# SCHOOL BASED SERVICES

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## SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts, Detroit Public Schools, and Michigan School for the Deaf.

This chapter describes the coverage and reimbursement policy for direct medical services, targeted case management, and personal care services. Coverage applies to individuals up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). The Centers for Medicare & Medicaid Services (CMS) has determined that services provided in the "school" setting include services provided by qualified school staff in the "home" setting when necessary.

These services assist students with a disability to benefit from special education and related services. Medicaid reimbursement, through the Michigan Department of Health and Human Services (MDHHS), addresses the medical service needs of beneficiaries receiving special education and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover "related services" which are specified in Federal Medicaid statute as medically necessary and "included in the child's IEP established pursuant to Part B of the IDEA or furnished to a handicapped infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act."

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services are described in an individualized service plan and provided free of charge to eligible individuals. Medicaid reimbursement is not allowed for these services.

Medicaid school based services are not covered for beneficiaries involuntarily residing in a detention setting with a Benefit Plan ID of INCAR-ESO, INCAR-MA, INCAR-MA-E, or MA-HMP-INC.

Coverage is based on medically necessary, Medicaid-covered services already being provided in the school setting and enables these services provided to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid covered services. Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to the Intermediate School Districts (ISDs), Detroit Public Schools, and Michigan School for the Deaf. For the purpose of this document, the ISDs, Detroit Public Schools, and Michigan School for the Deaf will be referred to as "ISDs" for simplicity.

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. Medicaid services provided by the ISDs are to be provided as outlined in the IEP/IFSP treatment plan and are not expected to replace or substitute for services already provided by other agencies. If services are being provided by another program, ISDs are expected to coordinate the services to prevent service overlap and to assure continuity of care to the Medicaid beneficiary. Enrollment as a SBS provider is not expected to result in any change in the education agency's set of existing services or service utilization. MDHHS periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.

Covered services do not require prior authorization but must be documented and provided by qualified personnel as specified in the Covered Services Section of this chapter.

The following terms have specific meanings in the school setting:

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| **Assistive Technology Device (ATD)** | Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. |
| **Assistive Technology Service** | The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device. |
| **Certified Public Expenditure** | A certified public expenditure is an expenditure of a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match. |
| **Claims Development Software** | The claims development software is a custom-developed software that automates the school district claiming process. The claims development process is comprised of three components: sampling, training, and costs/claim generation. |
| **Direct Medical Services Program** | Direct medical services, specialized transportation, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid. |

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| **Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)** | ▪ DME items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when:<br>➢ It is medically and functionally necessary to meet the needs of the beneficiary.<br>➢ It may prevent frequent hospitalization or institutionalization.<br>➢ It is life sustaining.<br>▪ Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that:<br>➢ Treat a medical condition.<br>➢ Prevent unnecessary hospitalization or institutionalization.<br>➢ Support DME used by the beneficiary.<br>▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to:<br>➢ Improve and/or restore the beneficiary's functional level.<br>➢ Enable a beneficiary to ambulate or transfer.<br>▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to:<br>➢ Improve and/or restore the beneficiary's functional level.<br>➢ Prevent or reduce contractures.<br>➢ Facilitate healing or prevent further injury. |
| **Enrolled Medicaid Provider** | The 56 Michigan Intermediate School Districts, Detroit Public Schools, and Michigan School for the Deaf that have enrolled and revalidated with the MDHHS CHAMPS Provider Enrollment subsystem. |
| **HT Modifier (Multi-disciplinary team)** | The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team). |
| **IEP (Individualized Education Program)** | A written plan for services for eligible students between the ages of 4 and 26 in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for beneficiaries up to the age of 21. |
| **IFSP (Individualized Family Service Plan)** | A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP. |

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| **IDEA (Individuals with Disabilities Education Act)** | The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities. |
| **IDEA Assessment** | An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the individual. |
| **ISD (District)** | A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 56 intermediate school districts. |
| **MDE (Michigan Department of Education)** | A department within the State of Michigan. |
| **Random Moment Time Study** | A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time. |
| **School-Based Services** | A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public Schools, and Michigan School for the Deaf participate in the Direct Medical Services Program. |
| **School Clinical Record** | All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement. |
| **Special Education Transportation** | Transport to and from the student's pick-up and drop-off site where school based services are provided. |
| **TL Modifier (Re-evaluation of Existing Data (REED))** | The TL modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services. |
| **TM Modifier (Individualized Education Program [IEP])** | The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]). |
| **Treatment Plan** | If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection of this section. |

### 1.1 Children's Special Health Care Services

The Medicaid School Based Services program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SBS providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only), and must not submit claims for these beneficiaries.

### 1.2 Third Party Liability

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the school district does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter for additional information.)

### 1.3 Medical Necessity

A Medicaid service provided by an ISD is determined medically necessary when all of the following criteria are met:

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self care;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

### 1.4 Under the Direction of and Supervision

Certain specified services may be provided under the direction of or under the supervision of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.

"Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner to learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

### 1.5 Covered Services

Medicaid covered services billed by ISDs include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services
- Assistive Technology Device Services
- Physical Therapy Services

- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatrist Services
- Personal Care Services
- Targeted Case Management (TCM) Services
- Specialized Transportation Services

### 1.6 Service Expectations

The IEP/IFSP treatment plan must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures, and schedules for determining whether the objectives are being achieved within an appropriate period of time (at least annually). All therapy services must be skilled (i.e., require the skills, knowledge, and education of a licensed occupational therapist, licensed physical therapist, or fully licensed speech-language pathologist or licensed audiologist). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, or speech, language and hearing therapy by this program.

To be covered by Medicaid, occupational, physical, and speech, language and hearing therapy must address a beneficiary's medical need that affects his/her ability to learn in the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure, and reading).

Group therapy or treatment must be provided in groups of two to eight. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one beneficiary who is part of the class currently in session, the service is not reimbursable.

Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music and recreation therapies are not covered services.

Medicaid is required to follow the procedure code definition from the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals. Procedure codes referencing office or outpatient facility include the medical services provided in the school setting. Procedure codes that do not specify a unit of time are to be billed per session. Group therapy is billed per beneficiary.

Certain CPT/HCPCS code descriptions include a specified unit of service time. Service times are based on the time it generally takes to provide the service. If the procedure code specifies "up to 15 minutes of service", the service may be billed in a unit of time from 1-15 minutes. If the procedure code specifies a unit of time "each 15 minutes", the code may be billed when the service time equals the specified unit of time. Any additional time cannot be billed unless the full time specified is reached.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

### 1.7 Treatment Plan

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| **Requirements** | If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the beneficiary. The beneficiary's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described below. Only qualified staff may initiate, develop or change the beneficiary's treatment plan. The treatment plan must be signed, titled and dated by the qualified staff prior to billing Medicaid for services and must be retained in the beneficiary's school clinical record. (Refer to the Covered Services Section of this chapter for definitions of qualified staff.) |
| **Components** | The treatment plan, which is an immediate result of the evaluation, must consist of the following components:<br>▪ Beneficiary's name;<br>▪ Description of the beneficiary's qualifying diagnosis and medical condition;<br>▪ Time-related goals that are measurable and significant to the beneficiary's function and/or mobility;<br>▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed;<br>▪ Anticipated frequency and duration of treatment required to meet the time-related goals;<br>▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP;<br>▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and<br>▪ All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis. |
| **Review** | The treatment plan must be reviewed and updated at least annually as part of the IEP/IFSP multi-disciplinary team assessment process, or more frequently if the beneficiary's condition changes or alternative treatments are recommended. |

### 1.8 Evaluations

Evaluations for medical services are covered when:

- Performed as part of the IDEA Assessment.
- The beneficiary left and is re-entering special education.
- An initial development, review or revision of the student's IEP/IFSP treatment plan will occur.
- A change or decrease in function occurs.

### 1.8.A. Evaluations Performed for DMEPOS Medical Suppliers

If an ISD physical therapist, occupational therapist, speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

## SECTION 2 – COVERED SERVICES

### 2.1 INDIVIDUALS WITH DISABILITIES EDUCATION ACT ASSESSMENT AND IEP/IFSP DEVELOPMENT, REVIEW AND REVISION

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| **Definition** | The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the beneficiary. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered. |
| **Provider Qualifications** | Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA Assessment. To be covered by Medicaid, the staff must have the following Michigan current credentials:<br>▪ A licensed occupational therapist (OT)<br>▪ A certified orientation and mobility specialist (O&M)<br>▪ A licensed physical therapist (PT)<br>▪ A fully licensed speech-language pathologist (SLP)<br>▪ A licensed audiologist<br>▪ A fully licensed psychologist<br>▪ A limited-licensed psychologist (under the supervision of a licensed psychologist)<br>▪ A licensed professional counselor<br>▪ A limited-licensed counselor (under the supervision of a licensed professional counselor)<br>▪ A licensed master's social worker<br>▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker)<br>▪ A licensed physician or psychiatrist (MD or DO)<br>▪ A registered nurse (RN) |

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| **Procedure Codes** | Qualified staff can bill for three distinct types of assessments/evaluations/tests. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)<br>▪ The **HT modifier** is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code below followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or early-on services. The determination date must be included in the assessment/evaluation/test.<br>▪ The **TL modifier** is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.<br>▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment.<br>▪ **52 Modifier (Reduced Services)** - The 52 modifier is used to describe circumstances in which services provided were reduced in comparison to the full description of the service.<br>▪ No modifier is used when assessments/evaluations/tests are provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with no modifier. The date of service is the date the assessment/evaluation/test is completed. |

## 2.2 Occupational Therapy (Includes Orientation and Mobility Services and Assistive Technology Device Services)

### 2.2.A. Occupational Therapy Services

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| **Definition** | **Occupational Therapy:**<br>Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. Occupational therapy services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or Orientation and Mobility specialist. |
| **Prescription** | Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.<br>Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year. |

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| **Provider Qualifications** | OT services may be reimbursed when provided by:<br>▪ A licensed occupational therapist (OT); or<br>▪ A licensed occupational therapy assistant (OTA) under the direction of a licensed occupational therapist (OT).<br><br>NOTE: The OTA's services must follow the evaluation and treatment plan developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising OT. |
| **Evaluations for Occupational Therapies** | Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist.<br>An evaluation includes:<br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current functional status (functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br>▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;<br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. |
| **Assessments for Durable Medical Equipment** | If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |

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| **Services** | Occupational therapy services include:<br>▪ Group therapy provided in a group of two to eight beneficiaries;<br>▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions;<br>▪ Wheelchair management/propulsion training;<br>▪ Independent living skills training;<br>▪ Coordinating and using other therapies, interventions, or services with the ATD;<br>▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian;<br>▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services;<br>▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities;<br>▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD; or<br>▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.2.B. Orientation and Mobility Services

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| **Definition** | **Orientation and Mobility Services:**<br>Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc.<br>Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low vision aids/devices, as appropriate. |
| **Prescription** | Orientation and mobility services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.<br>Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year. |
| **Provider Qualifications** | Orientation and mobility services may be reimbursed when provided by:<br>▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or<br>▪ A licensed occupational therapist. |

