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 and Blind.

This chapter describes the coverage and reimbursement policy for the fee-for-service (FFS) 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 Services Plan (IFSP). The Centers for Medicare and 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 Community Health (MDCH), 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, INCAR-ESO, INCAR-MA, or INCAR-MA-E.

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 and Blind. For the purpose of this document, the ISDs, Detroit Public Schools, and Michigan School for the Deaf and Blind 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. MDCH 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:

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 utilizes scanning hardware and software and spreadsheet software to automate the school district claiming process. The claims development software is comprised of three components: sampling, training, and costs/claim generation.
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: ➢ It is medically and functionally necessary to meet the needs of the beneficiary. ➢ It may prevent frequent hospitalization or institutionalization. ➢ It is life sustaining. ▪ 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: ➢ Treat a medical condition. ➢ Prevent unnecessary hospitalization or institutionalization. ➢ Support DME used by the beneficiary. ▪ 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: ➢ Improve and/or restore the beneficiary's functional level. ➢ Enable a beneficiary to ambulate or transfer.

	▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Prevent or reduce contractures. ➢ Facilitate healing or prevent further injury.
Enrolled Medicaid Provider	The 57 Michigan Intermediate School Districts, Detroit Public Schools, and Michigan School for the Deaf and Blind that have enrolled and revalidated with the MDCH CHAMPS Provider Enrollment subsystem.
FFS (Fee For Service) Program	The direct medical, specialized transportation, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid.
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 Services 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.
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 57 intermediate school districts.

MDE (Michigan Department of Education)	A department within the State of Michigan.
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 and Blind participate in the Fee-for-Service Direct Medical Program.
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 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.
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 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.

1.3 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.

1.4 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

1.5 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 certified and registered occupational therapist, licensed physical therapist or CCC (Clinical Certificate of Competency) certified 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, and 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. MDCH 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, and increasing attention span).

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.

1.6 Treatment Plan

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: ▪ Beneficiary's name; ▪ 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; ▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals; ▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ 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.

1.7 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.

1.7.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

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: ▪ A certified and registered occupational therapist (OTR) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (LPT) ▪ An American Speech-Language Hearing Association (ASHA) certified speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC) ▪ A licensed audiologist ▪ A fully licensed psychologist (Doctoral level) ▪ A limited-licensed psychologist (Doctoral level) (under the supervision of a licensed psychologist) ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A registered nurse (RN)

Procedure Codes	Qualified staff can bill for three distinct types of assessments/evaluations/tests as follows. 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. ▪ 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. ▪ 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. ▪ 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. Procedure codes to be used to bill for the above activities are: ▪ **T1024** - Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiply or severely handicapped children, per encounter. (This code can only be used with the TM modifier. Used by the Designated Case Manager billing for the IEP/IFSP multi-disciplinary assessment (TM) or an assessment not related to the revision of the IEP/IFSP (no modifier). The Designated Case Manager cannot bill using the HT modifier.) ▪ **99367** - Medical team conference with interdisciplinary team of health professionals, patient and/or family not present, 30 minutes or more; participation by physician. (Used by the physician billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **92506** - Evaluation of speech, language, voice, communication, and/or auditory processing. (Used by the speech pathologist or audiologist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **H0031** - Mental Health Assessment, by non-physician. (Used by the psychologist, counselor or licensed social worker billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).)

	▪ **T1001** - Nursing assessment/evaluation (registered nurse [RN]). (Used by the RN billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **97001**- Physical Therapy Evaluation. (Used by the physical therapist billing for either the IEP/IFSP multi-disciplinary assessment, an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **97003** - Occupational Therapy Evaluation. (Used by the occupational therapist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **V2799** – Vision services, miscellaneous. (Used by the orientation and mobility specialist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **96101** – Psychological testing (Used by the psychologist when billing for the evaluation [HT] when the psychological testing is performed as part of the assessment/evaluation process.) ▪ **96116** – Neurobehavioral status exam (Used by the psychologist when billing for the evaluation [HT] when the neurobehavioral status exam is performed as part of the assessment/evaluation process.) ▪ **96118** – Neuropsychological testing (Used by the psychologist when billing for the evaluation [HT] when the neuropsychological testing is performed as part of the assessment/evaluation process.)

