chapter 22)	GP	U3
Physical Therapist Aide	Under the direct on-site supervision of the KY licensed Physical Therapist or Physical Therapy Assistant (201 KAR 22:053, Section 5.)	GP	UA
Physical Therapy Student (Intern)	Student of Physical Therapy under the supervision of a KY licensed Physical Therapist (KAR 201 Chapter 22)	GP	HL
Intern	Per Practice Guidelines	HL	
Advanced Registered Nurse Practitioner (ARNP)	Current license from the Kentucky (KY) Board of Nursing (201 KAR 20:057)	SA	
Registered Nurse	Current license from the KY Board of Nursing (201 KAR 20:057)	TD	
Licensed Practical Nurse	Current license from the KY Board of Nursing under appropriate supervision and delegation (201 KAR 20)	TE	

Health Aide	Under the supervision of and with training by a KY licensed ARNP or RN and being monitored by the supervising nurse in provision of the delegated and supervised nursing services (201 KAR 20:400)	U1	
Audiologist	Current license from KY Board of Speech Language Pathology and Audiology (201 KAR 17:012)	U2	
Interpreter	Must be licensed by the KY Board of Interpreters for the Hearing Impaired as required by KRS 309.300 to 309.319	UB	
Orientation and Mobility	Current certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or the National Blindness Professional Certification Board (NBPCB)	UC	
Licensed Professional Art Therapist- LPAT	MASTERS LEVEL-Current license from the KY Board of License Professional Art Therapists (KRS Chapter 309)	HO	
Licensed Professional Art Therapist Associate- LPATA	MASTERS LEVEL-Current license from the KY Board of License Professional Art Therapists (KRS Chapter 309) under supervision	U4	
Licensed Marriage and Family Therapist- LMFT	MASTERS LEVEL-Current license from the respective KY Professional Board (KRS Chapter 335)	HO	
Marriage and Family Therapist Associate- MFTA	MASTERS LEVEL-Permit from the respective KY Professional Board (KRS Chapter 335)	U4	
Licensed Clinical Alcohol and Drug Counselor (LCADC)	MASTERS LEVEL-Current license from the respective KY Professional Board (KRS Chapter 309)	HO	
Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA)	MASTERS LEVEL-Current license from the respective KY Professional Board (KRS Chapter 309) under supervision	U4	

IEP Services

CODE	IEP PROCEDURE DESCRIPTION
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION CODE
90832	PSYCHOTHERAPY WITH PATIENT WITH AND OR FAMILY 30 MINUTES
90834	PSYCHOTHERAPY WITH PATIENT WITH AND OR FAMILY 45 MINUTES
90837	PSYCHOTHERAPY WITH PATIENT WITH AND OR FAMILY 60 MINUTES
90853	GROUP PSYCHOTHERAPY
96153	GROUP/BEHAVIORAL HEALTH THERAPY
BCBA/BCABA Services	
97151	Individual Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time in-person or via telehealth with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-in-person analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
97152	Individual Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, in-person or via telehealth, with the patient, each 15 minutes.
97153	Individual Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, in-person or via telehealth, with one patient, each 15 minutes.
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, in-person or via telehealth, with two or more patients, each 15 minutes.
97155	Individual Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, in-person or via telehealth, with one patient, each 15 minutes.
97156	Individual Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), in-person or via telehealth, with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), in-person or via telehealth, with multiple sets of guardians/caregivers, each 15 minutes.
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, in-person or via telehealth, with multiple patients, each 15 minutes.
Occupational Therapy	
97165	OT EVAL; LOW COMPLEXITY; 30 MINUTES
97166	OT EVAL; MEDIUM COMPLEXITY; 45 MINUTES
97167	OT EVAL; HIGH COMPLEXITY; 60 MINUTES
97110	OT WHEN ONE OUTCOME IS INTENDED BY THE EXERCISE/ INDIVIDUAL/15 MINUTES