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| **Evaluations** | Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an Orientation and Mobility Specialist (O&M) or a licensed occupational therapist.<br><br>An evaluation for Orientation and Mobility services includes:<br><br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br><br>▪ Medical history as it relates to the current course of therapy;<br><br>▪ The beneficiary's current functional status (functional baseline);<br><br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br><br>▪ Assessment of the beneficiary's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment;<br><br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br><br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. |
| **Services** | Orientation and mobility services include:<br><br>▪ Providing assistance in the development of skills and knowledge that enable the child to travel independently to the highest degree possible, based on assessed needs and the IEP;<br><br>▪ Training the child to travel with proficiency, safety and confidence in familiar and unfamiliar environments;<br><br>▪ Preparing and using equipment and material, such as tactile maps, models, distance low vision aids/devices, and long canes, for the development of orientation and mobility skills;<br><br>▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision;<br><br>▪ Communication skills training (teaching Braille is not a covered benefit);<br><br>▪ Systematic orientation training to allow safe movement within their environments in school, home and community;<br><br>▪ Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation;<br><br>▪ Visual training to understand and use the remaining vision for those with low vision;<br><br>▪ Training necessary to activate visual motor abilities;<br><br>▪ Training to use distance low vision aids/devices; and<br><br>▪ Independent living skills training. |

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| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.2.C. ASSISTIVE TECHNOLOGY DEVICE SERVICES

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| **Definition** | Assistive Technology Device Services General Description:<br>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training. |
| **Prescription** | Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. |
| **Provider Qualifications** | Assistive technology device services may be reimbursed when provided by:<br>▪ A licensed occupational therapist (OT); or<br>▪ A licensed occupational therapy assistant (OTA). |
| **Evaluations for Assistive Technology Devices** | Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist.<br>An evaluation includes:<br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current functional status (functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br>▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;<br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home. |

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| **Assessments for Durable Medical Equipment** | If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |
| **Services** | ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit.<br><br>Assistive Technology Device Services include:<br><br>▪ Coordinating and using other therapies, interventions, or services with the ATD.<br><br>▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian.<br><br>▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services.<br><br>▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.<br><br>▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD.<br><br>▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics.<br><br>▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medicaid medical supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

## 2.3 Physical Therapy Services (Includes Assistive Technology Device Services)

### 2.3.A. Physical Therapy Services

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| **Definition** | Physical therapy (PT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem. Physical therapy services must require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures. |
| **Prescription** | Physical therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. |
| **Provider Qualifications** | PT services may be reimbursed when provided by:<br>▪ A licensed physical therapist (PT); or<br>▪ A licensed physical therapy assistant (PTA) under the direction of a licensed physical therapist (PT) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising PT. |
| **Evaluations for Physical Therapies** | Evaluations are formalized testing and reports to determine a beneficiary's need for services and recommend a course of treatment. They may be completed by a PT.<br>Evaluations include:<br>▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current functional status (i.e., functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br>▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function;<br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. |

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| **Assessments for Durable Medical Equipment** | If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |
| **Services** | Physical therapy services include:<br>▪ Group therapy provided in a group of two to eight beneficiaries;<br>▪ Gait training;<br>▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);<br>▪ Stretching for improved flexibility; and<br>▪ Modalities to allow gains of function, strength or mobility. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.3.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

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| **Definition** | **Assistive Technology Device Services General Description:**<br>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training. |
| **Prescription** | Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. |
| **Provider Qualifications** | Assistive technology device services may be reimbursed when provided by:<br>▪ a licensed physical therapist (PT); or<br>▪ a licensed physical therapy assistant (PTA). |

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| **Evaluations for Assistive Technology Devices** | Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a PT.<br>An evaluation includes:<br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current functional status (functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br>▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;<br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home. |
| **Assessments for Durable Medical Equipment** | If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |

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| **Services** | ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit.<br><br>Assistive Technology Device Services include:<br><br>▪ Coordinating and using other therapies, interventions, or services with the ATD.<br>▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian.<br>▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services.<br>▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD.<br>▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics.<br>▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

## 2.4 Speech, Language and Hearing Therapy (Includes Assistive Technology Device Services)

### 2.4.A. Speech, Language and Hearing Therapy

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| **Definition** | Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist or audiologist to provide the therapy. |
| **Prescription** | Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.<br><br>Services supported by an Individualized Education Program can precede the signed referral by up to 90 days; however, the active period of the referral cannot be longer than one year. |

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| **Provider Qualifications** | Speech, language and hearing services may be reimbursed when provided by:<br>▪ A fully licensed speech-language pathologist (SLP);<br>▪ A licensed audiologist in Michigan;<br>▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or<br>▪ A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist. |
| **Evaluations for Speech Pathology Services** | Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by a licensed SLP or audiologist.<br>Evaluations include:<br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current communication status (functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.<br>Evaluations may also include, but are not limited to,:<br>▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis.<br>▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es).<br>▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, and measurable assessment of dysfluency, current means of communication, and a medical diagnosis.<br>▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment.<br>▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis. |

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| **Speech Assessments for Durable Medical Equipment** | If an ISD speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |
| **Services** | Speech, language and hearing services include:<br>▪ Group therapy provided in a group of two to eight beneficiaries<br>▪ Articulation, language, and rhythm<br>▪ Swallowing dysfunction and/or oral function for feeding<br>▪ Voice therapy<br>▪ Speech, language or hearing therapy<br>▪ Speech reading/aural rehabilitation<br>▪ Esophageal speech training therapy<br>▪ Speech defect corrective therapy<br>▪ Fitting and testing of hearing aids or other communication devices |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.4.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

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| **Definition** | **Assistive Technology Device Services General Description:**<br>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training. |
| **Prescription** | Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. |
| **Provider Qualifications** | Assistive Technology services may be reimbursed when provided by:<br>▪ A licensed audiologist;<br>▪ A fully licensed speech-language pathologist (SLP) |

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| **Evaluations for Assistive Technology Devices** | Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an audiologist or SLP.<br>An evaluation includes:<br>▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;<br>▪ Current therapy being provided to the beneficiary in this and other settings;<br>▪ Medical history as it relates to the current course of therapy;<br>▪ The beneficiary's current functional status (functional baseline);<br>▪ The standardized and other evaluation tools used to establish the baseline and to document progress;<br>▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;<br>▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and<br>▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home. |
| **Assessments for Durable Medical Equipment** | If an ISD audiologist or speech-language pathologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings. |
| **Services** | ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit.<br>Assistive Technology Device Services include:<br>▪ Coordinating and using other therapies, interventions, or services with the ATD.<br>▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian.<br>▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services.<br>▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. |

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| | ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES

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| **Definition** | Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech, language and hearing services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site). Services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Speech, language and hearing services administered by telepractice are subject to the same provisions as services provided to a patient in person. |
| **Prescription** | Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable. |
| **Provider Qualifications** | Speech, language and hearing services may be reimbursed when provided by:<br>▪ A fully licensed speech-language pathologist (SLP);<br>▪ A licensed audiologist in Michigan;<br>▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license) under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or<br>▪ A limited licensed speech language pathologist under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist. |
| **Conditions** | Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter for complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements.<br>The patient site may be located within the school, at the patient's home, or any other established site deemed appropriate by the provider. It must be a room free from distractions so as not to interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and physically present at the patient site during the entire telepractice session to assist the patient at the direction of the SLP or audiologist. |
| **Billing Instructions** | Telepractice services are billed using the same procedure codes as services rendered to a patient who is physically present. In addition to the procedure code, billers use the "GT" modifier to identify services provided by telepractice. |

## 2.5 Psychological, Counseling and Social Work Services

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| **Definitions** | Psychological, counseling and social work services include planning, managing and providing a program of face-to-face services for beneficiaries with diagnosed psychological conditions. Psychological, counseling and social work services must require the skills, knowledge and education of a psychologist, counselor or licensed social worker to provide treatment.<br><br>Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy.<br><br>▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a beneficiary who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication.<br><br>▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change. |
| **Provider Qualifications** | Psychological, counseling and social work services may be reimbursed when provided by:<br><br>▪ A licensed physician or psychiatrist in Michigan;<br><br>▪ A fully licensed psychologist in Michigan;<br><br>▪ A limited-licensed psychologist under the supervision of a licensed psychologist;<br><br>▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist;<br><br>▪ A licensed master's social worker in Michigan;<br><br>▪ A limited licensed master's social worker under the supervision of a licensed master's social worker;<br><br>▪ A licensed professional counselor in Michigan; or<br><br>▪ A limited licensed counselor under the supervision of a licensed professional counselor. |
| **Evaluations** | Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed social worker must complete them. |

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| **Psychological Testing** | Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A fully licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's condition. Medicaid does not cover the time that a beneficiary spends alone in testing. The beneficiary's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing.<br><br>The psychological testing report must include all of the following:<br>▪ Beneficiary name and birth date;<br>▪ Psychological tests administered;<br>▪ Summary of testing results;<br>▪ Treatment recommendations; and<br>▪ Psychologist name and dated signature. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| **Crisis Intervention** | Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the beneficiary's IEP/IFSP treatment plan.<br><br>Crisis intervention must be billed using the following procedure code:<br>▪ **S9484** – Crisis intervention mental health services, per hour. |

### 2.6 DEVELOPMENTAL TESTING

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| **Definition** | Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the beneficiary's history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid. |

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| **Documentation** | The developmental testing report must include all of the following:<br>▪ Beneficiary name and birth date;<br>▪ Tests administered;<br>▪ A completed quarterly claim breakdown, produced by the claims development software;<br>▪ Treatment recommendations; and<br>▪ The dated signature, address and phone number of the person administering the tests. |
| **Provider Qualifications** | Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials:<br>▪ A fully-licensed psychologist in the State of Michigan;<br>▪ A limited-licensed psychologist under the supervision of a licensed psychologist;<br>▪ A licensed master's social worker in Michigan;<br>▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; or<br>▪ A licensed physician or psychiatrist in Michigan. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

## 2.7 NURSING SERVICES

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| **Definition** | Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse (RN) and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis.<br><br>Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices.<br><br>Services include:<br>▪ Catheterizations or Catheter care<br>▪ Maintenance of tracheotomies<br>▪ Medication administration<br>▪ Oxygen administration<br>▪ Tube feeding<br>▪ Suctioning<br>▪ Ventilator care<br><br>Services considered observation or stand-by in nature are not covered.<br><br>LPN services can only be billed if performed under the supervision of an RN or physician. |
| **Prescription** | Direct service interventions require a physician's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the beneficiary's attending physician. The nurse is responsible for notifying the attending physician of any change in the beneficiary's condition which may result in a change or modification to the care plan. |
| **Provider Qualifications** | Nursing services may be reimbursed when provided by:<br>▪ A licensed Registered Nurse (RN) in Michigan; or<br>▪ A Licensed Practical Nurse (LPN) in Michigan. |
| **Evaluations** | A RN must complete the evaluations/assessments and prepare a nursing care plan. An evaluation/assessment may be performed when a change in the beneficiary's medical condition occurs. LPNs cannot bill for evaluations/assessments. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

## 2.8 Physician and Psychiatrist Services

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| **Definition** | Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a beneficiary's medical or other health-related condition. Physician/psychiatrist services include:<br>▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment.<br>▪ Record review for diagnostic and prescriptive services.<br>Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled ISD.<br>Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled ISD. |
| **Provider Qualifications** | A licensed physician or psychiatrist (MD or DO) in Michigan. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)<br>Procedure codes that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service.<br>If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable. |

