Franklin Pierce School of Law
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Medicaid to Schools Technical Assistance Guide

New Hampshire Department of Health and Human Services, Medicaid to Schools Program: Medical Assistance Services Provided by Education Agencies

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Disclaimers:

This document was issued in November 2021. Please be sure to check the Medicaid to Schools website for updates.

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Introduction

Purpose: The purpose of this Medicaid to Schools (MTS) Technical Assistance Guide is to memorialize in one document the formal existing rules and guidance approved by New Hampshire Department of Health and Human Services for the Medicaid to Schools program. The administrative rules (He-W) and formal guidance in the form of "Information Bulletins" is referenced and categorized by topic. The user can link internally to sections for clarification and can link to external sources for clarification.

Scope: This Technical Assistance Guide includes only those resources that have been formally adopted by DHHS.

Contents: Each section of this Technical Assistance Guide includes a summary of the applicable administrative rules promulgated by the Department for Medicaid to Schools services, as well as a reprint of the relevant portion of the rules. Please refer to the rules directly if you seek more information.

This MTS Technical Assistance Guide also includes the guidance and Q&A documents published by the Department. The Department's guidance is quoted directly in each section to ensure fidelity to the regulatory interpretations provided, although sections may have been moved and paragraphs numbered or renumbered. Please refer to the original guidance linked herein if you have questions. Each section includes a summary of the rule, the guidance, a restatement of the rule and a link to the Information Bulletin. Many subjects are linked, so a review of the table of contents is important.

Additional Resources: DHHS is finalizing Billing Guides for some of the Medicaid to Schools covered services which include includes procedure codes, service unit descriptions, and rates. These Billing Guides will be posted with and serve as detailed supplements to this Medicaid To Schools Technical Assistance Guide.

Instructions for Use: This *Medicaid To Schools Technical Assistance Guide* should be used as a primary resource for your schools and Medicaid to Schools program staff. Please consider the date of publication in your review. Updates will be published periodically and posted on the DHHS Medicaid to Schools Program website. The *Technical Assistance Guide* will be republished periodically to include the updates. https://www.dhhs.nh.gov/ombp/medicaid/mts/index.htm

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Overview: Medical Assistance Services Provided by Education Agencies

Summary

The purpose of these rules and guidance documents is:

- To describe the services provided by school districts and school administrative units that are reimbursable under NH Medicaid for which federal financial participation (FFP) can be claimed and
- To describe the required qualifications of clinicians, licensed by a board under the office of professional licensure and certification for healthcare professionals, delivering reimbursable services in schools and preschools.

As is described more fully in this Technical Assistance Guide, reimbursable services include both the NH Medicaid State Plan services, and other optional services that are not covered under the NH Medicaid State Plan, but covered pursuant to 1905(a) of the Social Security Act through the early and periodic screening, diagnostic, and treatment (EPSDT) benefit.

Requesting FFP for Medicaid services is optional for school districts and school administrative units. These service descriptions are established to allow students to receive medically necessary services within the least restrictive environment. Participation in Medicaid is discretionary on the part of school districts and school administrative units. These rules are not intended to impose upon school districts and school administrative units the responsibility to provide any services that they are not otherwise legally responsible to provide under RSA 186-C or other federal or state law.

Rule He-W 589:

He-W 589 Medical Assistance Services Provided by Education Agencies

CHAPTER He-W 500 MEDICAL ASSISTANCE

He-W 589.01 Purpose. The purpose of these rules is to describe the services provided by school districts and school administrative units that are reimbursable under NH medicaid for which federal financial participation (FFP) can be claimed and to describe the required qualifications of clinicians, licensed by a board under the office of professional licensure and certification for healthcare professionals, delivering reimbursable services in schools and preschools. Reimbursable services include both the NH medicaid state plan services, and other optional services that are not covered under the NH medicaid state plan, but covered pursuant to 1905(a) of the Social Security Act through the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Requesting FFP for medicaid services is optional for school districts and school administrative units. These service descriptions are established to allow students to receive medically necessary services within the least restrictive environment. Participation in medicaid is discretionary on the part of school districts and school administrative units. These rules are not intended to impose upon school districts and school administrative units the responsibility to provide any services that they are not otherwise legally responsible to provide under RSA 186-C or other law.

Information Bulletin(s) - Medical Assistance Services Provided by Education Agencies

(None)

Definitions

Activities of Daily Living: "Activities of daily living (ADL)" means basic self-care tasks such as personal hygiene, grooming, eating, dressing, transferring, mobility, and toileting. (He-W 589.02(a))

Applied Behavior Analysis: "Applied behavior analysis (ABA)" means a treatment modality that employs the process of systematically applying interventions based on the principles of learning theory to improve socially significant behaviors, and is covered through the EPSDT benefit pursuant to He-W 546 and in accordance with He-W 589.04(at). (He-W 589.02(b))

Augmentative and Alternative Communication (AAC): "Augmentative and alternative communication (AAC) aids" means electronic or non-electronic aids, devices, or systems ordered by a licensed speech-language pathologist that assist a student to overcome or ameliorate the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities, such as communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output. (He-W 589.02(c))

Care Plan: A "care plan" means a written health care plan, including, but not limited to, an individualized education program or a 504 plan, which is maintained in the student's file and documents and supports the medical necessity of all claims to NH Medicaid for FFP. (He-W589.02(d))

Carry-over Tasks: "Carry-over tasks" means tasks, therapies, or activities that a rehabilitative assistant performs as instructed by the licensed clinician in support of the care plan's goals or the clinician's treatment plan. (He-W 589.02(e))

Durable Medical Equipment: "Durable medical equipment (DME)" means a type of item pursuant to He-W 571 that is: (1) non-disposable and able to withstand repeated use; (2) primarily used to serve a medical purpose for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury; and (3) not useful to an individual in the absence of an acute or chronic medically diagnosed health condition, illness, or injury. (He-W 589.02(f))

Early and Periodic, Screening, Diagnosis and Treatment: "Early and periodic, screening, diagnosis and treatment (EPSDT) services" means a benefit pursuant to 42 CFR 440.40 and He-W 546, designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Medicaid enrolled individuals under age 21. (He-W 589.02(g))

Enrolled School Provider: An "enrolled school provider" means a NH local education agency (LEA) or school administrative unit (SAU) that has agreed to participate in NH Medicaid pursuant to these rules and enrolled with NH Medicaid. (He-W 589.02(h))

Federal Financial Participation: "Federal financial participation (FFP)" means the federal share of costs for services. (He-W 589.02(i))

Group: A "group" means 2 or more persons. (He-W 589.02(j))

Individualized Education Plan: An "individualized education plan (IEP)" means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with 34 CFR 300.320 through 300.324, and the applicable NH board of education administrative rules. (He-W 589.02(k))

Instrumental Activities of Daily Living: "Instrumental activities of daily living" (IADL) means personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. (He-W 589.02(l))

LEA: A local education agency refers to a school district, an entity which operates local public primary and secondary schools.