97150	OT- GROUP/15 MINUTES
97530	OT- INDIVIDUAL WHEN MORE THAN ONE OUTCOME IS EXPECTED-15 MINUTES
Physical Therapy	
97161	PT EVAL; LOW COMPLEXITY 20 MINUTES
97162	PT EVAL; MEDIUM COMPLEXITY 30 MINUTES
97163	PT EVAL; HIGH COMPLEXEXITY 45 MINUTES
97110	PT WHEN ONE OUTCOME IS INTENDED BY THE EXERCISE/ INDIVIDUAL/15 MINUTES
97150	PT GROUP 15 MINUTES
97530	PT INDIVIDUAL WHEN MORE THAN ONE OUTCOME IS EXPECTED-15 MINUTES
Speech Therapy	
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY/INDIVIDUAL
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR HEARING PROCESSING DISORDER/GROUP
92521	EVALUATION OF SPEECH FLUENCY/INDIVIDUAL
92522	EVALUATE SPEECH SOUND PRODUCTION/PURE TONE AUDIOMETRY/INDIVIDUAL
92523	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION/INDIVIDUAL
92524	BEHAVIORAL QUALITATIVE ANALYSIS OF VOICE AND RESONANCE/INDIVIDUAL
92551	AIR TONE CONDUCTION HEARING ASSESSMENT/SCREENING/INDIVIDUAL
NURSING SERVICES	
T1002	RN SERVICES UP TO 15 MINUTES
T1003	LPN/LVN SERVICES UP TO 15 MINUTES
T1004	NURSING AIDE UP TO 15 MINUTES
OTHER	
97533	ORIENTATION AND MOBILITY
A0160	TRANSPORTATION
E1399	ASSISTIVE TECHNOLOGY
T1013	INTERPRETER

Monitoring Compliance

In accordance with an interagency agreement between the Cabinet for Health and Family Services, the Kentucky Department for Medicaid Services (DMS) and the Kentucky Department of Education (KDE), the KDE conducts program monitoring. The DMS conducts periodic quality assurance, utilization reviews or other audit procedures required by state or administration of the Medicaid program.

Upon informed consent of the parent, the district provides records and other pertinent information, to the DMS, Center for Medicare and Medicaid Services (CMS), Health Human Services (HHS), Office of the Inspector General (OIG) or any agency commissioned to audit the program. Records are to be provided upon request and at no cost to the requesting party. As requested, each practitioner provides records or copies of records relating to and substantiating services billed by the practitioner. These records are provided without charge.

The KDE conducts site visits as part of an established monitoring protocol and issues a monitoring report to the district. The focus of the monitoring of each LEA includes:

- Medicaid related criteria (as stated in KDE monitoring documents);
- Review of records of Medicaid eligible students; and
- Addressing areas of noncompliance in the Corrective Action Plans (CAPs) submitted by LEAs.

The following records are reviewed during the site visit:

- Personnel files of the service providers (staff and other practitioners) including copies of licensure, certifications, employment contracts, and in-service (professional development) participation.
- Educational records of Medicaid eligible students receiving school-based health services.
- Financial records regarding the Medicaid program.
- A list of Medicaid covered school-based health services the LEA provides.
- The Quality Assurance Plan with verification of implementation within one (1) year of outline approval.
- Records of Peer Review Committee meetings.

Program Integrity

The quality assurance documents include activities used by the school district to monitor and evaluate the quality of covered school-based health services and document that the services were provided as indicated by program requirements.

The program ensures that all Medicaid students are provided any medically necessary services and that the services are efficient, appropriate and meets prevailing standards of quality consistent with the Medicaid program. The program includes:

- Participating in all program integrity activities
- Being responsible for the accuracy, compliance and completeness of all claims submitted for Medicaid reimbursement
- Recovering of overpayments if a school district is found not in compliance with agency requirements.
- Ensuring qualified staff
- Determining eligibility and developing an appropriate Individual Education Program (IEP) (Plan of Care)
- Annually notifying parents and obtaining consent to release records for Medicaid billing
- Collaborating with other Medicaid service providers
- Physician involvement
- Record keeping
- PEER review including medical necessity of services and accuracy of billing