## 2.9 Personal Care Services

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| **Definition** | Personal Care Services are a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself.<br><br>Personal Care Services may be provided when:<br><br>▪ The service is medically necessary.<br><br>Personal Care Services are not covered if they are:<br><br>▪ Provided by a family member. A family member is described by the Centers for Medicare & Medicaid Services (CMS) to be "legally responsible relatives"; thus, spouses of beneficiaries and parents of minor beneficiaries (including stepparents who are legally responsible for minor children).<br>▪ Not documented in the IEP/IFSP.<br>▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation.<br>▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially.<br><br>Personal Care Services may include, but are not limited to, assisting with the following:<br><br>▪ Eating/feeding<br>▪ Respiratory assistance<br>▪ Toileting<br>▪ Grooming<br>▪ Dressing<br>▪ Transferring<br>▪ Ambulation<br>▪ Personal hygiene<br>▪ Mobility/Positioning<br>▪ Meal preparation<br>▪ Skin care<br>▪ Bathing<br>▪ Maintaining continence<br>▪ Assistance with self-administered medications<br>▪ Redirection and intervention for behavior<br>▪ Health related functions through hands-on assistance, supervision and cueing |

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| **Personal Care Paraprofessional Provider Qualifications** | The personal care paraprofessional personnel are employed in the Special Education Program and shall be qualified under the requirements established by their respective ISD plan. Providers must be trained in the skills needed to perform covered services, and must be under the direction of a qualified professional as designated in the IEP/IFSP. Paraprofessional personnel include:<br>▪ Teacher Aides<br>▪ Health Care Aides<br>▪ Instructional Aides<br>▪ Bilingual Aides<br>▪ Program Assistants<br>▪ Trainable Aides |
| **Prescription** | In accordance with 42 CFR 440.167, authorization for Personal Care Services (PCS) may be done by a physician or "other licensed practitioner" operating within the scope of their practice. The State definition of "other licensed practitioner" consists of Registered Nurse (RN), Licensed Occupational Therapist, Licensed Physical Therapist (PT), Master of Social Work (MSW), or fully licensed Speech Language Pathologist (SLP). It is expected that personal care services will be authorized by the appropriate practitioner. |
| **Documentation** | Personal care services must be medically necessary and the need for the service must be documented in the student's IEP/IFSP. Each child's school clinical record must contain a completed, signed and dated monthly activity checklist. Service categories (i.e., toileting, feeding, transferring, etc.), times and frequencies must be documented either in the IEP/IFSP, in an attached document, or in the child's treatment authorization. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.10 TARGETED CASE MANAGEMENT SERVICES

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| **Definition** | Targeted case management (TCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational or other services.<br>Targeted case management services include the following assistance:<br>▪ A comprehensive assessment and periodic reassessment of an individual to determine the need for medical, social, educational or other services. These assessment activities include:<br>➢ Taking client history;<br>➢ Identifying the individual's needs and completing related documentation; and |

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| | ➢ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.<br>▪ Development (and periodic revision) of a specific care plan that:<br>➢ Is based on the information collected through the assessment;<br>➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the individual;<br>➢ Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and<br>➢ Identifies a course of action to respond to the assessed needs of the eligible individual.<br>▪ Referral and related activities:<br>➢ To help an eligible individual obtain needed services, including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;<br>➢ Monitoring and follow-up activities;<br>➢ Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met:<br>♦ Services are being furnished in accordance with the individual's care plan;<br>♦ Services in the care plan are adequate.<br>If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements.<br>TCM services may be reimbursed when provided by a Designated Case Manager.<br>Providers must maintain case records that document, for all individuals receiving case management, the following: the name of the individual, the dates of the case management services, the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the care plan have been achieved, whether the individual has declined services in the care plan, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the plan. |

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| **Provider Qualifications** | The Designated Case Manager is the person responsible for the implementation of the plan of care/treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria:<br>▪ A licensed RN in Michigan;<br>▪ A bachelor's degree with a major in a specific special education area;<br>▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or<br>▪ Has a minimum of three years' personal experience in the direct care of an individual with special needs.<br>In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following:<br>▪ Services for infants and toddlers who are eligible under the IDEA law as appropriate;<br>▪ Part C of the IDEA law and the associated regulations;<br>▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information;<br>▪ Provisions of direct care services to individuals with special needs; and<br>▪ Provisions of culturally competent services within the community being served. |
| **Designated Case Manager Services** | Targeted Case Management services include:<br>▪ Assuring that standard re-examination and follow-up of the beneficiary are conducted on a periodic basis to ensure that the beneficiary receives needed diagnosis and treatment;<br>▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers;<br>▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services;<br>▪ Assuring that case records are maintained and indicate all contacts with, or on behalf of, a beneficiary in the same manner as other covered services;<br>▪ Coordinating school based services and treatment with parents and the child;<br>▪ Monitoring and recommending a plan of action;<br>▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs;<br>▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team treatment plan;<br>▪ Activities that support linking and coordinating needed health services for the beneficiary;<br>▪ Providing a summary of provider, parent and student health and behavioral consultation; and<br>▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting. |

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| **Procedure Code** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

### 2.11 SPECIAL EDUCATION TRANSPORTATION

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| **Definition** | Special education specialized transportation services include transport to and from the beneficiary's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service.<br><br>The need for special education transportation must be specified in the beneficiary's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a beneficiary receives a Medicaid-covered service on the same day.<br><br>Medicaid does not reimburse for transportation provided in a regular or general education school bus. There is no additional payment for an attendant. |
| **Documentation** | Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip. |
| **Procedure Codes** | For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) |

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| **Taxi and Private Vehicle Transportation** | For a taxi or family vehicle transportation expense to be reimbursed, the following documentation must be on file at the local education agency (LEA) or intermediate school district (ISD):<br>▪ Specialized transportation must be included in the Individualized Education Program (IEP).<br>▪ A Medicaid covered medical service must be provided on the same day as the transportation.<br>▪ Dates and times of each trip must be listed on the LEA's or ISD's trip log.<br>▪ Documentation from the beneficiary's physician or a school provider treating the student, stating the reason taxi or family transportation is required must be retained in the student's file.<br>▪ For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file.<br>▪ For ongoing transportation needs, documentation is only required once per student per school year.<br>▪ For one-time or occasional use transportation, documentation is required for each trip, or trip period per beneficiary.<br>▪ The total number of trips claimed for taxi and family transportation must be included in the Special Education trip count on the Medicaid Allowable Expenditure Report (MAER).<br>Taxi and family vehicle cost reimbursement will be retroactive to July 1, 2012 if the proper documentation has been retained, and a claim for the trip has been approved through the Community Health Automated Medicaid Processing System (CHAMPS). Claims must be filed within one year from the date of service according to Medicaid timely filing requirements.<br>Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a patient (student) in a prone or supine position (e.g., Ambucab). |

# SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

## 3.1 QUALITY ASSURANCE

SBS providers must have a written quality assurance plan on file. SBS costs will be reviewed/audited by MDHHS for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.
- A monitoring program exists to ensure that services are appropriate, effective and delivered in a cost effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from special education.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop plans of care with all other providers, (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).
- Parent/guardian and beneficiary participation exists outside of the IEP/IFSP team process in evaluating the impact of the SBS program on the educational setting, service quality and outcomes.

## 3.2 SERVICE COORDINATION AND COLLABORATION

Children with special needs have access to services available in both outpatient and school-based treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct. School based services are provided to assist a child with a disability to benefit from special education. Outpatient services are provided to optimize the child's functional performance in relation to needs in the home or community setting and must not duplicate those provided in the school setting. Collaboration between the school and the community providers is mandated to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, or participation in team meetings such as the IEP/IFSP meeting.

## 3.3 ISD RESPONSIBILITIES

Each ISD must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the RMTS sample frame (designated employees), adherence to MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS),

maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

### 3.3.A. SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the ISDs or their vendors are not in compliance with Medicaid policy and procedures. If these actions are not successful, a payment freeze will be implemented and sanctions put in place until the matter is resolved. ISDs are responsible for the actions of their vendors.

The following are examples of causes for sanctions. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to use the claims development software.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDHHS, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through the Community Health Automated Medicaid Processing System (CHAMPS).

# SECTION 4 – PROVIDER ENROLLMENT

## 4.1 ENROLLMENT

The 56 Michigan Intermediate School Districts (ISDs), Detroit Public Schools, and Michigan School for the Deaf are the only providers eligible to bill Medicaid for School Based Services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

## 4.2 CERTIFICATION OF QUALIFIED STAFF

The Michigan Department of Education (MDE) must provide MDHHS with documentation that enrolled ISDs meet the regulatory requirements set forth for all staff providing services in the school setting.

Enrollment as a provider is predicated on certification to MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) who may be performing claimable activities have been met and are current. The MDE will assist any school district in this certification process and verify the status of its certification in writing, along with recommendations, with a copy sent to MDHHS.

## 4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual direct medical services activities that occur in a school on any given day. Because these activities and services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what activities and services are being provided. This is referred to as the "IEP Medicaid Eligibility Rate (MER)" for the direct medical services program.

IEP MER is determined by calculating the ratio of Medicaid eligible recipients with health-related services indicated on their IEP/IFSPs to the total number of special education population with health-related services indicated on their IEP/IFSPs.

# SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

## 5.1 FINANCIAL DATA

The financial data reported for the Direct Medical Services (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs are to include actual non-federal expenditures incurred during the claiming period, except for the summer quarter. These allowable expenditures include such things as salaries, wages, fringe benefits and medically related supplies, purchased services and materials.

## 5.2 UNALLOWABLE COSTS

Providers are not allowed to report any costs that are federal funds, State flow-through funds, or non-federal funds that have been committed as local match for other federal or State funds or programs.

Claims for approved Medicaid School Based Service functions may not include expenditures of:

- Federal funds received by the ISD/LEA directly
- Federal funds that have been passed through a State or local agency
- Non-Federal funds that have been committed as local match for other Federal or State funds or programs

Funds received by an ISD for school based direct medical services are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

# SECTION 6 – SCHOOL BASED SERVICES REIMBURSEMENT

## 6.1 METHOD OF REIMBURSEMENT FOR DIRECT MEDICAL SERVICES, PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

Payment for Michigan's school based services program is a cost-based, provider specific, annually reconciled and cost settled reimbursement methodology.

The Centers for Medicare & Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific direct medical services claims for all Medicaid allowable services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the recipient, and provide an audit trail. Interim monthly payments are tied to the submission of the direct medical services claims. If claim volume decreases significantly or drops to zero in any two consecutive months, all interim payments will be held until the provider is contacted and the issue resolved. MDHHS will monitor provider claim volume to make sure that this mandate is followed.

Claims are submitted and processed through the Community Health Automated Medicaid Processing System (CHAMPS); however, the procedure code fee screens are set to pay zero. SBS providers receive their cash flow from the interim monthly payment process described below.

The interim monthly payments are based on prior year actual costs and reconciled on an annual basis to the current year costs. Cost reporting and reconciliation are based on the school fiscal year which is July 1 through June 30 of each year.

The reimbursement process for the direct medical services is comprised of the following parts:

- The SBS direct medical services procedure code specific billing process;
- The random moment time study (RMTS) component;
- The interim payment process; and,
- The cost reconciliation and cost settlement process.

### 6.1.A. DIRECT MEDICAL SERVICES PROCEDURE CODE SPECIFIC BILLING

Providers must continue to submit procedure specific claims in addition to the expenditure reports. The procedure specific process is described in the Covered Services Section of this chapter.