LEIE: list of excluded/individual or entities which is a database on the Officer of Inspector General website as a searchable database. Summary: Any school participating in the NH Medicaid to Schools program and professional or other service provider seeking to provide covered services to students through the Medicaid to Schools program, must be properly enrolled in NH Medicaid.

Local Education Agency: A "local education agency (LEA)" means a local school district. (He-W 589.02(m))

Medical Assistance: "Medical assistance" means the federally financed medical assistance program established pursuant to Title XIX of the Social Security Act also known as the Medicaid program. (He-W 589.02(n))

Medically Necessary: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of, conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the student requesting the medically necessary service. (He-W 589.02(o))

MMIS: Medicaid Management Information Systems

Order: An "order" means a written authorization for the provision of services issued by an advance practice registered nurse (APRN), physician assistant, physician, or other licensed clinician with ordering privileges. (He-W 589.02(p))

ORP: Order, Referring or Prescribing Providers (ORP)

Other Licensed Clinician: "Other licensed clinician" means any person licensed under state law and practicing within the scope of his or her licensure as authorized by the appropriate board, commission, or council responsible for licensing and regulating health care professions under the NH office of professional licensure and certification. (He-W 589.02(q))

Performing-only Provider: A "performing-only provider" means a health care provider that the Medicaid program does not allow to independently enroll with Medicaid and is affiliated with an enrolled school provider. The term includes healthcare providers such as rehabilitative assistants pursuant to this part, personal care service workers for individuals under the age of 21, and Board Certified Behavior Analysts. (He-W 589.02(r))

Personal Care Services: "Personal care services" means medically necessary services related to assistance with ADL or IADL due to a student's illness, injury, or disability which are furnished to a student who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with developmental disabilities, or institution for mental illness, and are covered through the EPSDT benefit pursuant to He-W 546 and in accordance with He-W 589.04(at). (He-W589.02(s))

Physician: A "physician" means a person licensed to practice medicine in NH or the state in which he or she practices. (He-W 589.02(t))

Private Duty Nursing: "Private duty nursing" means the provision of skilled nursing services for students who require more individual and continual skilled nursing observation, judgment, assessment, or interventions than are available from a visiting nurse, in contrast to part-time or intermittent care, such as wound care. (He-W 589.02(u))

Provider: Medicaid enrolled entity that will be submitting claims for medical covered services

Psychologist: A "psychologist" means a person licensed to practice psychotherapy in NH pursuant to RSA 329-B or an equivalent licensing board in the state in which she or he practices. (He-W 589.02(v))

Psychotherapist: A "psychotherapist" means a licensed clinical social worker, pastoral psychotherapist, clinical mental health counselor, or marriage and family therapist licensed under RSA 330-A who provides mental health services. This term includes psychiatrists licensed as physicians under RSA 329, advanced practice registered nurse (APRN) licensed under RSA 326-B:18 as psychiatric nurse practitioners, and psychologists, school psychologists, or associate school psychologists licensed by the board of psychology under RSA 329-B. This term also includes "mental health practitioner". (He-W 589.02(w))

Psychotherapy: "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition. (He-W 589.02(x))

Rehabilitative Assistance Services: "Rehabilitative assistance services" means non-skilled interventions covered through the EPSDT benefit and ordered by a physician, physicians' assistant, APRN, or other licensed clinician, as listed in the student's care plan. (He-W 589.02(y))

Re-validation: Federally required every 5 years to complete a re-enrollment application

School Administrative Unit: A "school administrative unit (SAU)" means a legally organized administrative body responsible for one or more school districts pursuant to RSA 194-C:1. (He-W 589.02(z))

Section 504 Plan: A "section 504 plan (504 plan)" means a plan for services for a student in accordance with Section 504 of the Rehabilitation Action of 1973 as amended. (He-W 589.02(aa))

Signature: A "signature" means: (1) a person's name handwritten by that person, excluding any photocopy, stamp, or other facsimile of such name; or (2) an electronic signature that complies with RSA 294-E. (He-W 589.02(ab))

Student: A "student" means a person who is eligible for and receiving medical assistance under Medicaid pursuant to He-W 589.03. (He-W 589.02(ac))

Trading Partner: A third party administrator, agent or entity that enters into a business relationship with the Medicaid provider to complete transactions on behalf of the Medicaid provider, must be enrolled with MMIS, and have completed authorizations from each provider entity to act of their behalf.

Under the Direction: "Under the direction" means that, except as prohibited by state law, the licensed health care clinician, whether or not he or she is physically present at the time that services are provided: (1) assumes professional responsibility for the services provided; (2) assures that the services are medically appropriate and performed safely; and (3) assures compliance with the clinical oversight requirements as required by law or rule adopted by the appropriate board, commission, or council responsible for licensing and regulating health care professions under the NH office of professional licensure and certification. (He-W 589.02(ad))

Student Eligibility

Summary

To be eligible for reimbursement for covered services, a student shall:

- Have a care plan;
- Be less than 21 years of age;
- Be a Medicaid recipient; and
- Be served by an LEA or SAU that is a NH Medicaid enrolled school provider (He-W 589.03(a)-(d)).

Rule He-W 589.03 Student Eligibility.

To be eligible for medicaid reimbursement for covered services, a student shall:

(a) Have a care plan;
(b) Be less than 21 years of age;
(c) Be a medicaid recipient; and
(d) Be served by an LEA or SAU that is an enrolled school provider.

Informational Bulletin(s) – Student Eligibility

1) **For services rendered to a student to be eligible for MTS reimbursement, the student must:**
   - Be Medicaid eligible;
   - Have a care plan that is maintained in the student's file that documents and demonstrate the requisite criteria for any Medicaid covered services provided to the student (IEP, 504 plan, Healthcare plan);
   - Be under 21 years of age; and
   - Be served by a New Hampshire LEA or SAU that is an Enrolled Medicaid provider

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

Covered Services

Summary

The following sections are included under covered services:

- Provider Qualifications
- Covered Service Requirement
- Supplies and Equipment
- Medical Evaluation
- Nursing Services
- Occupational Therapy Services
- Physical Therapy Services
- Psychiatric Services
- Psychological Services
- Mental Health Services Other Than Psychiatric and Psychological Services Including Substance Use Disorder
- Rehabilitative Assistance
- Speech, Language, and Hearing Services
- Vision Services
- Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)
- Specialized Transportation

Provider Qualifications

Summary

All enrolled school providers shall:

- Be enrolled with NH Medicaid for the purposes of administration and billing;
- Verify the qualifications, licensure, and certifications, as applicable, of performing-only providers upon hire and at time of any licensure or certification renewal and maintain proof of verification;
- Screen all performing-only providers for Medicaid services for exclusions against the Office of Inspector General (OIG) exclusion and sanction database pursuant to section 1866(j)(2) of the Social Security Act, section 1903(i) of the Social Security Act, and 42 CFR 1001.1901. The OIG exclusion and sanction database may be found at https://exclusions.oig.hhs.gov;
- Screen all performing-only providers upon hire, prior to executing a contract, and on a monthly basis thereafter as long as the performing-only provider is providing Medicaid services for which the school is seeking federal FFP. (He-W 589.04(a)(1)-(a)(4))

In addition, all providers shall have knowledge in the following areas:

- Medicaid recipient rights, and the reporting of abuse and neglect; and
- Record keeping and documentation requirements pursuant to this part, including the penalties associated with improper recordkeeping and documentation. (He-W 589.04(a)(5))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(a) All enrolled school providers shall:

(1) Be enrolled with NH medicaid for the purposes of administration and billing;

(2) Verify the qualifications, licensure, and certifications, as applicable, of performing-only providers upon hire and at time of any licensure or certification renewal and maintain proof of verification;

(3) Screen all performing-only providers for medicaid services for exclusions against the Office of Inspector General (OIG) exclusion and sanction database pursuant to section 1866(j)(2) of the Social Security Act, section 1903(i) of the Social Security Act, and 42 CFR 1001.1901. The OIG exclusion and sanction database may be found at https://exclusions.oig.hhs.gov ;

(4) Screen all performing-only providers upon hire, prior to executing a contract, and on a monthly basis thereafter as long as the performing-only provider is providing medicaid services for which the school is seeking federal FFP; and

(5) Ensure all providers have knowledge in the following areas:

a. medicaid recipient rights, and the reporting of abuse and neglect; and

b. Record keeping and documentation requirements pursuant to this part, including the penalties associated with improper recordkeeping and documentation.

Informational Bulletin(s)- Provider Qualifications

Informational Bulletin Highlights:

- Claiming/Ordering
- Professional Qualifications

Claiming/Ordering

1) Exhibit B: Provider Type Ordering Chart; August 28, 2020
2) **Some school districts contract with vendors to provide professional staff who can order services during the annual IEP meetings. Would these qualified Medicaid providers obtain their own NH Medicaid enrolled provider number, or would they use the number of the Contractor? (i.e., CareerStaff or Pediatric PT, etc.)**
   A group provider (i.e. Pediatric PT) cannot be an ordering provider. An order must be obtained from an individual capable of ordering the services under their license. If the ordering provider is already enrolled with NH Medicaid, then the school can rely on NH Medicaid for the proper monthly screenings of that provider. If the provider is not enrolled with NH Medicaid, then the school is responsible for ensuring the provider has been properly screened, even if that provider is employed by a separate vendor. The vendor can be responsible for the monthly screenings, but the school must have a process to ensure those screenings are being done before services are rendered. Proof of screening must be available upon request and during audits. If the screenings cannot be proven, then funds may be recovered.

   Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

3)
   I. **Orders must encompass the date of service in order for that service to be billed to Medicaid**
   (This must be in place for School Year 2020-2021)

   All orders must:
   - Have a date span of no more than one year. If there is no date span, or the date span extends beyond one year, the orders are effective for one year from the date of the signature. To be clear, the date span or date of signature must be on the order itself.
   - Be in place before services are billed

   II. **Content of Orders**
   (This must be in place for School Year 2021-2022)

   All orders must:
   - Meet the criteria of Section I above
   - Include a description of medical condition to verify medical necessity
   - Describe the actual service needed i.e. occupational therapy, skilled nursing, etc.
- Be signed and dated by a physician, advanced practice registered nurse, physician assistant, or other licensed practitioner. *Please consult the guidance issued by the Office of Professional Licensure and Certification for specific information regarding scope of practice and authority to order services which is posted on the DHHS Medicaid to Schools website under the Communication Guidance link:* http://www.dhhs.nh.gov/ombp/medicaid/mts/index.htm.

Examples

The IEP team finalizes the IEP and obtains parental signatures and consents on August 1, 2020. The services included in the IEP require a signature from a physician/advanced practice registered nurse/physician assistance.

- A physician reviews the IEP and signs an order on August 10, 2020. The order states that services are authorized from August 1, 2020, through August 1, 2021. *In this case, the order has date span; therefore, it covers dates of services beginning on the date of the signature on the order.*

    - The school may submit a claim on or after August 10, 2020, for services delivered with a date of service from August 1, 2020, through August 1, 2021
- A physician reviews the IEP and signs an order on August 10, 2020. The order does not have a date span, just the date it is signed. *This order does not have a date span; therefore, it covers dates of service on or after the date of the signature on the order (August 10, 2020)*
    - The order is valid from August 10, 2020, through August 10, 2021.
    - The school may submit a claim on or after August 10, 2020, for services delivered with a date of service on or after August 10, 2020.

4) **If a school district has an order that is effective from February 3, 2021, through February 3, 2022, that complies with Section I above. Will that order be accepted for School Year 2021-2022? Or, must the school get a new order for School Year 2021-2022 that also complies with Section II above?**

If the order is currently in place and carries over into a part of next school year (as in the example in this question) it will be accepted. However, any changes to the IEP/504/Health Care Plans or new IEP/504/Health Care Plans created on or after September 1, 2021, must comply with Section II.

Source: May 2021; Authorization and Orders for Medicaid to Schools Questions and Answers

5) **Can the requirement for an ordering provider to have an NPI and be NH Medicaid enrolled be waived?**

Order requirements are established in federal regulations and cannot be waived. Any provider that is licensed and able to order services would already have a National Provider Identifier (NPI). All claims processors use an NPI to pay claims; therefore, any provider would require an NPI for services billed to any insurance, Medicare, or Medicaid.

DHHS has not implemented the hard edit, which will require the ordering provider NPI of a Medicaid enrolled provider on the claim form. This is a Federal requirement and DHHS is in the process of implementing the requirement. The schools will be informed, well in advance with instructions, when this information is required on claims. Until this is implemented, DHHS does not require the ordering provider to be enrolled with NH Medicaid, but if the school is using a provider that is not enrolled with NH Medicaid then the school is responsible for ensuring the provider has been properly screened on the LEIE (OIG screening) and has an active license at the time of the order. This must be documented by the school.