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

2.2.A. Occupational Therapy Services

Definition	**Occupational Therapy:** 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 an OTR, COTA or Orientation and Mobility specialist to provide services.
Prescription	Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	OT services may be reimbursed when provided by: ▪ A certified and registered occupational therapist in Michigan (OTR); or ▪ A certified occupational therapy assistant (COTA) registered in Michigan and under the direction of a currently-Michigan-registered OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising OTR.
Evaluations for Occupational Therapies	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an OTR. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ 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.
Services	Occupational therapy services include: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; ▪ Wheelchair management/propulsion training; ▪ Independent living skills training; ▪ Coordinating and using other therapies, interventions, or services with the ATD; ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian; ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services; ▪ Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; ▪ 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 ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	The following procedure codes may be used to bill for occupational therapy services: ▪ **97003** – Occupational therapy evaluation. This code can be used by itself, or with the HT or TM modifiers. ▪ **97110** – Therapeutic procedure, one or more areas, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion, and flexibility. ▪ **97150** – Therapeutic procedure(s), group (2 or more individuals).

	▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers. ▪ **97755** – Assistive technology assessment (e.g., to restore, augment or compensate for existing functional tasks and/or maximize environmental accessibility), direct one-on-one contact by providers, with written report, each 15 minutes. (If assessments are done for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.)

2.2.B. Orientation and Mobility Services

Definition	**Orientation and Mobility Services:** 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. 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.
Provider Qualifications	Orientation and mobility services may be reimbursed when provided by: ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or ▪ A certified and registered occupational therapist in Michigan (OTR).
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 certified and registered Occupational Therapist (OTR). An evaluation for Orientation and Mobility services includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;

	▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ 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; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Services	**Orientation and mobility services include:** ▪ 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; ▪ Training the child to travel with proficiency, safety and confidence in familiar and unfamiliar environments; ▪ 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; ▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision; ▪ Communication skills training (teaching Braille is not a covered benefit); ▪ Systematic orientation training to allow safe movement within their environments in school, home and community; ▪ 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; ▪ Visual training to understand and use the remaining vision for those with low vision; ▪ Training necessary to activate visual motor abilities; ▪ Training to use distance low vision aids/devices; and ▪ Independent living skills training.

Procedure Codes	The following procedure codes may be used to bill for orientation and mobility services: ▪ **97533** – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes. ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. ▪ **G9041** – Rehabilitation services for low vision by qualified occupational therapist, direct one-on-one contact, each 15 minutes. ▪ **G9042** – Rehabilitation services for low vision by certified orientation and mobility specialist, direct one-on-one contact, each 15 minutes. ▪ **V2799** – Vision services, miscellaneous

2.2.C. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	**Assistive Technology Device Services General Description:** 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: ▪ A certified and registered occupational therapist (OTR) in the state of Michigan; or ▪ A certified occupational therapy assistant (COTA) in the state of Michigan.
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 OTR. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy;

	▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ 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 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. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ 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.

	▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ 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	The following procedure codes may be used to bill for ATD services: ▪ **97112** – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. ▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers. ▪ **97760** – Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk, each 15 minutes. ▪ **97761** – Prosthetic training, upper and/or lower extremity(s), each 15 minutes.

2.3 Physical Therapy Services (Includes Assistive Technology Device Services)

2.3.A. Physical Therapy Services

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 an LPT or CPTA 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 or licensed physician's assistant and updated annually. A stamped physician signature is not acceptable.