Claim documentation must be sufficient to identify the patient clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be adequate enough to demonstrate that the service was provided and that the service followed the "approved plan of treatment" (for school-based services, the service must be identified in the child's IEP/IFSP).

The ISD may either purchase software for the claims submission function or it may utilize the services of a billing agent. The cost of this process is the responsibility of the ISD.

### 6.1.B. Random Moment Time Study

For the Random Moment Time Study, all ISDs will be required to utilize the services of the State Contractor who will conduct the statewide time studies.

The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.

Costs are reported for direct medical services and specialized transportation services on the Medicaid Allowable Expenditure Report (MAER) and collected via financial worksheets for Personal Care Services and Targeted Case Management.

Electronic Data Systems (EDS) combines all cost information and the RMTS results, the indirect cost rate, and the Medicaid eligibility rate to calculate the total allowable costs. The MDHHS Hospital and Health Plan Reimbursement section performs the reconciliation and cost settlement process.

The ISD and/or State Contractor must comply with all conditions set forth by MDHHS as SBS policy.

The cost for the State Contractor is charged back to providers based on the State Contractor's projected cost per ISD (after federal match).

For detailed description and instructions regarding the Random Moment Time Study, refer to the School Based Services Random Moment Time Study chapter of this manual.

**Summer Quarter Process**

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter will be divided into two parts. The first part of the quarter will extend from July 1 to the date the students return to school. The second part of the quarter will be from the date the students return to school through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the staff start back to work and will only be applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS will be performed during a shorter time period.

### 6.1.C. Interim Payment Process

Interim payments are calculated based on an estimated monthly cost formula. The monthly cost formula utilizes prior year costs plus any inflation or program changes to calculate a monthly interim reimbursement amount. After the final cost reports have been reviewed and reported to MDHHS, reconciliation will be performed and settlements will be made to make the providers whole.

Interim payments are issued on the first pay cycle of each month based on prior year costs.

To justify an increase in the interim payment, providers must submit written documentation of significant changes in coverage, service utilization or staff costs.

Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the MAER. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to the SBS providers (ISDs), how the interim payment revenue is distributed to the respective LEAs and how the initial and final settlements are handled is up to the discretion of the ISD.

### 6.1.D. Cost Reconciliation and Settlement

Allowable cost will be based on the following components:

- Costs from the MAER
- Targeted Case Management and Personal Care Services Financial Worksheets
- MDE Indirect Cost Rate
- Random Moment Time Study Percentage
- Health Related IEP Medicaid Eligibility Rate (IEP MER)
- Federal Medical Assistance Percentage (FMAP)

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| Allowable costs (MAER & financial worksheets for TCM and PCS) | X | Indirect Cost Rate | X | Annual average % time claimable to Medicaid from the time studies | X | Discounted by the Medicaid eligibility percentage | X | % Federal Medical Assistance Percentage (FMAP) rate | = | Medicaid reimbursement amount |

The Medicaid Allowable Expenditure Report (MAER) (modeled after the MDE SE-4096 cost report) is utilized to collect allowable costs for the medical professional staff. Costs for the staff providing targeted case management services and personal care services

that are not included in the direct medical costs are obtained from the participating ISD's financial accounting system via financial worksheets sent out by the State Contractor.

To report direct service-related costs, providers will utilize the Medicaid Allowable Expenditure Report. This cost report template may be obtained from the School Based Services Provider Specific webpage. (Refer to the Directory Appendix for website information.) An Excel printable version of the cost report is also available on the website for those providers in need of a paper version. Cost reports from the Local Educational Agencies will be submitted to their Intermediate School District for summation utilizing the Michigan Medicaid Forms (MMF) summary software (available to providers via the File Transfer Service). Providers must register and have access to the secure MILogin in order to utilize the MMF summary software. MILogin registration instructions are also available on the School Based Services Provider Specific webpage.

The filed cost data is used to calculate an initial settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

Within six months after the close of the school fiscal year, the School Based Services providers will review, certify, and finalize the MAER and transmit the report to the MDHHS Medical Services Administration for reconciliation. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed. The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion. (Refer to the Forms Appendix for a copy of the CMS-10231.)

ISDs/LEAs may submit revisions to the MAER until the final settlements are processed. Instructions for completing revisions are attached to the MAER.

## 6.2 Method of Reimbursement for Specialized Transportation

### 6.2.A. Reimbursement

Specialized transportation costs reported on the Michigan Department of Education Transportation Expenditure Report (form SE-4094) are only the costs associated with the special education buses, taxis or private vehicles used for the specific purpose of transporting only special education children. This report does not include any federal dollars.

Medicaid-allowable specialized transportation costs include the following costs from the SE-4094:

- Salaries [Sec. 52 & Sec. 53a]
  - Bus Drivers
  - Aides
  - Employee Benefits (Bus Drivers and Aides only)
- Purchased Services – Staff (Bus Drivers and Aides only)

- Purchased Services – Vehicle Related Costs [Sec. 52 & Sec. 53a]
  - Pupil Transportation by Carrier
  - Pupil Transportation by Carrier (b/y)
  - Family Vehicle K Cost
  - Contracted Taxis
  - Pupil Transportation Fleet Insurance
  - Contracted/Leased Buses
- Supplies [Sec. 52 & Sec. 53a]
  - Gasoline/Fuel
  - Oil/Grease
  - Tires/Batteries
  - Other Expense/Adjustments, only the costs associated with adjustments to allowable costs
  - Bus Amortization

For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's Individualized Education Program (IEP).

### 6.2.B. Specialized Transportation Reconciliation and Settlement

On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from CHAMPS to arrive at the Medicaid allowable cost.

An "allowable" one-way trip is one that is provided to a Medicaid beneficiary and fulfills all of the following requirements:

- Documentation of ridership is on file;
- The need for the specialized transportation service is identified in the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP); and
- A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid covered service must also be documented in the IEP/IFSP.

The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for the Direct Medical Services, Targeted Case Management, and Personal Care Services; any over/under adjustments are processed as one transaction.

# SECTION 7 – INDIRECT COST RATE (ICR)

## 7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district is approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

# SECTION 8 – COST CERTIFICATION

## 8.1 COST CERTIFICATION

Once all cost reports and financial worksheets have been received by MDHHS, the summary worksheet of the Medicaid Allowable Expenditure Report (MAER) will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for annually certifying that the total amount of expenditures for covered services has been expended and that none of the expenditures have been used as match for other programs or services. MDHHS will be utilizing the CMS-10231, "Certification of Public Expenditures (CPE)" form, for this purpose. (Refer to the Forms Appendix.)

# SECTION 9 – COST ALLOCATION FACTORS

## 9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATE

Federal regulations allow for payments to States on the basis of a Federal medical assistance percentage for part of their expenditures for services under an approved State plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55%. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50%. If a State's per capita income is lower than the national average, the Federal share is increased, with a statutory maximum of 83%.

## 9.2 DISCOUNTED HEALTH-RELATED MEDICAID ELIGIBILITY RATE (MER)

The discounted health-related Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the special education student population that is Medicaid eligible in each ISD with a health-related support service code indicated on their December 1 Student Count Report. Support service codes are gleaned from Fields 43 and 57 of the December 1 Student Count Report. Only those codes that relate to covered school based health services are to be utilized.

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| **Field 43** | 290, 310, 320, 360, 370, 400, 450, 460, 470 |
| **Field 57** | 801, 804, 805, 807, 808, 809, 812, 814, 816, 818 |

MDHHS receives the file of special education children with health-related support services indicated on their IEPs and matches the names and birthdates of those with health-related support services against the Medicaid eligibility file to identify the percentage that are Medicaid eligible. The eligibility rate is determined once each year utilizing the December 1 Student Count Report. The calculation for the eligibility rate is as follows:

$$\frac{\text{Medicaid special education students with a health-related support service in their IEP}}{\text{Total special education students with a health-related support service in their IEP}}$$

## 9.3 ALLOCATION OF SALARIES AND BENEFITS OF PERSONNEL PROVIDING DIRECT CARE SERVICES

Actual expenditures for salaries and benefits of all personnel are to be obtained from each participating ISD's financial accounting system. Expenditures related to the performance of approved Medicaid contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD's financial accounting system.

# SECTION 10 – DOCUMENTATION

## 10.1 DIRECT MEDICAL SERVICES DOCUMENTATION

For covered services, the school clinical record must include all of the following:

- Beneficiary name and birth date;
- Date of service/treatment;
- Type (modality) of service/treatment;
- The response to the service/treatment; and
- The name and title of the person providing the service/treatment and a dated signature.

For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the school clinical record. The record must indicate the specific findings or results of the diagnostic or therapeutic procedures. The student's school clinical record should include documentation of the implementation and coordination of services for the special education student.

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment with rationale for change.

(Refer to the General Information for Providers Chapter of this manual for additional information regarding clinical record requirements.)

## 10.2 RMTS DOCUMENTATION

Each participating LEA must maintain a separate audit file for each quarter billed. The following minimum documentation is required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results produced by the State Contractor.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that payment from MDHHS was received.

ISDs/LEAs must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

## SECTION 11 – AUDIT AND RECOVERY PROCEDURES

### 11.1 DIRECT SERVICE/TRANSPORTATION PROGRAM AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD cost reports for the Direct Service/Transportation Program may include the following activities:

- Verification that the Medicaid Allowable Expenditure Report (MAER) accurately reports the allowable costs incurred for the appropriate period.
- Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the MAER staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on MAER cost reports and that MAER costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported MAER costs.

### 11.2 STUDENT CLAIMS AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD for approved SBS student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual.
- Verification that occupational, physical, and speech, language and hearing therapy address a beneficiary's medical need that affects his/her ability to learn in the classroom environment.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.
- Verification that the providers requiring supervision both "under the direction of" and "under the supervision of" have the necessary support documentation on file.

- Verification that the beneficiary receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation.
- Confirmation that support documentation for personal care services includes a completed, signed and dated monthly activity checklist.
- Verification that group therapy or treatment was provided in groups of two to eight.
- A standard review of the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) treatment plan areas, such as the inclusion of a description of the beneficiary's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the beneficiary's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

### 11.3 Audit Activities to be Performed by MDHHS Office of Audit Staff

MDHHS audit review of selected ISD/DPS cost reports for the Administrative Outreach Program may include the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the staff pool list, and therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

### 11.4 Audit Findings and Resolution

Audit findings and resolution will include the following:

- Identified overstatement of expenditures on the MAER will require the revision of the MAER and a revised final settlement for all specifically identified overstatements.
- For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.

# SCHOOL BASED SERVICES ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT

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# SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDHHS will select one Contractor to implement and administer the random moment time study. The Contractor will also provide the ISDs/DPS the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPS that choose to participate in this portion of the State contract and pay for these services.

## 1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All ISDs/DPS will be required to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies and develop and submit claims on their behalf each quarter.

The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the claims development software, as well as complete all other key functions required for valid claim development.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPS (after federal match).

## 1.2 OVERVIEW OF CLAIMS DEVELOPMENT PROCESS

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor utilizing the claims development software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement.
- The cost/claim generation component of the claims development software uses ISD/DPS costs and other claim factors to calculate and produce the claim.
- The claim is submitted to MDHHS with verification of claim validity from each ISD/DPS.
- The ISD/DPS and/or Contractor must comply with all conditions set forth by MDHHS as SBS policy.