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

6) **Given that it is quite a feat to actually obtain the original, signed MD order from the doctor's office, I am wondering the following:**

    a. **Is it acceptable if providers check off that they are enrolled NH Medicaid providers but fail to include their provider number on the MD order form? In other words, they have filled in all the information requested at the bottom with the exception of their provider # and/or their NPI #.**

    b. **If it is not acceptable for them to omit the actual provider number, in lieu of it and to avoid having to send it back to the doctor's office, can we conduct a search online to confirm that they are enrolled providers and attach a copy of the search results to the MD order and keep that in the student's file?**

    c. **If #b is acceptable, I am wondering if you can provide reliable links that we can use to search for a provider? I have gone to the link below but the DHHS provider directory**

link at the bottom of the page is coming up with an error and the Well Sense link/search tool is also giving me errors. The only one I am having any luck with is NH Healthy Families.

d. **For missing NPI numbers, is it acceptable for us to conduct a search of the NPI database (link is below) and attach the search results to the MD order that we keep in the student's file? https://npiregistry.cms.hhs.gov/registry/?**

The school must validate that the provider is an enrolled NH Medicaid provider by checking the MMIS portal even if the provider did not provide their NPI number. (See the Department's response to question 3 above). The search results can be maintained along with the order in the student's file.

Tips on how to find a provider and the contact information for the managed care organizations can be found at https://www.dhhs.nh.gov/ombp/caremgt/find-provider-tips.htm.

A search can be conducted on the NPI registry at https://npiregistry.cms.hhs.gov/registry/ and the search results maintained in the student's file.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

7) **The Department previously issued guidance to the effect that orders can be retroactive six months. It is very difficult to get orders timely given the impact COVID-19 has had on school districts and on providers. Can the Department extend this retroactive authority to cover the current school year? Note: The answer below replaces the Q&A previously provided relative to retro orders in FAQ 2020-03 Q4 (issued October 19, 2019)**

Yes, the Department will extend the retroactive order authority to cover services rendered for the 2019-2020 school year. The order must clearly cover the date of the service and be effective for a 12-month period. All orders for the 2019-2020 school year must be written by December 31, 2020. Additionally, the Department will allow retroactive orders for the first four months of the 2020-2021 school year, if the order is written before December 31, 2020. Example 1: Service is provided August 28, 2019. A school may bill Medicaid if the order is written before August 28, 2020. The order must clearly cover the date of service and is only effective for a 12-month period. Example 2: Service is provided April 2, 2020. A school may bill Medicaid if the order is written before December 31, 2020. The order must clearly cover the date of service and is only effective for a 12-month period. Example 3: Service is provided September 15, 2020. A school may bill Medicaid if the order is written before December 31, 2020. The order must clearly cover the date of service and is only effective for a 12-month period.

Source: SFY 2020-07; May 2020; Operational Policy Clarification

8) **Does the order have to include the frequency and duration of medically necessary services?**

At this time, orders do not have to include frequency and duration of the medically necessary services being ordered.

Source: SFY 2020-07; May 2020; Operational Policy Clarification

9) **The administrative rule says that there shall be an order for preschool services. Can you clarify who can sign this order?**

Preschool is a setting within the school setting. Thus, each distinct service being delivered in the pre-school setting require an order to be billable to NH Medicaid. In the regular rulemaking proposal, the Department will remove preschool services as a service category because

preschool is a setting in which discreet coverable services are being delivered. Schools will be provided with updated CPT codes to bill the discreet services rather than a bundled code.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

10) As RSA 326-C:2, II states, occupational therapy does not require an order to provider education-related services. Does that mean I do not need to seek an order for OT provided in schools?

Per OPLC guidance document 2020-02, occupational therapy does not require a referral for the purpose of evaluation. Additionally, the occupational therapist does not require an order to provide "prevention, wellness, and education-related services." However, to initiate "occupational therapy services to individuals with medically related conditions," the occupational therapist requires an order from a physician, physician assistant, chiropractor, APRN, optometrist "or any other qualified health care professional who, within the scope of the professional's licensure, is authorized to [order] health care services." RSA 326-C:2, II. As Medicaid covers medically necessary services, an order is required for occupational therapy services.

This information bulletin section also appears in the Occupational Therapy Services section

Source: SFY 2020-07; May 2020; Operational policy clarification

11) Would an occupational therapist (OT) that will be providing consults with a student present 51% of the time and OT evaluations be required to be NH Medicaid enrolled? Would it be considered the same as an order, but only for the services their scope of practice allows for?

As noted in OPLC guidance, while consultation and evaluation do not require an order, initiation of OT services to individuals with medically-related conditions must be ordered by a physician, physician assistant, APRN, chiropractor, optometrist, or any other qualified health care professional. At present, NH Medicaid does not require rendering providers or providers directly providing the service to be enrolled with NH Medicaid or to be noted on the claim form. In the future, should NH Medicaid require the rendering provider be identified on the claim form, then all individual providers giving services, or their supervising provider, will be required to submit their NPI on claims. NH Medicaid will inform the school districts of any billing changes in the future along with a transition period if that should happen.

This informational bulletin section also appears in the Occupational Therapy Services section

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

12) Who can order for rehabilitative assistance services?

Most commonly, rehabilitative assistance is a multi-disciplinary function provided by a Rehabilitation Assistant or paraprofessional. Therefore, an order should come from a physician, physician's assistant, or APRN to cover all of the services involved. Alternatively, the school may determine it is more practical to obtain individual orders from multiple licensed clinicians to cover each service type, which is acceptable so long as every other licensed clinician is ordering within his or her scope of practice. In any instance that rehabilitative assistance is offered as a single-discipline service, such as behavior management provided by a psychologist or physical therapy offered by a physical therapist, that provider may be able to self-order, or provide the order for the Rehabilitation Assistant or paraprofessional.

Note: The order requirement is separate from the sign-off requirement. For sign off requirement, please refer to the guidance issued in January: 2020-05 Q9:

This informational bulletin section also appears in the Rehabilitative Assistance section

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

13) What needs to be done if it is found the para/rehabilitation assistant's order is incorrect after services were delivered?

If you find that the order for para/rehabilitation assistant services was not executed by a Physician, APRN, physician assistant, or qualified treatment providers (when they are acting within the scope of their board license), then a new, correct order can be obtained and made retroactive as long as the service was in the 2019-2020 school year and the new order was written before December 31, 2020.

This informational bulletin section also appears in the Rehabilitative Assistance section

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

14) The administrative rule states that there are covered services if ordered by a licensed audiologist or licensed speech pathologist but it also says that there shall be an order from a physician, APRN or PA. Could you clarify if a speech language pathologist licensed by the NH board is allowed to order services in the scope of their practice instead of a physician?

The Department is seeking clarification from OPLC to further clarify those other licensed treatment providers who may, as permitted under their board licensure, order or prescribe services, what type of services are included under their scope of practice, and who they may supervise pursuant to their license. As the Department receives guidance and information from OPLC on the scope of licensed practitioner's licenses, the Department will issue new guidance and will modify the administrative rule accordingly. Our understanding based on recent conversations with the NH Speech-Language Pathology Governing Board is that the board believes speech-language services require an order but the Department is continuing to seek guidance from the board regarding speech-language pathologists' scope of practice as the Board is considering the scope of services being delivered in the school setting. As previously stated, OPLC is committed to issuing a guidance document related to scope of practice issues and plans to do so in December.