Excluded Services

- Some of the IDEA required services are specifically excluded from Medicaid reimbursement.
- For example, child find is excluded from Medicaid reimbursement. Part B of the IDEA provides for the identification, location, and evaluation of children with disabilities within the state, and mandates that a “practical” method be developed and implemented to determine which children with disabilities should be provided services. A state is only eligible for funding under IDEA if the state demonstrates that it meets certain conditions, including conducting “child find” activities, as defined in the IDEA. These “child find” activities are undertaken to identify children in need of special education and related services. Medicaid is not responsible for covering or paying for “child find” or other activities that fulfill education mandates. Other services not covered by Medicaid reimbursement include:
 - Any services not listed under covered services.
 - Solely educational or academic assessment.
 - Education-based costs normally incurred to operate a school and provide an education.
 - Routine group speech or language screenings.
 - Services provided to the school district by an educational cooperative during the normal course of business without charge to the district.
 - Time spent on documenting clinical service notes, treatment plans, or summaries on progress.
 - Information furnished to the district (i.e., the provider) by the recipient over the phone.
 - Cancelled visits or missed appointments or services.
 - Concurrent services for the same child involving similar services or procedures.
 - Combined billing for same day services (IEP make-up session is allowed).
 - Transportation of therapist to or from the site of therapy except for contract therapists.
 - Medical care not addressed in the child’s IEP. However, medical care not addressed in the child’s IEP may be covered under the Expanded Access Program.

Timed and Untimed Procedure Codes

School districts and providers are responsible for billing the appropriate procedure codes and units for the service(s) provided.

If a code's short description does not include time, the code is billed as one unit regardless of how long the service takes, unless otherwise in a current CPT or HCPCS manual. Consult the CMS website for additional guidance if needed.

The agency denies claims submitted for more than the maximum allowable units per day.

For any code reimbursed based on time, each measure of time as defined by the code description equals one unit. For codes that are billed per 15 minutes, a minimum eight minutes of service must be provided to bill for one unit. Partial units must be rounded up or down to the nearest quarter hour.

To calculate billing units for 15-minute timed codes, count the total number of billable minutes for the calendar day for the eligible student and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, $68 \text{ total billable minutes} = 5 \text{ units of service}$.

Minutes	Units
0 min-7 mins	0 units
8 mins-22 mins	1 unit
23 mins-37 mins	2 units
38 mins-52 mins	3 units
53 mins-67 mins	4 units
68 mins-82 mins	5 units

Sanctions

The Kentucky department of education or Kentucky department for Medicaid services may impose sanctions against a provider (LEA) for any one or more of the following reasons:

- Violations of applicable laws, regulations, or codes of ethics related to programs or conduct of Medicaid providers (LEA's) or service providers (practitioners). (Failure to meet standards required by state or federal law for participation.)
- Failure to correct deficiencies within specified timelines after receiving written notice of these deficiencies from the KDE. (Failure to comply with a corrective action plan)
- Obtaining funds through deception:
 - Charging recipients for services (this does not include incidental fees charged to all students as part of the regular education program.)
 - Presenting for payment false or fraudulent claims for services or equipment.
 - Submitting false information to obtain greater reimbursement than that to which the lea is legally entitled, including charges in excess of the fee schedule.
 - Overusing the program by inducing, furnishing or otherwise causing an eligible student to receive service(s) or equipment not otherwise medically required or requested through the IEP.
 - Submission of a false or fraudulent application for provider status.
- Failure to adequately or appropriately manage programs.
 - Failure to provide and maintain services to eligible students within accepted community standards
 - Breach of the requirements for provider participation, or failure to comply with the terms of the provider certification
 - Engaging in a course of conduct or performing an act deemed improper or abuse. Examples of abusive acts include:
 - Furnishing services or supplies to eligible students that are substantially in excess of the needs, harmful or grossly inferior in quality.
 - Solicitation or acceptance of any amount from the family of eligible child for specially designed instruction and related services specified in the IEP or is otherwise medically necessary, unless it is an incidental fee normally charged to all enrolled students as part of the regular education program.
 - Separate schedule of charges for services to eligible children and non-eligible students which results in higher charges for eligible students than non-eligible students.
- Failure to disclose or make available to the KDE or DMS records of services provided to eligible students and records of payments made.
- Conviction of a criminal offense relating to negligent practice resulting in death or injury, or misuse or misapplication of program funds.
- Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the lea's students.