## 1.3 IMPLEMENTATION PLAN

Each ISD/DPS must submit an Implementation Plan that reflects the details of their SBS Administrative Outreach Program operation for review and approval by MDHHS and by CMS. Any subsequent changes must also be reported and receive approval.

Claims may not be submitted to MDHHS for reimbursement until MDHHS has approved the Implementation Plan that will be utilized based on this published policy.

# SECTION 2 - CLAIM CALCULATIONS

## 2.1 IMPLEMENTATION PLAN

Each ISD/DPS must submit an implementation plan that reflects the details of their SBS Administrative Outreach Program for review and approval by MDHHS and CMS. Any subsequent changes must also receive approval.

Each implementation plan must include explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the sample frame (designated employees), adherence to the MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

## 2.2 SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the State-selected contractors, the ISD/DPS, or their vendors are not in compliance with the new SBS Administrative Outreach published policy. If this is not successful, a contract payment freeze will be implemented and sanctions put in place until the matter is resolved. Those independent ISDs/DPS not participating in the State's claims development contract will be held accountable for their vendor's actions.

The following are examples of causes for implementation of sanctions for all districts. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to use the CLAIMS DEVELOPMENT software.
- Failure to cooperate with, or submit requested information, reports, or data to the Special Monitoring Contractor, CMS, MDHHS, MDE, and other staff involved during site visits, reviews or audits.

## 2.3 FACTORS FOR CLAIMS DEVELOPMENT

MDHHS will submit quarterly claims on behalf of all participating school districts to the CMS. Each claim will be based on the following factors: The cost pool, percentage of time claimable to Medicaid Outreach Program administration, the Federal Financial Participation (FFP) rate, and the discounted Medicaid eligibility percentage rate for that district. The factors for the summer quarter are described above.

### 2.3.A. COST POOL

This consists of the actual costs incurred for the quarter being claimed, such as salaries, overhead, etc. Each participating ISD/DPS must certify that the claim they submit to MDHHS contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

### 2.3.B. Federal Financial Participation Rate

Federal regulations allow for a reimbursement rate of 50% for Medicaid administrative activities.

### 2.3.C. Discounted Medicaid Eligibility Percentage

The discounted Medicaid eligibility percentage is determined by the percentage of the student population in each ISD/DPS who are actually Medicaid beneficiaries. The discounted Medicaid eligibility rates will be determined twice each year and applied to certain activities in the claim calculation formula. To calculate the discounted Medicaid eligibility rates, the claiming entity will obtain the September and February fourth Wednesday pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will include the student name and date of birth. MDHHS will provide a method for using the list to verify the number of Medicaid-eligible students. This number will be used in a calculation with the total pupil count to determine the discounted percentage of Medicaid-eligible students in the ISD/DPS. The September pupil count list will be used to determine discounted Medicaid eligibility rates for time studies conducted in the Fall and Winter quarters, and the February pupil count will be used for time studies conducted in the Spring and Summer quarters.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

**Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cost pools (salaries, overhead, etc.) | **X** | % time claimable to Medicaid Outreach Administration from time studies | **X** | Discounted by the Medicaid eligibility percentage | **X** | % Federal Financial Participation (FFP) rate | **=** | The amount of the claim submitted for Medicaid reimbursement |

**Summer Quarter Formulas**

The summer quarter will be divided into two parts. The sum of both parts will be submitted to Medicaid for reimbursement. There will be two workbooks created for the summer quarter, one for each part.

**Part I - Summer Quarter Formulas from July 1 to the Date Students Return to School**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cost pool (only the 9-month salaries and related costs that are paid during this time period) | **X** | Average % of time claimable to Medicaid Outreach Administration from the previous three quarters | **X** | Discounted by the Medicaid eligibility percentage | **X** | Percent of FFP rate | **=** | The amount of the partial claim for Part I of the Summer Quarter |

- Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month staff are not included in the cost pool.
- The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results and Medicaid Eligibility (MAE) rate from the previous three quarters.

**Part II - Remainder of the Summer Quarter – Begins on the Date Students Return to School through September 30**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cost pools (include all allowable salaries, overhead, etc.) | X | % of time claimable to Medicaid Outreach from the Summer Quarter time study | X | Discounted by the Medicaid eligibility percentage | X | Percent of FFP rate | = | The amount of the claim for Part II of Summer Quarter |

- Salary and related costs of all staff eligible for the time study are included in the cost pool, along with other allowable overhead.
- An RMTS is performed and applied to determine the percent of time claimable for Outreach during Part II of the summer quarter.

**The claims development software will add the Summer Quarter Part I and Part II claim amounts together to reach the dollar amount of the total Summer Quarter claim submitted to MDHHS for reimbursement.**

### 2.4 Financial Data

The financial data reported (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to include only actual expenditures incurred during the claiming period, except for the summer quarter.

### 2.5 Allocation of Salaries and Benefits of Personnel Providing Direct Care Services

Actual expenditures for salaries and benefits of all personnel included in an Administrative Outreach claim are to be obtained from each participating ISD/DPS financial accounting system. Expenditures related to the performance of approved Medicaid Administrative Outreach functions by contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.

### 2.6 RMTS Documentation and Recordkeeping/Audit File Requirements

Each participating school district will maintain a separate audit file for each quarter billed. The following minimum documentation will be required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results, produced by the State's RMTS and Claims Development Contractor.
- A completed quarterly claim, produced by the claims development software and signed by the Chief Financial Officer of the ISD/DPS.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation, verifying that payment from MDHHS was received.

Districts must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

### 2.7 Non-Student Specific/Pre-Medicaid Eligibility Determination

There are some Administrative Outreach activities and expenditures that are approved by Medicaid that have not been addressed thus far. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual students, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid administrative outreach claim based on the results of the time study conducted during the claiming period.

### 2.8 Student-Specific Administrative Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted Medicaid eligibility rate.

### 2.9 Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200, must be followed. Examples include conference fees, registration fees, mileage, pagers, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS

financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

### 2.10 Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/LEA unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district has been approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

### 2.11 Claim Certification

The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPS designee. Such certification is to be documented on an MDHHS-approved certification form, and conform to the certification requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPS for audit or future reference purposes according to the terms identified in the interagency agreement between the district and MDHHS.

The Electronic Signature Verification Statement (DCH-3890) form must be completed by each provider and submitted to MDHHS to certify costs electronically. A copy of the completed DCH-3890 must be kept on file by the provider until the individual signing the certification changes. (Refer to the Forms Appendix for a copy of the form.)

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.

### 2.12 Annual Reconciliation

At the end of the district's fiscal year, and after its annual financial audit is completed, a reconciliation of the filed administrative outreach claims, with the financial accounting records and supporting documentation, must be performed. Adjustments to future administrative claims must be made based on the results of the reconciliation analyses to consider any year-end adjustments to accounting entries of any items which might have impacted the claim amounts.

### 2.13 Fiscal Provisions

School districts must use an appropriate Revenue Code to identify the Medicaid SBS Administrative Outreach Program funds within their accounting records.

### 2.14 Submission of Claims

All claims must be developed and submitted using the reporting format (structured spreadsheet template) and approved certification forms.

The claim package consists of completed Excel workbooks for each individual ISD/DPS and are combined and consolidated into one claim that is submitted to MDHHS.

All claims are to be submitted in accordance with the reporting requirements established by MDHHS. It is imperative that districts work closely with the Claims Development Contractor to provide pertinent financial, enrollment and personnel data and meet their deadlines and any other technical specifications. Claims not submitted on time must be submitted the following quarter as an adjustment to the prior missed quarter and will be processed for that following quarter. Claims not conforming to reporting requirements will not be accepted or processed.

### 2.15 Periodicity of Reporting

Districts must submit claims for expenditures related to approved Medicaid administrative outreach activities to MDHHS on a quarterly basis. The claim is due to MDHHS on or before 120 calendar days after the end of the reporting quarter.

**Timeframes to Submit Administrative Outreach Claims to MDHHS**

| | REPORTING PERIOD | | CLAIM DUE TO MDHHS | CLAIM SUBMITTED TO CMS BY MDHHS |
|---|---|---|---|---|
| | BEGIN DATE | ENDING DATE | | |
| Summer | July 1 | September 30 | January 31 | March 31 |
| Fall | October 1 | December 31 | April 30 | June 30 |
| Winter | January 1 | March 31 | July 31 | September 30 |
| Spring | April 1 | June 30 | October 31 | December 31 |

# SCHOOL BASED SERVICES RANDOM MOMENT TIME STUDY

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# SECTION 1 – GENERAL TIME STUDY INFORMATION

This chapter describes the random moment time study process for the School Based Services (SBS) direct medical services program.

In accordance with the Centers for Medicare & Medicaid Services (CMS) reimbursement policy, some activities performed by medical professionals and Intermediate School District (ISD) staff in a school-based setting are eligible for federal matching funds. These activities may be performed by staff with multiple responsibilities. CMS reimbursement requirements include the use of a random moment time study (RMTS) as a component of the Medicaid reimbursement methodology. The time study results are used to determine the amount of staff time spent on Medicaid-allowable activities. One statewide time study per staff pool is performed each quarter.

## 1.1 ADMINISTRATIVE OUTREACH PROGRAM ACTIVITIES

The School Based Services Administrative Outreach Program (AOP) offers reimbursement for the cost of administrative activities that support efforts to identify and enroll potentially eligible persons into Medicaid and that are in support of the state Medicaid plan.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determinations
- Health-related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Transportation and Translation Services

## 1.2 DIRECT MEDICAL SERVICES

Medicaid covered services that are medically necessary and specified in the beneficiary's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) include:

- Occupational Therapy Services
- Orientation and Mobility Services
- Physical Therapy Services
- Assistive Technology Device Services
- Speech, Language and Hearing Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatric Services

- Personal Care Services
- Targeted Case Management Services

### 1.3 Staff Pools and Confidence Levels

The RMTS is carried out utilizing customized claims development software that automates aspects of the school district time study process. The claims development software is comprised of three components: sampling/staff pool lists, training, and cost/claim generation. All ISDs are required to utilize the services of the State's RMTS and Claims Development Contractor (hereafter referred to as the Contractor). The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools and Michigan School for the Deaf (hereafter referred to as the ISDs).

Time studies will be carried out over the following staff pools:

- AOP Only Staff – This staff pool consists of individuals who perform only administrative outreach activities. They do not perform any direct medical activities.
- AOP & Direct Medical Staff – This staff pool consists of individuals who perform both Direct Medical activities and AOP activities.
- Personal Care Services Staff – This direct medical only staff pool consists of individuals who perform direct care Personal Care Services.
- Targeted Case Management Services Staff – This direct medical only staff pool consists of individuals who perform Targeted Case Management (TCM) Services.

The RMTS results identifying the percentage of claimable time are applied to the allowable correlating cost pool. All staff pools are mutually exclusive.

The sample size of each cost pool ensures a quarterly level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level and an annual level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level.

Valid moments are completed moments that have been received by the Contractor and determined to be complete and accurate. Invalid moments are moments that are assigned to staff who are no longer in the position as selected, moments that are outside of paid work hours, and moments not returned for any other reason (including Activity Code 18).

As long as the completed observation rate meets or exceeds 85%, missing observations will be dropped from all calculations. Should the completion rate fall below 85%, missing observations will be included as non-matchable.

## SECTION 2 – CENTRALIZED CODING

The Contractor is responsible for coding the time study moments. MDHHS oversees the Contractor and ISDs participating to assure their compliance with all aspects of program policy and federal regulations.