This informational bulletin section also appears in the Speech, Language, and Hearing Services section

Source: SFY 2020-04; November 2019; Billing and policy guidance document

15) If a provider is already a billable NH Medicaid enrolled provider, do they also need to be a "non-billable ordering, rendering prescribing (ORP) provider (ORP)" for the purpose of Medicaid to Schools?

No. If the provider is already actively enrolled in NH Medicaid as a billing provider, then they do not need to enroll as an ORP provider

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI numbers

Professional Qualifications

1) What is NH Medicaid 's policy on BCBAs?

In NH, BCBAs are not licensed under NH state law, rather they are certified by the National Behavior Analyst Certification Board (BACB). The NH Medicaid state plan nor the NH Medicaid Fee for Service rules (He-W 500s) officially recognize BCBAs as a billable provider type.

However, per the Centers for Medicare and Medicaid Services Informational Bulletin Dated 7/1/2014, (which can be accessed at https://www.Medicaid .gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf), services performed by BCBAs are coverable under 1905(a) of the Social Security Act even if they are not covered in a state's Medicaid state plan. Accordingly, autism spectrum disorder services or applied behavior analysis (ABA) services delivered by a BCBA can be covered in the school setting if medically necessary. At this time, the Department is maintaining the current waiver process in the administrative rule, which many school districts use for BCBAs, until the Department implements prior authorization for applied behavior analysis pursuant to the EPSDT benefit under administrative rule He-W 546. BCBAs must have a certification from the national board, and if supervising, the individual must have a supervisor certification as part of their overall certification from BACB. Since BCBAs are not licensed by the NH Office of Professional Licensure and Certification, they do not have ordering privileges as part of the scope of their board certification. Licensed healthcare providers with ordering privileges can order autism spectrum disorder services such as ABA services if the provider is acting within the scope of their board licensure.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

2) Licensed Clinician Qualifications

All individuals ordering and supervising medical services delivered to a student must meet the licensure and/or certification standards as set forth in He-W 589. Also see the August 28, 2020 Provider Type Ordering Chart which can be found at https://www.dhhs.nh.gov/ombp/Medicaid /mts/index.htm under the Communication and Guidance link. Licensed clinicians are responsible for development and documentation of student-specific health information related to the individual provider's scope of practice.

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

3) Does the Office of Licensed Allied Health Professionals License/Certificate NH that my SLP, OT and PT staff have permit them to order services?

The Department is not restricting licensed qualified treatment providers or clinicians from practicing within the scope of their board licensure, including those that can act independently to treat or order services. An order prescribing the Medicaid covered service is generally required from a Physician, APRN or physician assistant for the services to be reimbursable by NH Medicaid; however, some qualified treatment providers may order services if state statute allows them to do so, and when they are acting within the scope of their board license. Whether your physical therapists, occupational therapists or speech-language pathologists can order services is determined by the scope of their licensure, which is determined by the applicable licensing board. These therapists should know whether they can order services under their license, but if you should have questions, the Department recommends that you contact the applicable licensing board. A list of contacts for each board can be accessed at this website: https://www.oplc.nh.gov/contact-us/contact-your-board.htm. The main phone number to the Office of Professional Licensure and Certification (OPLC) is (603)-271-2152.

The Department is seeking clarification from OPLC to further clarify those other licensed treatment providers who may, as permitted under their board licensure, order or prescribe services and what type of services are included under their scope of practice. In its regular rulemaking proposal, the Department will clarify the definition for "order" to include those licensed treatment practitioners whose

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Covered Services: Requirements

Summary

In order to be "covered" by the Medicaid to Schools program as "covered services," services must be provided through a student's Local Education Agency (LEA) or School Administrative Unite (SAU). In addition, "covered services" must be medically necessary and both included and documented in the student's care plan in accordance with the rules. Covered services can be provided:

> …in a variety of locations and settings as specified in a student's care plan and may occur outside the hours of the usual school day. All "covered services" must be provided by qualified clinicians, pursuant to the rules, who comply with the scope of his or her board licensure for his or her clinical practice including supervision and ordering requirements and be "prior authorized" if required by the NH Medicaid state plan, federal or state law, or the rules adopted thereunder. (He-W 589.04 (b)).

Covered services may be provided by staff employed or subcontracted by the enrolled school provider and who are either licensed by the applicable clinical healthcare boards to provide the services provided or otherwise under the direction of the appropriate licensed clinician to provide the services as permitted by applicable licensure law. Covered services may also be provided by employed or subcontracted Board Certified Behavior Analysts (BCBA) appropriately certified by the national Behavior Analyst Certification Board, and if supervising others, have a supervisory certification issued by the national board and be acting within the scope of that certification. (He-W 589.04 (b) and (c)).

Rule He-W 589.04 Covered Services and Provider Qualifications.

(b) *All covered services shall be:*

(1) Provided through a student's LEA or SAU;
(2) Medically necessary;
(3) Included and documented in the student's care plan in accordance with this part;
(4) Provided in a variety of locations and settings as specified in a student's care plan and may occur outside the hours of the usual school day;
(5) Provided by qualified clinicians pursuant to this part and who comply with the scope of his or her board licensure for his or her clinical practice including supervision and ordering requirements; and
(6) Prior authorized if required by the NH medicaid state plan, federal or state law, or the rules adopted thereunder.

(c) Covered services may be provided by staff employed or subcontracted by the enrolled school provider and who are:

(1) Either licensed by the applicable clinical healthcare boards to provide the services provided or otherwise under the direction of the appropriate licensed clinician to provide the services as permitted by applicable licensure law; or
(2) Board Certified Behavior Analysts (BCBA) appropriately certified by the national Behavior Analyst Certification Board, and if supervising others, have a supervisory certification issued by the national board and be acting within the scope of that certification.

Informational Bulletin(s)-Covered Services: Requirements

Informational Bulletin Highlights:

- "Covered Services" definitions
- "Medically necessary" services

- Out-of-District Billing & Consultation Services

Covered Services - Definitions

1) **Covered Services:**

Covered services shall be provided through a student's LEA or SAU and designed to meet the health needs of the student by facilitating reduction of a physical or mental disabilities and any other remedial services that are included in the student's care plan as medically necessary excluding educational and social activities such as classroom instruction and academic tutoring.

Such services may be provided in a variety of locations and settings as stated in the care plan; may be provided outside of school hours provided as part of an extended school program; and can be provided by staff employed or subcontracted by the enrolled provider.