The following **sanctions** may be invoked by the KDE or the DMS against providers, based on a finding of violation consistent with grounds for sanctions:

- Corrective action plan
- Termination from participation in the program.
- Suspension or withholding of payments.
- Recoupment of funds
- Referral to the office of education accountability for investigation.
- Referral to the appropriate licensing/certification organization for investigation and appropriate disciplinary action.
- When a provider (lea) has been sanctioned, the DMS notifies the KDE of the findings made and the sanctions imposed. If, during the course of program monitoring, the KDE finds grounds for imposing sanctions, the KDE notifies the DMS and other appropriate agencies in writing within 30 calendar days of the finding(s).

PEER Review

The PEER Review process, by reviewing students' records, is established by the district to verify the provision of appropriate and quality health services. During PEER Review, service logs are compared with medical records, IEPs, ARC Conference Summaries, student evaluation reports and any additional progress reports to validate that services have been provided for eligible children and within the practitioner's scope of practice.

A PEER Review team meets periodically during the school year to review records, discuss results, and recommend necessary changes. The team should conduct PEER Reviews on at least a quarterly basis but is only required one time annually. The Medicaid Liaison (or Director of Special Education) should organize the team and determine the meeting schedule. The PEER Review team is comprised of professionals who are employed or on contract with the district. The peers serving on the team should be familiar with the types of services provided to the student whose records are reviewed to validate that services have been provided as determined by the ARC and within the scope of practice of the providing practitioner. As appropriate, a PEER Review team may be organized by a Special Education Cooperative to perform PEER Reviews throughout the participating districts of the Cooperative.

The PEER Review team must have a majority of the members present in order to conduct a review. No member of the team reviews the records of a student he/she serves. At least **10** percent of the Medicaid eligible students' records are reviewed annually. The Medicaid Liaison considers these factors when selecting records for review:

- Records from a variety of service providers' professional disciplines;
- Schools where principals or other district administrators have requested the PEER Review team to review records;
- The Peer team will review each new student record before claims are submitted for reimbursement.

The Medicaid Liaison maintains the record review forms and minutes of each meeting. The minutes of each meeting include the names and titles of the reviewers, any concerns identified in the review, and the disposition of the team's recommendations. The Medicaid Liaison takes steps necessary to correct any concerns including reimbursement to the Department of Medicaid Services. The provider's immediate supervisor and other relevant administrators will be notified as deemed appropriate.

Glossary

This section defines terms and abbreviations, including acronyms, used in this billing guide.

- **Admissions and Release Committee** or "ARC" means a group of individuals required by 707 KAR 1:320 and 34 C.F.R. 300.344 who are responsible for developing, reviewing, and, as necessary, revising the individualized education program for a child with a disability.
- **Audit** means checking the district's documentation and procedures to determine if claims were consistent with Medicaid and IDEA program requirements
- **Assessment** – medically necessary tests given to a child by a licensed professional to evaluate whether a child is determined to be a child with a disability, and is in need of special education and related services. Assessments are a part of the evaluation and reevaluation process and must accompany the individualized education program (IEP) or individualized family service plan (IFSP).
- **Assistive technology device** means an item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of a child with a disability; and medically necessary to implement the health services in the child's individualized education program.
- **Certification** means the process used for the Kentucky department of education to recommend approval to the department of Medicaid services for a school district to become a health services provider in Kentucky.
- **Claim** means the form or electronic request for reimbursement submitted by the provider (the school district) to the department of Medicaid services.
- **CMS** means the centers for Medicare and Medicaid services, which is the federal agency that is responsible for administering the Medicaid program .
- **Consent** means that the parent was informed of all information relevant to the activity for which consent is sought, in his or her native language or other mode of communication, and the parent understands and agrees in writing to the carrying out of the activity for which his or her consent is sought. The signed consent describes that activity and lists the records that will be released and to whom. The parent understands that the granting of consent is voluntary and may be revoked at any time.
- **CPE – certified public expenditure**
- **CPT code** - Current Procedural Terminology is a standardized code established by the American medical association that is used by Kentucky department for Medicaid services to document and identify medical services, procedures, and interventions performed by practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association
- **Child with a disability** – a child evaluated and determined to need special education and related services because of a disability.
- **Dos-date of service** means the actual date that the covered service was provided.
- **Early intervention services** - services designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development, as identified in the infant or toddler's individualized family service plan (IFSP), in any one or more of the following areas, including:
 - Physical development;
 - Cognitive development;