# SECTION 3 – TIME STUDY METHODOLOGY

## 3.1 RANDOM MOMENT TIME STUDY OVERVIEW

The time study design logs only what the participant is doing at one moment in time. A random moment consists of one minute of work done by one employee, both chosen at random, from among all such minutes of work that have been scheduled for all designated staff statewide.

The RMTS measures the work effort of each group of approved staff involved in the time study process by sampling and analyzing the work efforts of a randomly-selected cross-section of each staff pool. The RMTS methodology employs a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the three-month period comprising each federal quarter of the year, except for the abbreviated sample period used in the summer quarter (July through September).

The Contractor will use the claims development software to conduct the statewide time studies each quarter. This software produces random moments concurrent with the entire reporting period which are then paired with randomly selected members of the designated staff pool population. The sampling is constructed to provide each staff person in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

### 3.1.A. LONG-TERM SUBSTITUTES

Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized:

- A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter.
- The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed.
- The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid school based services program staff pool.
- If listed on the staff pool list, the substitute staff must complete the time study moment.
- The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.

- All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity.
- All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

### 3.2 Random Moment Time Study Form Completion

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to three questions (What are you doing? Who are you with? Why are you doing it?). These questions relate to their activities at the time of their randomly selected moment.
- In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the three time study questions.

The Contractor conducts the statewide time studies each quarter for all ISDs and produces a report detailing the results. This involves importing clinician information from the ISDs to compile the statewide pool of all eligible time study participants for each staff pool list. There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. All staff pools have 800 moments randomly selected for the summer quarter (July-September). For the remaining three quarters, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.

The Contractor monitors the status of each time study form so that appropriate follow-up calls are made for delinquent moments or missing data. The ISD is responsible for ensuring that a copy of the time study form and instructions are distributed to staff just prior to the assigned moment. The completed time study forms are returned to the Contractor, generally on a weekly basis, for data entry and tabulation.

At the end of the sampling period after all data has been collected and tabulated, program precision tables will be produced by the Contractor. These tables will verify that a sufficient number of personnel were sampled to ensure time study results that have a confidence level of at least 95% quarterly with a precision level of +/- 2% annually.

### 3.3 Time Study Staff Pools

To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor.

If staff pool lists and/or financials for the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the LEA staff pool lists and correlating financials will be removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

When providing the staff pool list of those eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted and that appropriate credentials are in place for billing Medicaid.

### 3.3.A. AOP Only Staff Pool

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Physician Assistants
- Teacher Consultants
- School Psychologists (certified by the Michigan Department of Education but without Michigan licensure)
- Limited Licensed Speech Language Pathologists (without their American Speech-Language-Hearing Association Certificate of Clinical Competence)
- School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)

### 3.3.B. AOP & Direct Medical Services Staff Pool

AOP & Direct Medical Services Staff Pool:

- Fully Licensed Speech Language Pathologists
- Audiologists
- Counselors
- Licensed Practical Nurses
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Psychologists (not School Psychologists)
- Registered Nurses
- Social Workers

### 3.3.C. Personal Care Services Staff Pool

The following staff may be appropriate for inclusion in time studies if they are involved in Personal Care activities in the school setting:

- Bilingual Aides
- Health Aides
- Instructional Aides
- Paraprofessionals
- Program Assistants
- Teacher Aides
- Trainable Aides

### 3.3.D. Targeted Case Management Services Staff Pool

Staff with the following credentials may be appropriate for inclusion in time studies if they are involved in Targeted Case Management activities in the school setting:

- A bachelor's degree with a major in a specific special education area.
- Coursework credit equivalent to a major in a specific special education area.
- Minimum of three years' personal experience in the direct care of an individual with special needs.
- A licensed Registered Nurse (RN) in Michigan.

Targeted case managers must also demonstrate knowledge and understanding of all of the following:

- Services for infants and toddlers who are eligible under the IDEA law as appropriate;
- Part C of the IDEA law and the associated regulations;
- The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information;
- Provision of direct care services to individuals with special needs; and
- Provision of culturally competent services within the community being served.

## SECTION 4 – ADMINISTRATIVE OUTREACH AND DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the code categories utilized for the random moment time study and indicates whether they are claimable for reimbursement under the AOP only, the AOP & Direct Medical program (including Personal Care Services and Targeted Case Management Services), allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities are those that are purely educational in nature.

Activities can fall into one of the following categories for Medicaid reimbursement purposes:

- "A" - Allowable means the expense is allowable for Medicaid reimbursement
  - AOP services have a federal financial participation (FFP) rate of 50%
  - Direct medical IEP/IFSP services have a federal medical assistance percentage (FMAP) rate that varies from year to year
- "U" - Unallowable means the expense is not allowable for Medicaid reimbursement
- "R" - Reallocated means reimbursement across multiple activities that is allocated to isolate the amount applicable to the Medicaid allowable category
- "AOP Medicaid Eligibility Rate (MER)" - The AOP MER is determined by calculating the percentage of the county student population that is Medicaid eligible
- "IEP MER" - The direct medical IEP MER is determined by calculating the percentage of special education students under the age of 21 with health related support services documented in their IEP/IFSPs that are Medicaid eligible

These codes represent activities that may be performed by any time study participants during a typical workday. Some of these activities may be claimed under Medicaid and some may not. In the following section, examples and clarifications of each code are provided to assist with the appropriate coding of the activities.

| Activity Code | | Federal Matching Rate | Reimburse | | IEP MER |
|---|---|---|---|---|---|
| | | | DMS | AOP | |
| 1 | Medicaid Outreach and Public Awareness | 50% | U | A | AOP MER |
| 2 | Non-Medicaid Outreach | | U | U | U |
| 3 | Facilitating Medicaid Eligibility Determination | 50% | U | A | AOP MER |
| 4 | Facilitating Application for Non-Medicaid Programs | | U | U | U |
| 5 | Program Planning, Policy Development and Interagency Coordination Related to Medical Services | 50% | U | A | AOP MER |
| 6 | Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services | | U | U | U |
| 7 | Referral, Coordination, Monitoring of Medical Services (services that are not part of a direct service – AOP only) | 50% | U | A | AOP MER |

| Activity Code | | Federal Matching Rate | Reimburse | | IEP MER |
|---|---|---|---|---|---|
| | | | DMS | AOP | |
| 9 | Referral, Coordination, and Monitoring of Non-Medical Services | | U | U | U |
| 10 | Medicaid-Specific Training on Outreach, Eligibility and Services | 50% | U | A | AOP MER |
| 12 | Non-Medicaid Training | | U | U | U |
| 13 | IEP/IFSP Direct Medical Services | Annual FMAP Rate | A | U | IEP MER |
| 13(A) | IEP/IFSP Personal Care Services | Annual FMAP Rate | A | U | IEP MER |
| 13(B) | IEP/IFSP Targeted Case Management Services | Annual FMAP Rate | A | U | IEP MER |
| 13(C) | Other and Non IEP/IFSP Direct Medical Services | | U | U | U |
| 14 | Transportation and Translation Services in Support of Medicaid-Covered Services (not specialized direct medical services transportation services) | 50% | U | A | AOP MER |
| 15 | Transportation and Translation Services in Support of Non-Medicaid-Covered Services | | U | U | U |
| 16 | General Administration | | R | R | N/A |
| 17 | School-Related and Educational Activities | | U | U | U |
| 17(D) | Non-Returned Moments | | U | U | U |
| 18 | Not Scheduled to Work and Not Paid | | U | U | U |

## 4.1 Activity Coding

### 4.1.A. Code 1 - Medicaid Outreach and Public Awareness

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is used when school staff are performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. This code is also used for describing the services covered under the Medicaid program and how to obtain Medicaid preventive services. Activities related to Child Find are not recorded here, but instead under Code 2.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families and distributing literature about the services and availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs such as Healthy Kids, MIChild and Children's Special Health Care Services.
- Informing and encouraging families to access Medicaid managed care systems, i.e., Medicaid Health Plans.
- Informing families about the EPSDT and Medicaid health-related programs and the value of preventive health services and periodic exams.
- Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program by informing individuals, students, and their families about health resources available through the Federal Medicaid Program.
- Conducting Medicaid outreach campaigns and activities not related to Child Find (e.g., health fairs) that provide information about services provided by such entities as the Community Mental Health Service providers, Local Health Departments, etc.
- Conducting a family planning health education outreach program or campaign, if it is targeted specifically to Medicaid-covered family planning services.
- Contacting pregnant and parenting teenagers about the availability of Medicaid services, including referral to family planning and well baby care programs and services.
- Providing referral assistance to families with information about the Medicaid program.
- Providing information about Medicaid screenings that will help improve the identification of medical conditions that can be corrected or ameliorated through Medicaid services.
- Notifying families of EPSDT program initiatives such as Medicaid screenings conducted at a school site. These screenings are distinct from other general health screenings that are covered by Code 2.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about EPSDT screenings, health fairs and other health related services, programs and activities organized by the school.
- Coordinating or attending child health fairs that emphasize preventive health care and promote Medicaid services by presenting Medicaid material in areas with the likelihood of high Medicaid eligibility.
- Informing families about the availability of Medicaid providers of specific covered services, and how to effectively utilize services and maintain participation in the Medicaid program.
- Providing parents, on report card pick-up day or at parent conferences, information about the Medicaid program and health care services available to eligible children, including EPSDT screening services and medically necessary treatment.

### 4.1.B. Code 2 - Non-Medicaid Outreach

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for performing activities that inform eligible or potentially eligible individuals about social, vocational and educational programs, including special education, that are not covered by Medicaid and how to access them. Activities include describing the eligible or potentially eligible individuals, the range of benefits covered under these non-Medicaid social, vocational, and educational programs, and how to obtain them (e.g., WIC, SSI, LIF, Child Find).

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various Child Find activities.
- Developing the school district's student/parent handbook.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about upcoming events such as health fairs or screenings that focus on non-Medicaid social, vocational and educational programs, and activities such as scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.
- Providing parents, on report card pick-up day or at parent conferences, information about non-Medicaid programs, social, vocational and educational, and general health care services available in the community or the school for their children.

### 4.1.C. Code 3 - Facilitating Medicaid Eligibility Determination

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is used for assisting an individual to become eligible for Medicaid. This activity does not include the actual determination of Medicaid eligibility.

It includes paperwork, clerical activities, or staff travel required to perform the following activities:

- Verifying an individual's current Medicaid eligibility status.
- Facilitating eligibility determination for Medicaid by planning and implementing a Medicaid information program.
- Participating as a provider of Medicaid eligibility outreach information.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Referring an individual or family to the local MDHHS office or other local office to make application for Medicaid benefits.
- Assisting individuals or families to complete the Michigan Medicaid eligibility application.
- Assisting the individual or family in collecting/gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring families to appropriate sources to obtain Medicaid applications.