Provider Qualifications	PT services may be reimbursed when provided by: ▪ A licensed physical therapist (LPT) in Michigan; or ▪ A certified physical therapy assistant (CPTA) in Michigan and under the direction of a licensed physical therapist in Michigan (i.e., the LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriately licensed supervising LPT.
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 an LPT. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (i.e., functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ 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 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: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
Procedure Codes	The following procedure codes may be used to bill for physical therapy services: ▪ **97001** – Physical therapy evaluation. This code can be used by itself or with the HT or TM modifiers. ▪ **97110** – Therapeutic procedure, one or more areas, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion, and flexibility. ▪ **97116** – Gait training (includes stair climbing), each 15 minutes. ▪ **97150** – Therapeutic procedure(s), group (2 or more individuals). ▪ **97530** – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. ▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. (If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers. ▪ **97755** – Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes. (If assessments are done for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.)

2.3.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	**Assistive Technology Device Services General Description:** 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: ▪ a licensed physical therapist (LPT) in the state of Michigan; or ▪ a physical therapy assistant (PTA) in the state of Michigan.
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 LPT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ 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.
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.

	Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ 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. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ 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	The following procedure codes may be used to bill for ATD services: ▪ **97112** – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. ▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers. ▪ **97760** – Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk, each 15 minutes. ▪ **97761** – Prosthetic training, upper and/or lower extremity(s), each 15 minutes.

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

2.4.A. Speech, Language and Hearing Therapy

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 qualified American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence (CCC) 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.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A speech-language pathologist (SLP) possessing a current ASHA Certificate of Clinical Competence (CCC); ▪ A licensed audiologist in Michigan; ▪ 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 CCC), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately-credentialed SLP or licensed audiologist; or ▪ A teacher of students with speech and language impairments (TSLI), under the direction of an ASHA-CCC SLP or audiologist. All documentation must be reviewed and signed by the appropriately-credentialed 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 an ASHA-CCC SLP or audiologist. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.

	Evaluations may also include, but are not limited to,: ▪ 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. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ 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. ▪ 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. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.
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: ▪ Group therapy provided in a group of two to eight beneficiaries. ▪ Articulation, language, and rhythm. ▪ Swallowing dysfunction and/or oral function for feeding. ▪ Voice therapy. ▪ Speech, language or hearing therapy. ▪ Speech reading/aural rehabilitation. ▪ Esophageal speech training therapy. ▪ Speech defect corrective therapy. ▪ Fitting and testing of hearing aids or other communication devices.

Procedure Codes	The following procedure codes may be used to bill for speech, language and hearing therapy services: ▪ **92506** – Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. This code can be used with no modifier, or with the HT or TM modifiers. ▪ **92507** – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehab); individual. ▪ **92508** – Therapeutic procedure(s), group (2 or more individuals).

2.4.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	**Assistive Technology Device Services General Description:** 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: ▪ A licensed audiologist; ▪ A speech-language pathologist (SLP) possessing a current ASHA Certificate of Clinical Competence (CCC).
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. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;

	▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ 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. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ 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. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	The following procedure code may be used to bill for ATD services: ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. (Use this code only when billing for speech-related ATD services.)

	▪ **97755** – Assistive technology assessment (e.g., to restore, augment, or compensate for existing functional tasks and/or maximize environmental accessibility), direct one-on-one contact by providers, with written report, each 15 minutes. (If assessments are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.)

2.5 PSYCHOLOGICAL, COUNSELING AND SOCIAL WORK SERVICES

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. 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. ▪ 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. ▪ 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: ▪ A licensed physician or psychiatrist in Michigan; ▪ A fully licensed psychologist in Michigan; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist;

	▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; ▪ A licensed professional counselor in Michigan; or ▪ 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.
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. The psychological testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.