- Communication development;
 - Social or emotional development; or
 - Adaptive development.
- **Denial** means that Medicaid refuses a claim for reimbursement.
 - **Direct supervision** means that the licensed or certified practitioner is physically present as required by Kentucky statute, regulation or the Kentucky board issuing the practitioner’s license or certification.
 - **Electronic signature** - a signature in electronic form attached to or associated with an electronic record including, but not limited to, a digital signature.
 - **Evaluation** – procedures used to determine whether a child has a disability, and the nature and extent of the special education and related services that the child needs.
 - **EPSDT** – early and periodic screening, diagnostic and treatment
 - **Expanded access**- means a medically necessary, non-IEP Medicaid-covered service for any Medicaid eligible child.
 - **FAPE - free appropriate public education** is defined in the IDEA as special education and related services (1) provided to children with disabilities at public expense; (2) under public supervision and direction, and without charge; (3) meet the standards of the state education agency; and (4) are provided in conformance with an individualized education program (IEP) that is developed consistent with the federal regulations.
 - **FERPA** – Family Educational Rights and Privacy Act, 20 USC § 1232g; 34 [CFR](#) Part 99.
 - **FMAP** – Federal Medicaid Assistance Percentages.
 - **FQHC** – Federally Qualified Health Center
 - **FERPA** – Family Educational Rights and Privacy Act, 20 USC § 1232g; 34 [CFR](#) Part 99
 - **FMAP** – Federal Medicaid Assistance Percentages
 - **FQHC** – Federally Qualified Health Center
 - **HIPAA – Health Insurance Portability and Accountability Act**
 - **Habilitation** – Services that address cognitive, social, fine motor, gross motor, or other skills that contribute to mobility, communication, and performance of activities of daily living skills (ADLs) to enhance the quality of life.
 - **Handwritten signature** – A scripted name or legal mark of an individual on a document to signify knowledge, approval, acceptance, or responsibility of the document.
 - **HCPCS-Health care common procedure coding system.** Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. **Health care-related services** – Developmental, corrective, and other supportive services required to assist an eligible child to benefit from special education. For the purpose of the School-Based Health Care Services program, related services include audiology, counseling, nursing, occupational therapy, physical therapy, psychological assessments, and speech-language therapy.
 - **IDEA - Individuals with Disabilities Education Act** – A United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities from birth through age 20.

- **IEP- Individualized Education Program** – A written educational program for a child, who is age three through twenty and eligible for special education. An IEP is developed, reviewed, and revised in accordance with 707 KAR 1:002 and 707 KAR 1:320.
- **IFSP - Individualized family service plan** - A plan for providing early intervention services to a child, birth through age two, with a disability or developmental delay and the child's family. The IFSP is based on the evaluation and assessment described in 34 CFR 303.321 and includes the content specified in 34 CFR 303.344. The IFSP is developed under the IFSP procedures in 34 CFR 303.342, 303.343, and 303.345.
- **Incidental interpreter services** mean those interpreter services that are necessary to allow the child to benefit from other covered school-based health services.
- **LEA** – Local Educational Agency
- **MCO** – Managed Care Organization
- **Medically necessary** – “Medically Necessary” or “Medical Necessity” means health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient. The CMS defines medical necessity as “services that meet accepted medical standards or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member.”
- **NPI - National Provider Identifier**
- **Practitioner** means the covered professional or other approved individual providing the covered health service.
- **Progress note** means a dated, signed or initialed entry on the service log detailing the service provider’s encounter with the student and the student’s response to the encounter.
- **Provider** means the local school district, the Kentucky School for the Deaf or the Kentucky School for the Blind providing covered health services under the Medicaid school-based health services program.
- **Provider agreement** means a contract between the school district (provider) and the Kentucky Department of Medicaid Services that states the conditions of participation the Medicaid SBHS program.
- **Provider number** means the number assigned by the Kentucky Department of Medicaid Services to the provider (i.e., the approved participating school district, Kentucky School for the Blind (KSB) or Kentucky School for the Deaf (KSD)).
- **Qualified health care provider** –an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice
- **RAC** – Recipient Aid Category -Categories assigned to a Medicaid recipient that are used to assign benefits.
- **Recipient** means a Medicaid-eligible child under the age of twenty-one (21), including the entire month in which the child becomes twenty-one (21).
- **Re-evaluation** – Procedures used to determine whether a child continues to be in need of special education and related services.
- **Rehabilitation** – Services provided to address a child’s physical, sensory, and mental capabilities lost due to an injury, illness, or disease. Services are prescribed in the IEP or IFSP and are designed to assist a child in compensating for deficits that cannot be reversed medically.