Services Eligible for Medicaid Reimbursement:

- Occupational Therapy, Physical Therapy, Speech/Language Services
  - Individual and group treatment
  - Evaluation
  - Supplies and Equipment
- Hearing Services
  - Evaluation
- Nursing
  - Assessment
  - Direct Treatment (positioning, management and care of specialized medical equipment, observation, etc.)
  - Medical Administration
  - Nursing Supplies and Equipment
- Mental Health services
  - Individual, group, and family counseling
  - Behavioral management
  - Crisis intervention
- Psychological Services
  - Testing
  - Evaluation
  - Individual and group treatment
  - Family Counseling
- Vision Services
  - Examinations
  - Prescriptions o Evaluations
  - Supplies and Equipment
- Substance Use Disorder (SUD) Services
  - Services provided by Licensed Alcohol Drug Counsel (LADC) or Master Licensed Alcohol Drug Counselor (MLADC)
- Rehabilitative Assistance o Medically related, non-academic, health related services for the maximum reduction in a student's physical or mental disabilities
  - Personal care
  - Mobility o Nutrition
  - Communication
  - Behavior management, etc.
- Psychiatric Services

- Evaluation/Diagnosis
- Treatment

- Specialized Transportation
  - Transportation to and from school- only on a day when the student receives a Medicaid coverable service at school during the school day; and
  - Transportation to and from a Medicaid coverable service in the community during the school day.
  - An Information Bulletin focused on transportation is forthcoming.

In order to be identified as a service to be provided, the best practice is to include these services in the healthcare plan in the "Related Service/Special Education" table grid.

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

Medically Necessary Services

1) **If a student requires medically necessary ABA services as part of their IEP and they are also receiving funding for medically necessary ABA services which are delivered at their home or clinic, is this considered a duplication of services? For example, if the IEP requires BCBA support, staff training and other services and the child's MCO pays for 20-30 hours per week of "outside ABA" how do these two entities work together? Does one funding source supersede the other? Can the MCO funded ABA service occur during the child's school day at the child's school?**

   Services delivered in the school and services delivered in the home are not considered duplicative as the settings are different pursuant to RSA 186-C:29.1 The goals being addressed may be the same but the strategies utilized may be different given the settings. For example, the school may be working on personal care issues; however, at home the family may be working on showering skills. Coordination of services is expected to assure that approaches are complementary and not in conflict with each other. Coordination of services is not currently reimbursable but may be reimbursable as part of administrative claiming at a future date.

   Source: SFY 2020-05; January 2020; Billing and policy guidance document

Out-of-District Billing & Consultation Services

1) **Out-of-District Services Billed with an Invoice**

   Ex. A student from your district receives medical services outside of your district. If you are billing Medicaid for those services, the invoice from the entity providing the services must include:

   - The student's name
   - The type of service provided
   - The date(s) of service
   - The number of units or minutes/hours of service
   - If service was provided to one child or in a group setting (include how many in group regardless of Medicaid eligibility)
   - The provider's rate
   - The provider's name and signature
   - Supervisor's name and signature if the service provider worked under a supervisor

   Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) **We are an out of district provider. We have obtained physician orders for all of our related and medical (nursing) services. All of our providers have NPI numbers. Do they need to be Medicaid Enrolled providers as well?**

Beginning in the 2021-2022 school year, the ordering provider must be enrolled with NH Medicaid.

For the 2020-2021 school year, if the provider is not enrolled with NH Medicaid, then the school is responsible for ensuring the provider has been properly licensed and screened. If the provider is enrolled with another State Medicaid program, then the school is still responsible for ensuring the provider meets licensure and screening criteria and the school must provide supporting documentation of this upon request and audit.

This informational bulletin section also appears in the Provider Enrollment section

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

3) **Can consultation services be billed?**

CMS has advised that in order for medical services to be billed to Medicaid, a student must be present for some portion of a consultation, because Medicaid is a medical assistance program, which means services are being delivered directly to a Medicaid beneficiary. CMS further advised that "This is not a federal regulation but as a result of a General Counsel opinion. Medicaid benefits are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purposes of assisting in the beneficiary's recovery." Given this CMS clarification, schools should only seek reimbursement for consultations that include the student for at least 51% of the consultation time and bill the correct CPT code for this service.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Supplies and Equipment

Summary

Covered supplies and equipment described under He-W 589.04 shall:

- Be acquired for the use of a specific student;
- When purchased, be the property of the student and his or her family; and
- When rented or acquired through a used equipment exchange program, be the property of the student and his or her family during the period used. (He-W 589.04(d))

DME shall be provided by a qualified DME provider, and in accordance with the separate requirements pursuant of the rules in He-W 571 (explaining coverage for Durable Medical Equipment, Prosthetic and Orthotic Devices, and Medical Supplies). Augmentative and Alternative Communication (AAC) devices and aids shall also be provided by a qualified DME provider, and in accordance with the requirements of He-W 575 (explaining coverage for Augmentative and Alternative Communication Aid Services). (He-W 589.04(e)-(f))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(d) Covered supplies and equipment described under He-W 589.04 shall:

(1) Be acquired for the use of a specific student;

(2) When purchased, be the property of the student and his or her family; and

(3) When rented or acquired through a used equipment exchange program, be the property of the student and his or her family during the period used.

(e) DME shall be provided by a qualified DME provider, and in accordance with the requirements pursuant to He-W 571.

(f) AAC devices and aids shall be provided by a qualified DME provider, and in accordance with the requirements of He-W 575.

Informational Bulletin(s) – Supplies and Equipment

(None)

Medical Evaluation

Summary

"Medical evaluation" shall include the following:

- Those services rendered by a physician, APRN, or physician assistant whose opinion or advice is requested regarding the evaluation or treatment of a student's condition; *and*
- An initial evaluation if the physician, APRN, or physician assistant assumes the continuing care of the student.

However, any service(s) provided by the physician, APRN or physician assistant subsequent to the initial evaluation by such physician, APRN, or physician assistant *shall not* be considered an evaluation. These subsequent services might be coverable as another service pursuant to this part. (He-W 589.04(g))

The following "medical evaluation" services performed by the providers above shall be billable under the category of medical evaluation:

- Examination of a single organ system, including:
  - Documentation of complaint(s);
  - Physical examination and diagnosis of current illness; and
  - Establishment of a plan of management relating to a specific problem; and
- In-depth evaluation with development and documentation of medical data, including:
  - Chief complaint;
  - Present illness;
  - Family history;
  - Medical history;
  - Personal history;
  - System review; and
  - Physical examination (He-W 589.04(h))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(g) Medical evaluation shall include the following:

(1) Those services rendered by a physician, APRN, or physician assistant whose opinion or advice is requested regarding the evaluation or treatment of a student's condition; and

(2) An initial evaluation shall be covered, however, if the physician, APRN, or physician assistant assumes the continuing care of the student, any service(s) provided subsequent to the initial evaluation by such physician, APRN, or physician assistant shall not be considered an evaluation but might be coverable as another service pursuant to this part.