Procedure Codes	The following procedure codes may be used to bill for psychological testing: ▪ **96101** – Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. To evaluate intellectual abilities, psychopathology, psychodynamics, risk for mental illness and other factors influencing treatment and diagnosis. ▪ **96116** – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. ▪ **96118** – Neuropsychological testing (e.g., Halstead-Reitan Neurological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), per hour of the psychologist's time or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report.
	The following procedure codes may be used to bill for psychological, counseling and social work services. Only one individual psychotherapy procedure code (20 to 30 minutes or 45 to 50 minutes) may be billed per day: ▪ **90804** – Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, 20 to 30 minutes, face-to-face with the patient. ▪ **90806** – Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient. ▪ **90810** – Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with patient. ▪ **90812** – Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with patient. ▪ **90846** – Family psychotherapy (conjoint psychotherapy), without the patient present. ▪ **90847** – Family psychotherapy (conjoint psychotherapy), with patient present. ▪ **90853** – Group psychotherapy (other than a multiple-family group). ▪ **H0004** – Behavioral health counseling and therapy, per 15 minutes. ▪ **H0031** – Mental health assessment, by non-physician (e.g., psychologist, counselor, licensed social worker). This code can be used by itself or with the HT or TM modifiers.

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. Crisis intervention must be billed using the following procedure code: ▪ **S9484** – Crisis intervention mental health services, per hour.

2.6 DEVELOPMENTAL TESTING

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.
Documentation	The developmental testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ 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: ▪ A fully-licensed psychologist (Doctoral level) in the State of Michigan; ▪ A limited-licensed psychologist (Doctoral level) under the supervision of a licensed psychologist; ▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; or ▪ A licensed physician or psychiatrist in Michigan.

Procedure Codes	The following codes may be used to bill for developmental testing: ▪ **96110** – Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. ▪ **96111** – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments), with interpretation and report.

2.7 NURSING SERVICES

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. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices. Services include: ▪ Catheterizations or Catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. 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: ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ 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	To bill for nursing services, use procedure codes: ▪ **T1001** – Nursing assessment/evaluation. To be billed by the RN only. This code can be used by itself or with the HT or TM modifiers. ▪ **T1002** – RN services, up to 15 minutes ▪ **T1003** – LPN/LVN services, up to 15 minutes

2.8 PHYSICIAN AND PSYCHIATRIST SERVICES

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: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled ISD. 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	The procedure codes listed below may be used to bill for physician or psychiatrist services. Procedure codes 99367 and G9008 will not be reimbursed for the same date of service. 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. ▪ **99367** – Medical team conference with interdisciplinary team of health professionals, patient and/or family not present, 30 minutes or more; participation by physician. This code can be used by itself, or with the HT or TM modifiers. ▪ **G9008** – Coordinated care fee, physician coordinated care oversight services. (This code is to be used for billing the physician record review.)

2.9 Personal Care Services

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/her self. Personal Care Services may be provided when: ▪ The service is medically necessary. Personal Care Services are not covered if they are: ▪ 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). ▪ Not documented in the IEP/IFSP. ▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation. ▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. Personal Care Services may include, but are not limited to, assisting with the following: ▪ Eating/feeding; ▪ Respiratory assistance; ▪ Toileting; ▪ Grooming; ▪ Dressing; ▪ Transferring; ▪ Ambulation; ▪ Personal hygiene; ▪ Mobility/Positioning; ▪ Meal preparation; ▪ Skin care; ▪ Bathing; ▪ Maintaining continence; ▪ Assistance with self administered medications; ▪ Redirection and intervention for behavior; and ▪ Health related functions through hands-on assistance, supervision and cueing.

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: ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ 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), Registered and Certified Occupational Therapist (OT), Licensed Physical Therapist (LPT), Master of Social Work (MSW), or ASHA-CCC 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. (added per bulletin MSA 09-07)
Procedure Codes	The following procedure code may be used to bill for personal care services. ▪ **T1020** – Personal care services, per diem; not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD; part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).