- **Reimbursement** means the amount of money remitted to the provider from the Department of Medicaid Services.
- **Related services** are defined at 34 CFR 300.24 as “transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education.” This includes:
 - Counseling services;
 - Early identification and assessment of disabilities;
 - Medical services for diagnostic and evaluation purposes;
 - Occupational therapy;
 - Orientation and mobility services;
 - Parent counseling and training;
 - Physical therapy;
 - Psychological services;
 - Rehabilitation counseling services;
 - School health services;
 - Social work services in schools; and
 - Speech-language pathology and audiology services
- **RMTS** – Random Moment in Time Study
- **School-Based Health Care Services Program (SBHS)**- School based health care services for infants and toddlers receiving early intervention services and children who require special education services which are diagnostic, evaluative, habilitative, and rehabilitative in nature; are based on the child’s medical needs and are included in the child’s IEP or IFSP. The agency pays school districts for school-based health care services delivered to Medicaid- eligible children who require special education services under Section 1903 (c) of the Social Security Act, and Individuals with Disabilities Education Act (IDEA) Part B (3 through 20 years of age).
- **School-Based Health Care Services Program Specialist or SBHS Specialist**- An individual identified by the agency who is responsible for managing the SBHS program.
- **School-based health services (SBHS)** means medically-necessary health services provided for in 907 KAR 1:034 for any Medicaid eligible child as well as services specified in an individualized education program for a child determined to be Medicaid eligible and eligible under the provisions of the Individuals with Disabilities Education Improvement Act, 20 U.S.C. Chapter 33, and 707 KAR Chapter 1.
- **Service log** means the documentation, which supports the district’s claims that are submitted to Medicaid for reimbursement.
- **Service logs:**
 - Identify the student and the approved individual providing the service;
 - Show the time, date, and units of service provided;

- Contain legible statements written in an objective manner that describe the services performed and the progress being made, any change in treatment, and response to the treatment; and
 - Are signed and dated by the professional who provided or supervised the service.
- **Signature log** - A typed list that verifies a licensed provider's identity by associating each provider's signature with their name, handwritten initials, credentials, license and national provider identification (NPI) numbers.
- **Special education** – See **Supervision** - Supervision that is provided by a licensed health care provider either directly or indirectly in order to assist the supervisee in the administration of health care-related services outlined in the IEP or IFSP.
- **SPA – State Plan Amendment** – A formal, written agreement between the state Medicaid program and CMS that outlines the operational and policy decisions that determine who is eligible for Medicaid, what services and providers are covered and how payments are made.
- **Special Education** is defined in federal regulations (34 CFR 300.26) to mean specially designed instruction, which meets the unique needs of the child and includes instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education.
- **Tele-medicine** – Tele-medicine is when a qualified health care provider uses HIPAA compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within the provider’s scope of practice to a client at a site other than the site where the provider is located.
- **Unit** means a (15, 30 or 45) minute block of time. Medicaid reimburses school districts for the cost of services in units. For example, a school district would bill for Medicaid for two units of a practitioner’s cost if the practitioner provided a covered service that runs concurrently.

Frequently Asked Questions

1. Why are schools billing Medicaid?

Medicaid and the Individuals with Disabilities Education Improvement Act (IDEA) allow some Individualized Education Program (IEP) services or medically necessary services to be covered by Medicaid. School districts may optimize the use of financial resources by billing Medicaid when possible.

2. How do schools use the money received from Medicaid?

Money that school districts receive is applied to the district's general fund and can be used as that local school board determines.