### 4.1.D. Code 4 - Facilitating Application for Non-Medicaid Programs

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for informing an individual or family about programs such as Child Find, Food Stamps, SSI, WIC, Daycare, Legal Aid, Free and Reduced Lunch, and other social or educational programs and referring them to the appropriate agency to make application.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family to collect/gather information and documents for the non-Medicaid program applications.
- Assisting the individual or family in completing the non-Medicaid programs application(s).
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

### 4.1.E. Code 5 - Program Planning, Policy Development and Interagency Coordination Related to Medical Services

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is used for performing activities associated with the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered medical/mental health services to school-age children. It applies only to employees whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Defining the scope of each agency's Medicaid service in relation to the other, and identifying gaps or duplication of medical/mental health programs.
- Analyzing Medicaid data related to a specific program, population, or geographic area and working with Medicaid resources, such as Medicaid Health Plans, to locate and develop EPSDT health services referral relationships and expanding school medical/mental health programs to school populations of need.
- Creating a collaboration of health professionals to provide consultation and advice on the delivery of health care services to the school populations, and developing methods to improve the referral and service delivery process by Medicaid health providers.
- Containing Medicaid costs for individuals with multiple challenging disabilities by reducing overlap and duplication of Medicaid services through collaborative efforts with Medicaid Health Plans, local Community Mental Health Service providers and Local Health Departments.
- Monitoring and evaluating policies and criteria for performance standards of medical/mental health delivery systems in schools and designing strategies for improvements.
- As a part of the school health policy quality assurance system, maintain and ensure the continuity of all Medicaid health-related services, including developing and monitoring contracts with private providers, agencies and/or provider groups.
- Overseeing the organization and outcomes of the coordinated medical/mental health service provision with Medicaid Health Plans.
- Developing internal referral policies and procedures for use by staff so that appropriate coordination of health services occurs between the various Medicaid providers and entities, such as Community Mental Health Service providers, Local Health Departments, Medicaid Health Plans, and those in the educational setting.

- Designing and implementing strategies to:
  - identify students who may be at high risk for poor outcomes because of poverty, dysfunctional families, and/or inappropriate referrals, and need medical/mental health interventions.
  - identify pregnant students who may be at high risk of poor health outcomes because of drug usage, lack of appropriate prenatal care, and/or abuse or neglect.
  - assure that students with any significant health problems are diagnosed and treated early.
- Presenting specific provider information about Medicaid EPSDT screening in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid.
- Developing procedures for tracking and resolving families' requests for assistance with Medicaid services and providers. This does not include the actual tracking of requests for Medicaid services.
- Developing new health programs with local community health providers for the Medicaid population, as determined by a needs assessment and geographic mapping.
- Working with requests and inquiries from local school board members, county commissioners, or State legislators to resolve unique or unusual requests or boundary issues regarding appropriate care for certain Medicaid-eligible groups or populations.
- Coordinating with interagency committees to identify, promote and develop medical services in the school system.

### 4.1.F. Code 6 - Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used when performing activities associated with the development of strategies to improve the coordination and delivery of community services to school-age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational and educational programs) to school-age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Developing procedures for tracking and resolving families' requests for assistance with non-medical services and the providers of such services.

- Developing and coordinating advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.
- Developing non-medical referral sources.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the scope of each agency's non-medical service in relation to the other.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Monitoring the non-medical delivery system in schools.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

### 4.1.G. Code 7 - Referral, Coordination, and Monitoring of Medical Services

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is issued for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

**This code is not to be used for providing IEP/IFSP targeted case management referral, coordination and monitoring of Medicaid eligible services. IEP/IFSP targeted case management is reported under code 13(C).**

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, medical services.
- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or scheduling appropriate Medicaid-covered immunizations, vision, and hearing testing, but not to include the child health screenings (vision, hearing and scoliosis) and immunizations that are required for all students.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.

- Contacting Medicaid providers of pediatric services in lower income areas to determine the scope of EPSDT screening and treatment services available to meet the needs of the at-risk child.
- Reviewing clinical notes of staff by a designated clinician to identify medical referral and follow-up practices, and making recommendations to supervisors for improvements as needed.
- Conducting quality assurance reviews of specific health-related programs objectives.
- Providing both oral and written instructions about the referral policies and procedures between the various agencies to parents for appropriate coordination of health services in the educational setting and for follow-up at home.

### 4.1.H. Code 9 - Referral, Coordination, and Monitoring of Non-Medical Services

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational, services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, social and educational services, such as childcare, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of immunizations and child health screenings (vision, hearing, and scoliosis) that are required for all students.
- Making referrals for, coordinating, and monitoring the delivery of educational, scholastic, vocational, and other non-health-related examinations/assessments.
- Gathering any information that may be required in advance of these non-Medicaid-related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for instructional, scholastic, vocational, and non-health-related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan, such as parent-teacher conferences regarding a student's educational progress, or compiling attendance reports.
- Linking or referring a family to a non-medical service delivery system.
- Evaluating curriculum and instructional services, policies and procedures.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of those services, such as tutors or remedial education courses.

- Health networking beyond the scope of Medicaid that is necessary to coordinate or monitor health fairs or screenings that focus on non-Medicaid social, vocational or educational programs and activities, i.e., scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.

### 4.1.I. CODE 10 - MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Training for Child Find activities is NOT recorded here, but under Code 12.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services.
- Coordinating training to assist families to access Medicaid services.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to new staff about the EPSDT referral process or available EPSDT and health-related services.
- Conducting Medicaid outreach training of non-medical professional staff for the purpose of targeting and identifying children with special or severe health or mental health needs for appropriate referral to EPSDT screening services.
- Disseminating information on training sessions and conducting all related administrative tasks.
- Conducting seminars and presentations to teachers, parents, and community members on:
  - appropriately identifying students concerning indications of mental health behavioral conditions (i.e., bi-polar disorders, drug/substance abuse, autism, attention deficit, mood disorders, pervasive disability disorder, suicidal tendencies, and clinical depression);
  - identifying physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid; and
  - providing information on where and how to seek assistance through the Medicaid system.

### 4.1.J. Code 12 - Non-Medicaid Training

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the programs other than the Medicaid program. Programs may include educational programs such as how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA Child Find Programs.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Participating in training to improve computer skills to collect data.
- Training regarding educational issues.
- Training regarding other non-medical social service issues.
- Participating in or coordinating training that improves the medical knowledge and skills of skilled professional medical personnel.
- Training on general health awareness and prevention programs, such as DARE, sex education, the Michigan Model, vocational or scholarship programs, MEAP tests, etc.

### 4.1.K. Code 13 - IEP/IFSP Direct Medical Services

**A – Direct Medical Services**

**U – Administrative Outreach**

This code is used for providing medically necessary direct medical services which are part of an IEP/IFSP treatment plan. These services are provided to an individual in order to correct or ameliorate a specific condition. Medical evaluations or assessments that are conducted to determine a child's health-related needs for purposes of the special education eligibility and for the development of the IEP/IFSP are covered under this code.

Direct Medical Services includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Occupational therapy services
- Physical therapy services

- Speech, language and hearing services
- Orientation and mobility services
- Psychological, counseling and social work services
- Developmental testing and assessments
- Nursing services
- Physician and psychiatrist services
- Assistive technology device services
- Providing health/mental health services contained in an IEP/IFSP
- Medical/health assessment and evaluation as part of the development of an IEP/IFSP
- Conducting medical/health assessments/evaluations and diagnostic testing, and preparing reports
- Providing or participating in face-to-face interventions with either an individual student or a group (2-8 students)
- Administering/monitoring medication included as part of an IEP/IFSP and documented in the IEP/IFSP

### 4.1.L. CODE 13(A) - IEP/IFSP PERSONAL CARE SERVICES

**A – Direct Medical Services**

**U – Administrative Outreach**

This code is used for providing a range of human assistance services to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself. The need for services must be documented in the child's IEP/IFSP. Services are not covered when provided by a family member or if they are educational in nature.

Personal care services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Eating/feeding
- Respiratory assistance
- Toileting
- Grooming
- Dressing
- Transferring
- Ambulation

- Intervention for seizure disorder
- Personal hygiene
- Mobility/Positioning
- Meal preparation
- Skin care
- Muscle strengthening
- Bathing
- Maintaining continence
- Medical equipment maintenance
- Assistance with self-administered medications
- Redirection and intervention for behavior
- Health related functions through hands-on assistance, supervision and cueing

### 4.1.M. CODE 13(B) - IEP/IFSP TARGETED CASE MANAGEMENT SERVICES

**A – Direct Medical Services**

**U – Administrative Outreach**

This code is used for providing services which are a part of the IEP/IFSP treatment plan. These services identify and address special health problems and needs that affect the student's ability to learn, and assist the student to gain and coordinate access to a broad range of medically-necessary services covered under the Medicaid program.

Targeted Case Management Services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Assure that standard re-examination/follow-up of the student is periodically conducted to ensure the student receives needed diagnosis and treatment
- Assist families in identifying/choosing appropriate care providers and services
- Maintain case records and indicate all contact for student in the same manner as other covered services
- Coordinate performance evaluations/assessments and other service needs for the student
- Prevention of duplicate services
- Facilitation/participation in development, review and evaluation of the multi-disciplinary assessment
- Supporting activities that link or coordinate needed health services for the student
- Meeting with teachers and other professional staff to discuss testing, planning, treatment, coordinating effective interventions, and student progress

- Coordinating school based services and treatment with parents and student
- Monitoring and recommending a plan of action
- Providing modifications to the multi-disciplinary, patient-centered treatment plan
- Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting
- Provide summary of provider, parent and student consultation

### 4.1.N. Code 13(C) - Other and Non IEP/IFSP Direct Medical Services

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used when providing direct medical services that are not documented in an IEP/IFSP or for services that are not allowable for Medicaid federal matching purposes.

- Administering first aid
- Performing routine or mandated child health screens including, but not limited to, vision, hearing, dental, scoliosis, and EPSDT screens
- Administering immunizations
- Discussing health care needs and the importance of well-baby care with adolescents
- Routine medication administration (such as over-the-counter medications or maintenance medications)

### 4.1.O. Code 14 - Transportation and Translation Services in Support of Medicaid-Covered Services

**U – Direct Medical Services**

**A – Administrative Outreach**

This code is used for assisting an individual to obtain transportation to Medicaid-covered services. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This code also does not include activities that contribute to the actual billing of transportation as a medical service, nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

This code is used for school employees who provide translation services related to Medicaid-covered services as an activity. Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Scheduling or arranging transportation to Medicaid-covered services.
- Assisting or arranging for transportation for the family in support of the referral and evaluation activities.
- Arranging for or providing translation services that assist the individual to access transportation and medical services.
- Arranging for or providing translation services that assist the individual to "communicate" with service providers about medical services being provided.
- Arranging for or providing translation services that assist the individual to understand necessary care or treatment.
- Assisting the student to define/explain their symptoms to the physician.
- Arranging for or providing signing services that assist family members to understand how to provide necessary medical support and care to the student.

### 4.1.P. Code 15 - Transportation and Translation Services in Support of Non-Medicaid Covered Services

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid.

This code is used for school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Scheduling or arranging transportation to and from school when no Medicaid service has been provided.
- Arranging for or providing translation services that assist the individual to access and understand non-medical services, programs, and activities.
- Arranging for or providing signing services that assist the individual's or family's access to and understanding of non-medical programs and activities.

### 4.1.Q. Code 16 - General Administration

**R – Direct Medical Services**

**R – Administrative Outreach**

This code is used for time study participants performing activities that are not directly assignable to program activities.