(h) The following medical evaluation services performed by the providers in (g) above shall be billable under the category of medical evaluation:

(1) Examination of a single organ system, including:

a. Documentation of complaint(s);

b. Physical examination and diagnosis of current illness; and

c. Establishment of a plan of management relating to a specific problem; and

(2) In-depth evaluation with development and documentation of medical data, including:

a. Chief complaint;

b. Present illness;

c. Family history;

d. Medical history;

e. Personal history;

f. System review; and

g. Physical examination.

Informational Bulletin(s) – Medical Evaluation

(None)

Nursing Services

Summary

Nursing services are "medically necessary" to meet the health needs of a student and include:

- Any assessments or treatments performed by a licensed registered nurse, licensed practical nurse (LPN), or APRN for a student that are "medically necessary"; *and*
- Supplies and equipment necessary for the provision of the covered nursing services as determined by the licensed registered nurse, LPN, or APRN. (He-W 589.04(i))

Additionally, "nursing services" must be performed by the following:

- An APRN licensed to practice in NH by the NH board of nursing in accordance with RSA 326-B:18 or the state in which he or she practices as a registered nurse in an advance practice role;
- A registered nurse who is:
  - Licensed to practice in NH or the state in which he or she practices in accordance with RSA 326-B; and
  - Acting under the direction of a physician, APRN, or physician assistant for those activities that require an order; or
- A LPN who is:
  - Licensed to practice in NH under RSA 326-B or the state in which he or she practices; and
  - Acting under the direction of a physician, APRN, registered nurse, or physician assistant. (He-W 589.04(j))

"Nursing services" also includes the following services:

- Administration of medication(s);
- Positioning or repositioning;
- Assistance with specialized feeding programs;
- Management and care of specialized medical equipment such as:
  - Colostomy bags:
  - Nasogastric tubes;
  - Tracheostomy tubes; and
  - Related medical devices;
- Observation of students with chronic medical illnesses in order to assure that medical needs are being appropriately identified, addressed, and monitored; and
- Other services determined by a registered nurse, LPN, or APRN to be medically necessary and appropriate. (He-W 589.04(k))

Billable categories of nursing services shall include the following:

- Nursing assessment;
- Nursing treatment; and
- Supplies and equipment necessary to provide covered nursing services. (He-W 589.04(l))

"Private duty nursing services" includes:

- Covered services when they are part of the student's medical regimen and rendered under the order and under the direction of the student's physician; and
- Covered and delivered in accordance with the requirements of He-W 540. (He-W 589.04(m))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(i) Nursing services shall be medically necessary to meet the health needs of a student and include:

(1) Any assessments or treatments performed by a licensed registered nurse, licensed practical nurse (LPN), or APRN for a student that are medically necessary; and

(2) Supplies and equipment necessary for the provision of the covered nursing services as determined by the licensed registered nurse, LPN, or APRN.

(j) Nursing services shall be performed by the following:

(1) An APRN licensed to practice in NH by the NH board of nursing in accordance with RSA 326-B:18 or the state in which he or she practices as a registered nurse in an advance practice role;

(2) A registered nurse who is:

a. Licensed to practice in NH or the state in which he or she practices in accordance with RSA 326-B; and

b. Acting under the direction of a physician, APRN, or physician assistant for those activities that require an order; or

(3) A LPN who is:

a. Licensed to practice in NH under RSA 326-B or the state in which he or she practices; and

b. Acting under the direction of a physician, APRN, registered nurse, or physician assistant.

(k) Nursing services shall include the following:

(1) Administration of medication(s);

(2) Positioning or repositioning;

(3) Assistance with specialized feeding programs;

(4) Management and care of specialized medical equipment such as:

a. Colostomy bags:

b. Nasogastric tubes;

c. Tracheostomy tubes; and

d. Related medical devices;

(5) Observation of students with chronic medical illnesses in order to assure that medical needs are being appropriately identified, addressed, and monitored; and

(6) Other services determined by a registered nurse, LPN, or APRN to be medically necessary and appropriate.

(l) Billable categories of nursing services shall include the following:

(1) Nursing assessment;

(2) Nursing treatment; and

(3) Supplies and equipment necessary to provide covered nursing services.

(m) Private duty nursing services shall be:

(1) Covered services when they are part of the student's medical regimen and rendered under the order and under the direction of the student's physician; and

(2) Covered and delivered in accordance with the requirements of He-W 540.

Informational Bulletin(s) – Nursing Services

1) **Does the administration of medication need to be in the student's care plan to be billed by the nurse?**

If medication administration is going to be billed to Medicaid that service must be ordered by a qualified Medicaid licensed clinician i.e. a physician, an advanced registered nurse practitioner or physician assistant and identified in the student's IEP, 504 Plan, or Health Care Plan.

Source: 2021-04; May 2021; Nursing Services and Related Questions

2) **We have nurses at our school who administer medication, assist with feeding tubes, and catheters. We have orders from qualified medical professionals (doctor/physician assistant/nurse practitioner) for all these services. Do we need to have the prescribing doctor sign off for all entries on a medication administration log?**

The physician is not required to sign off on the nurse's medication administration logs kept for documentation purposes and Medicaid billing purposes.

Source: 2021-04; May 2021; Nursing Services and Related Questions

3) **If a school nurse has a prescription from a physician to administer medication to a student, does the nurse need a separate order?**

An order is needed for the administration of the medication described in the students' IEP, 504 Plan or Health Care Plan in order for that service to be covered by Medicaid. A prescription is considered an order. If the student's IEP, 504 Plan or Health Care Plan does not include medication administration as a medical service, then the administration of the medication cannot be billed to Medicaid.

Source: 2021-04; May 2021; Nursing Services and Related Questions

4) **Would a diagnosis on file in the nurse's office be sufficient evidence of medical necessity?**

No, a diagnosis is a description of the medical condition and is not an order for a service. Documentation of medical necessity must be in an order and part of the student's IEP, 504 Plan or Health Care Plan.

Source: 2021-04; May 2021; Nursing Services and Related Questions

5) **Can an RN sign off on a paraprofessional or rehabilitative assistant's documentation?**

Yes, if a paraprofessional or rehabilitative assistant is performing delegated medical treatment tasks, the RN can sign off on the documentation if the paraprofessional or rehabilitative assistance is working under the direction of the RN.

Source: 2021-04; May 2021; Nursing Services and Related Questions

6) **We understand that a RN can deliver services while working with the direction of an APRN/PA/physician. What does "under the direction" mean?**

"Under the direction" mean that, except as prohibited by state law, the licensed clinician, whether or not he or she is physically present at the time that services are provided:

(1) Assumes professional responsibility for the services provided;
(2) Assures that the services are medically appropriate and performed safely; and
(3) Assures compliance with the clinical oversight requirements as required by law or rule adopted by the appropriate board, commission, or council responsible for licensing and regulating health care professions under the NH office of professional licensure and certification.