3. Do schools need parental consent to bill Medicaid?

Yes, schools are required to receive consent for treatment. The Kentucky Family Educational Rights and Privacy Act (FERPA), KRS 160.700, requires parental consent before disclosing information about a student. This includes providing information to Medicaid.

4. Will my school bill my private insurance as well?

No, schools do not bill private insurance.

5. If schools bill Medicaid for IEP services, will Medicaid services that I receive outside of school be affected?

No, schools are required to provide all IEP services even if the school cannot bill Medicaid. Medicaid services received outside of school and the child's IEP are authorized separately. If outside services have been affected, families are encouraged to share concerns with the local school district and the Department of Education.

6. Are SBHS claims submitted to a Managed Care Organization (MCO)?

No, SBHS claims for eligible clients are covered under Kentucky Medicaid Fee for Services (FFS) program and directly bill Medicaid.

7. Is there a way to enter more than one clinical diagnosis, or is it acceptable to only document one of the clinical diagnoses when billing?

It is acceptable to use only one diagnosis code. KDE does not audit on the diagnosis code like they would in private practice.

8. For school-based Medicaid billing, how long should records be kept?

Records should be kept for five (5) years.

9. Who do I contact if I'm interested in contracting with the SBHS Program?

Lindsey.kimbleton@education.ky.gov.

10. Who do I contact if I need a copy of my SBHS interagency agreement?

Lindsey.kimbleton@education.ky.gov.

11. Who do I contact if I have questions on denied claims?

Districts that have contracted with a billing agency, contact your billing agency. Districts that bill directly should contact Lindsey.kimbleton@education.ky.gov.

12. Who do I contact if I have questions regarding SBHS Program Policy?

Erica.davis@ky.gov.

13. Who do I contact if I need help with provider applications?

Medicaid Provider Enrollment at (877) 838-5085.

14. Who do I contact if I have questions on the CPE process?

Medicaid Division of Financial Management at (502) 564-8217.

Resources

If you can't find the information you need within this guide or have additional questions, please direct your inquiries to:

FFS Billing Questions: Gainwell Technologies at (800) 807-1232

Prior Authorization: CareWise at (800) 292-2392

Provider Questions: (855)824-5615

Provider Enrollment or Recertification: (877) 838-5085

Report Fraud and Abuse: (800) 372-2970

DMS Site Manager: dmsweb@ky.gov

Web Links:

- DMS Regulations Title Page: [907 KAR](#)
- School-Based Health Services Regulations: [907 KAR 1:715](#)
- Medical Necessity and Clinically Appropriate Determination Basis: [907 KAR 3:130](#)
- Enroll as a Kentucky Medicaid Provider: <https://medicaidsystems.ky.gov/Partnerportal/home.aspx>
- Kentucky Medicaid Partner Portal Application (KY MPPA):
<https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/mppa.aspx>
Includes the following services - register for a KY MPPA account, access KY MPPA training resources, register for or view pre-recorded webinars, subscribe to CHFS email for updates
- [Medicaid School-Based Health Services \(SBHS\) Program](#)
- [Provider Letter Home](#)
- [PT 21 - School-Based Services Provider Summary](#)

Forms:

Parental Consent

- <https://education.ky.gov/districts/Documents/Medicaid%20Parental%20Consent%20052620%20edit.docx>.

Annual Letter

- <https://education.ky.gov/districts/Documents/Updated%20Medicaid%20Annual%20Parent%20Notification%20Letter%2001.12.21.pdf>.
- [MAP-735 - Quarterly Certification of State Expenditures by School Districts](#)

Billing Information

- [Provider Billing Instruction Home](#)
- [School-Based Services Billing Instructions](#)
- [Fee and Rate Schedule Page](#)

Contacts

Kentucky Department of Education

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Division of Budgets & Financial Management
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Kentucky Department for Medicaid Services

Erica Jones Davis, MA
Cabinet for Health and Family Services
Department for Medicaid Services
Division of Health Care Policy
Maternal and Child Health Branch
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Frankfort, Kentucky 40621
(502) 564-6890
erica.davis@ky.gov

BILLING

Gainwell Technologies
800-807-1232

Note: Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.