2.10 TARGETED CASE MANAGEMENT SERVICES

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

	➢ Identifying the individual's needs and completing related documentation, ▪ 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. ▪ Development (and periodic revision) of a specific care plan that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the individual; ➢ 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 ➢ Identifies a course of action to respond to the assessed needs of the eligible individual. ▪ Referral and related activities: ➢ 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; ➢ Monitoring and follow-up activities; ➢ 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: ♦ Services are being furnished in accordance with the individual's care plan; ♦ Services in the care plan are adequate. ▪ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements. TCM services may be reimbursed when provided by a Designated Case Manager. 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.
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: ▪ A licensed RN in Michigan;

	▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of an individual with special needs. 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: ▪ 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; ▪ Provisions of direct care services to individuals with special needs; and ▪ Provisions of culturally competent services within the community being served.
Designated Case Manager Services	Targeted Case Management services include: ▪ 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; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services; ▪ 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; ▪ Coordinating school based services and treatment with parents and the child; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team treatment plan; ▪ Activities that support linking and coordinating needed health services for the beneficiary; ▪ Provide summary of provider, parent and student consultation; and ▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.
Procedure Code	▪ **T2023** – Targeted case management, per month

2.11 Special Education Transportation

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. 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. 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	Use the following procedure codes when billing for Special Education Transportation. Bill the applicable code for each one-way trip: ▪ **A0120** – Non-emergency transportation (one-way): mini-bus, mountain area transports, or other transportation systems. ▪ **A0130** – Non-emergency transportation (one-way): wheelchair van.

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 the MDCH 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, Department of Human Services (DHS), 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 the MDCH-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 Department of Health and Human Services (DHHS),

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, MDCH, 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 57 Michigan Intermediate School Districts (ISDs), Detroit Public Schools, and Michigan School for the Deaf and Blind 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 MDCH 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 the MDCH.

4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual FFS/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 fee for service 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 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 under the fee-for-service component 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 (FFS), 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 and Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific fee for service 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 fee for service 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. MDCH 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 fee-for-service (FFS) 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. FEE FOR SERVICE 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 and entered onto the first sheet of the claims development software Workbook. Once complete, the workbooks are forwarded to the Michigan Department of Community Health (MDCH) where they are uploaded into the cost settlement program.

Costs are reported for FFS direct medical 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 MDCH 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 MDCH 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 employees are working. The majority of school employees works 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 9-month staff return to work. The second part of the quarter will be from the date the 9-month staff return to work through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the employees 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 MDCH, 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.

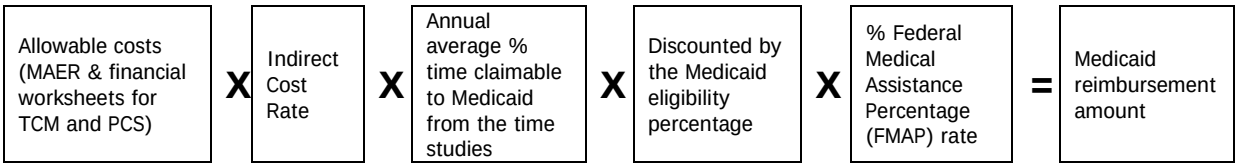
Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the MAER. Any written inquiries should be addressed to MDCH Hospital and Health Plan Reimbursement Division. (Refer to the Directory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

All payments and adjustments are issued by the MDCH Hospital and Health Plan 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 (revised 4/1/09).

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)



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.

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 MDCH Medical Services Administration for reconciliation. The initial settlement process will begin in January. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDCH before a final settlement will be processed. The final settlement process will begin within 18 – 20 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 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: columns 4 & 6; lines 2, 4 & 7
- Benefits: columns 4 & 6; line 8
- Purchased Services: columns 4 & 6; lines 13-18 (vehicle-related costs)
- Supplies: columns 4 & 6; lines 20-22 (gasoline, oil/grease, tires, etc.)
- Other Expenses: columns 4 & 6; line 26 (only the costs associated with adjustments to the allowable costs listed above)
- Bus amortization: columns 4 & 6; line 27

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 the Medicaid Invoice Processing system 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 Program (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 Fee For Service (FFS) Direct Medical, 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 Circular A-87 "Indirect Cost Allocation Principles." 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 MDCH, 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. MDCH 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.

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

MDCH 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 FEE FOR SERVICE 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 MDCH was received.

ISDs/LEAs must cooperate fully with any review requested by the MDCH and the 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.