It includes related paperwork, clerical activities, or staff travel required to perform these activities. Typical examples (not all inclusive) of general administrative activities may include:

- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan
- Reviewing school or district procedures and rules
- Attending or facilitating school or unit staff meetings, training, or board meetings
- Performing administrative or clerical activities related to general building or district functions or operations
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance
- Reviewing technical literature and research articles
- Taking lunch, breaks, or time not at work when staff are paid for these activities
- Paid leave day
- Paid leave of absence
- Processing payroll/personnel-related documents
- Maintaining inventories and ordering supplies
- Developing budgets and maintaining records
- Training (not related to curriculum or instruction), such as how to use the district's new computer system
- Other general administrative activities of a similar nature, as listed above, which cannot be specifically identified under other activity codes

### 4.1.R. Code 17 - School-Related and Educational Activities

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for any other school-related activities that are not health-related, such as social services, educational services and teaching services, and employment and job training. These activities include the development, coordination, and monitoring of a student's education plan.

It includes related paperwork, clerical activities, or staff travel required to perform these activities. Examples of activities may include:

- Providing classroom instruction (including lesson planning)
- Testing and correcting papers
- Compiling attendance reports
- Performing activities that are specific to instructional, curriculum, and student-focused areas
- Reviewing the education records for students who are new to the school district
- Providing general supervision of students (e.g., playground, lunchroom)
- Monitoring student academic achievement
- Providing individualized instruction (e.g., math concepts) to a special education student
- Conducting external communications related to school educational issues/matters
- Compiling report cards
- Applying discipline activities
- Activities related to the immunization requirements for school attendance
- Compiling, preparing, and reviewing reports on textbooks or attendance
- Enrolling new students or obtaining registration information
- Conferring with students or parents about discipline, academic matters, or other school-related issues
- Evaluating curriculum and instructional services, policies, and procedures
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction)
- Translating an academic test for a student
- Transportation, if covered as a medical service under Medicaid

#### 4.1.S. CODE 17(D) – NON-RETURNED MOMENTS

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for moments that are not returned by the published deadline. As long as the compliance rate remains above 85%, these moments will not be used as a negative factor in the RMTS calculation.

### 4.1.T. Code 18 - Not Scheduled to Work and Not Paid

**U – Direct Medical Services**

**U – Administrative Outreach**

This code is used for time study participants who are not scheduled to work and not paid on the randomly selected moment pre-printed on the time study form.

Examples of this may include:

- Participant is a part-time employee who is not scheduled to work at the selected sample time
- The selected sample time falls before or after the participant's scheduled work day
- School is closed due to an unpaid holiday or an unpaid school district day off (i.e., winter break, spring break, or a built-in "bad weather day")
- Unpaid leave of absence

## SECTION 5 – CONFIDENTIALITY

Aggregate time study data may occasionally be useful for other administrative tasks (i.e., planning) and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy.

# SECTION 6 – TIME STUDY TRAINING

## 6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies.

The Contractor, along with MDHHS, is responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide and other services that will be provided to the individual ISDs.

### 6.1.A. LOCAL ISD COORDINATOR TRAINING

All ISDs have an ISD Coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study and cost reporting activities. These individuals must understand their role as the liaison between the Medicaid Program, the Contractor, and other staff. They must understand and be able to convey to others the basic purpose of the program, assist the Contractor with follow-up as needed, and serve as a facilitator for the Contractor to "navigate" the district as necessary.

### 6.1.B. TIME STUDY PARTICIPANT TRAINING

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form, and that their role is crucial to the success of the time study. The Contractor develops and provides detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet provides a "tutorial" with the aforementioned basics of the program as well as information about the Medicaid covered services provided in the school setting.

## SECTION 7 – SUMMARY OF TIME STUDY STEPS

The Contractor duties are to:

- Import eligible school district staff information to create the RMTS staff pools.
- Randomly select staff/moments to be sampled.
- Generate printed or electronic RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD Coordinators as a local control list.
- Generate mailing labels addressed to randomly selected staff.
- Code the time study responses.
- Calculate activity percentages for each of the activity codes.
- Scan completed and coded time study forms.
- Transfer raw data from scanned forms to the claims development software to calculate activity percentages for each of the activity codes.
- Produce quarterly reports summarizing the results of the random moment time studies (RMTS) and RMTS compliance reporting. (Both reports are forwarded to the MDHHS Program Policy Division for posting on the MDHHS website. Refer to the Directory Appendix for website information.)
- Produce periodic and special RMTS reports that provide data and information sorted by LEA and ISD that are provided to the CMS, MDHHS, MDE, ISDs and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs.
- Distribute time study forms and collect completed time study forms.
- Code the activity forms received from the ISDs.
- Initiate and complete the ISD claim workbooks by obtaining the financial data from each LEA and compiling data to complete the workbook.

# SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

## 8.1 AOP QUARTERLY CLAIM (OTHER THAN SUMMER QUARTER)

The claim consists of the results of the quarterly RMTS of the approved staff pool for the quarter and the correlating allowable costs applied to the reimbursement methodology.

## 8.2 AOP SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter is divided into two parts producing two partial claims. For the AOP process, the sum of both claims is submitted to Medicaid for reimbursement for the summer quarter. The first part of the quarter is from July 1 to the date students return to school. The second part of the quarter is from the date students return to school through September 30.

The summer time study of 800 moments is performed after students return to school and is only applied to the staff pool costs for the second part of the summer quarter (Fall staff pool costs). The RMTS is performed during a shorter time period to accurately reflect the work efforts being performed when all staff have returned to work.

The sums of Part I and Part II are utilized to calculate the claim submitted to Medicaid for reimbursement.

### 8.2.A. PART I - JULY 1 TO THE INDIVIDUAL ISD DATE THAT STUDENTS RETURN TO SCHOOL

Part I of the summer quarter is comprised of the following elements:

- Staff Pool – those eligible staff in the April through June staff pool
- Costs – April through June allowable staff pool costs
- A weighted average of the October-December, January-March, April-June, and the summer time study results.

### 8.2.B. PART II – DATE STUDENTS RETURN TO SCHOOL THROUGH SEPTEMBER 30

Part II of the summer quarter is comprised of the following elements:

- Staff Pool – the eligible new Fall staff returning to work
- Costs – the allowable cost associated with the new Fall staff pool
- RMTS – the time study for Part II is performed for a shortened period of time from the day students return to school through September 30. The start date will vary by ISD depending on the date the students return to school.

### 8.3 Direct Medical Summer Quarter Formula and Random Moment Time Study

A weighted average of the four time study results for the staff pool periods listed below is applied to the Medicaid Allowable Expenditure Report (MAER) total costs. The MAER costs include the annual costs associated with the direct medical services, personal care services and targeted case management services.

The direct medical services time study application is comprised of the following elements:

- Staff Pools – Those individuals eligible to participate in the following four staff pool periods:
  - October through December
  - January through March
  - April through June
  - Date students return to school through September 30 (summer time study)
- Cost Pool – The costs from the annual Medicaid Allowable Expenditure Report (direct medical services, targeted case management and personal care services).
- RMTS – A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

### 8.4 Financial Reporting Compliance Requirements

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from LEA payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.

# SECTION 9 – AUDIT AND QUALITY ASSURANCE

## 9.1 AUDIT

### 9.1 A. ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit staff review of selected ISD cost reports includes the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the relevant staff pool list and, therefore, allocable to that staff pool cost. For the Direct Medical program, all supplies and materials must be medically related.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on the cost reports and that costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts.
- Verification of recipient eligibility, documentation of services in the IEP/IFSP, and provider credentials.

The ISD must be prepared to direct the auditor to any document used to support and identify the reported RMTS costs.

### 9.1.B. SSAE 16 AUDIT REQUIREMENTS

The Contractor is required to have a Type II Statement on Standards for Attestation Engagements (SSAE) 16 audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) have been properly applied.

In a SSAE 16 Type II engagement, the service auditor expresses an opinion on whether the description of the service organization's system is fairly presented, whether the controls included in the description are suitably designed, whether the controls were

operating effectively, and provides a description of the service auditor's tests of operating effectiveness and the results of those tests.

The Contractor must undergo a SSAE 16 audit annually. The SSAE 16 audit must be submitted within 90 days after the end of the examination period.

Three (3) copies of the audit should be forwarded to the MDHHS Program Policy Section. (Refer to the Directory Appendix for contact information.)

### 9.2 Quality Assurance, Oversight and Monitoring

Quality assurance, oversight and monitoring activities include:

#### 9.2.A. MDHHS Program Policy – Oversight of Administration and Operations

MDHHS policy staff responsibilities are:

- Review quarterly time study results against historical benchmarks according to:
  - Overall results and matchable percentages
  - Benchmarks by activity code and by staff category
- Detailed investigation of anomalies in results.
- Determination of policy or procedure changes based on results of anomaly review.
- Overall statistical requirements in terms of confidence and precision levels on a quarterly basis and an annual basis.
- Sampling to review coding activities performed by the Contractor.
- Disseminate CMS guidance.
- Monitor ISDs processing of claims for compliance with State and Federal regulations and program guidelines.
- Assure that billing entities have the processes in place to correct any claims paid in error.
- Provide information and training to billing entities as needed for program compliance.
- Provide operational oversight and technical assistance.
- Assist the ISDs with quality assurance and compliance monitoring.
- Provide oversight of the ISDs quality assurance and compliance plans to insure that they provide oversight and monitoring of such things as documentation, provider credentials, record retention, parental consent, and confidentiality.

### 9.2.B. MDHHS Office of Inspector General – Post Payment Review and Compliance

MDHHS Office of Inspector General staff responsibilities are:

- Post payment review for the purpose of adherence to provider policy, provider credentials and appropriate billing practices.
- Post payment review for the purpose of reported fraud or abuse.

For more detailed information regarding the Fraud and Abuse and Post Payment Review, refer to the Post Payment Review and Fraud/Abuse Section of the General Information for Providers Chapter.

### 9.2.C. MDHHS Rate Review Section – Cost Settlement Review

MDHHS Rate Review Section staff responsibilities are:

- Import and create a database of the cost report data submitted by the ISDs.
- Perform reviews of the data for accuracy and completeness.
- Summarize the data and forward to the ISDs for final approval.
- Compile cost settlement summaries and prepare over/under adjustments.

### 9.2.D. Contractor Oversight and Quality Assurance

There are several levels of quality assurance and validation built into the RMTS process.

- In terms of coding, the Contractor has a coding process in place in which centralized coders code all moments, and then a second coder reviews all moments coded as matchable for verification of accurate and consistent application of activity codes. The second coder also reviews a random sample of 10% of all non-matchable moments for quality assurance purposes.
- Quality assurance and validation includes the quarterly review which includes the Contractor meeting with MDHHS staff specifically to review time study results and other procedural issues. Each quarter, the team reviews detailed reports which outline the current quarter time study results benchmarked against past quarter results. The results are reviewed by activity code as well as by matchable/non-matchable categories. Comparisons are made of the variances in the overall quarterly results from the same quarter in the previous year, as well as variances of the current quarter against the average of the past four quarters. Results are reviewed and discussed in terms of results by staff category. Any anomalies identified are pursued through a detailed investigation of the moments which produced the anomaly. The Contractor, in conjunction with MDHHS, then determines how to handle any issues in terms of additional communication or training for RMTS participants, policy or procedural changes, etc.
- ISDs utilizing the web-based input process may view compliance reporting online.
- ISDs utilizing the paper methodology are sent compliance reporting on a weekly basis.

### 9.2.E. ISD OVERSIGHT

ISD responsibilities are to:

- have systems in place to monitor service delivery, claim documentation, claim billing, and payments received.
- verify that the credentials of all clinicians are current and appropriate for Medicaid billing and that services rendered are within the scope of the clinician's practice.