In accordance with the Nurse Practice Act, Registered Nurses operate under orders to perform medical treatment tasks hence the terminology under the direction. There is no requirement that a physician, APRN or physician assistant review and sign off on written documentation that the registered nurse performed medical treatment.

Source: 2021-04; May 2021; Nursing Services and Related Questions

7) Can a School nurse (RN) supervise an LPN?

In accordance with scope of practice, a currently licensed RN may supervise the practice of a currently licensed LPN.

Source: SFY 2020-03; October 2019; Billing and policy guidance document

Occupational Therapy Services

Summary

Occupational therapy services are covered by the Medicaid to Schools program if the services are "medically necessary" to implement a program of activities to develop or maintain adaptive skills necessary to achieve adequate and appropriate physical and mental functioning of a student, including:

- Any evaluations, treatment, or assessments performed by an occupational therapist of students whose abilities to carry out age appropriate tasks are threatened or impaired by physical illness or injury, mental illness, emotional disorder, or congenital or developmental disability;
- Supplies and equipment necessary to provide the covered occupational therapy services as recommended by an occupational therapist; and
- Occupational therapy services performed by an occupational therapy assistant carrying out a therapy plan developed by the occupational therapist. (He-W 589.04(n))

To be considered "covered services" occupational therapy services must be provided by:

- An occupational therapist who is licensed to practice in NH or the state in which he or she practices, and is either:
  - Registered by the National Board for Certification in Occupational Therapy Inc.; or
  - A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the National Board for Certification in Occupational Therapy, Inc.; or
- An occupational therapy assistant as defined in RSA 326-C:1, IV working under the direction of a licensed occupational therapist. (He-W 589.04(o))

Occupational therapy services, other than an evaluation, shall require an order. According to *He-W 589*, occupational therapy services shall include:

- Task-oriented activities to correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the student;
- Evaluations of:
  - Sensorimotor abilities;
  - Self-care activities;
  - Capacity for independence;
  - Physical capacity for prevocational and work tasks; and
  - Play and leisure performance;
- Specific occupational therapy techniques involving:
  - Improving skills for ADLs;
  - The fabrication and application of splinting devices;
  - Sensorimotor activities;
  - The use of specifically designed manual and creative activities;
  - Guidance in the selection and use of adaptive equipment; and
  - Specific exercises to enhance functional performance and physical capabilities needed for work activities; and

Occupational therapy services can also include the services determined by an occupational therapist to be "medically necessary" and appropriate. (He-W 589.04(p)-(q))

Billable categories of occupational therapy services shall include:

- Occupational therapy evaluation;

- Occupational therapy, individual;
- Occupational therapy, group; and
- Supplies and equipment necessary for the provision of covered occupational therapy services. (He-W 589.04(r))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(n) Occupational therapy services shall be covered if the services are medically necessary to implement a program of activities to develop or maintain adaptive skills necessary to achieve adequate and appropriate physical and mental functioning of a student including:

(1) Any evaluations, treatment, or assessments performed by an occupational therapist of students whose abilities to carry out age appropriate tasks are threatened or impaired by physical illness or injury, mental illness, emotional disorder, or congenital or developmental disability;

(2) Supplies and equipment necessary to provide the covered occupational therapy services as recommended by an occupational therapist; and

(3) Occupational therapy services performed by an occupational therapy assistant carrying out a therapy plan developed by the occupational therapist.

(o) Occupational therapy services shall be provided by:

(1) An occupational therapist who is licensed to practice in NH or the state in which he or she practices, and is either:

a. Registered by the National Board for Certification in Occupational Therapy Inc.; or

b. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the National Board for Certification in Occupational Therapy, Inc.; or

(2) An occupational therapy assistant as defined in RSA 326-C:1, IV working under the direction of a licensed occupational therapist.

(p) Occupational therapy services, other than an evaluation, shall require an order.

(q) Occupational therapy services shall include:

(1) Task-oriented activities to correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the student;

(2) Evaluations of:

a. Sensorimotor abilities;

b. Self-care activities;

c. Capacity for independence;

d. Physical capacity for prevocational and work tasks; and

e. Play and leisure performance;

(3) Specific occupational therapy techniques involving:

a. Improving skills for ADLs;

b. The fabrication and application of splinting devices;

c. Sensorimotor activities;

d. The use of specifically designed manual and creative activities;

e. Guidance in the selection and use of adaptive equipment; and

f. Specific exercises to enhance functional performance and physical capabilities needed for work activities; and

(4) Other services determined by an occupational therapist to be medically necessary and appropriate.

(r) Billable categories of occupational therapy services shall include the following:

(1) Occupational therapy evaluation;

(2) Occupational therapy, individual;
(3) Occupational therapy, group; and
(4) Supplies and equipment necessary for the provision of covered occupational therapy services.

Informational Bulletin(s) – Occupational Therapy Services

1) **As RSA 326-C:2, II states, occupational therapy does not require an order to provider education-related services. Does that mean I do not need to seek an order for OT provided in schools?**

Per OPLC guidance document 2020-02, occupational therapy does not require a referral for the purpose of evaluation. Additionally, the occupational therapist does not require an order to provide "prevention, wellness, and education-related services." However, to initiate "occupational therapy services to individuals with medically related conditions," the occupational therapist requires an order from a physician, physician assistant, chiropractor, APRN, optometrist "or any other qualified health care professional who, within the scope of the professional's licensure, is authorized to [order] health care services." RSA 326-C:2, II. As Medicaid covers medically necessary services, an order is required for occupational therapy services

This informational bulletin section also appears in the Provider Qualifications section

Source: SFY 2020-07; May 2020; Operational policy clarification

2) **Would an occupational therapist (OT) that will be providing consults with a student present 51% of the time and OT evaluations be required to be NH Medicaid enrolled? Would it be considered the same as an order, but only for the services their scope of practice allows for?**

As noted in OPLC guidance, while consultation and evaluation do not require an order, initiation of OT services to individuals with medically-related conditions must be ordered by a physician, physician assistant, APRN, chiropractor, optometrist, or any other qualified health care professional. At present, NH Medicaid does not require rendering providers or providers directly providing the service to be enrolled with NH Medicaid or to be noted on the claim form. In the future, should NH Medicaid require the rendering provider be identified on the claim form, then all individual providers giving services, or their supervising provider, will be required to submit their NPI on claims. NH Medicaid will inform the school districts of any billing changes in the future along with a transition period if that should happen.

This informational bulletin section also appears in the Provider Qualifications section

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

Physical Therapy Services

Summary

The Medicaid to Schools Program covers physical therapy services including:

- Any evaluations to determine a student's level of physical functioning, including performance tests to measure strengths, balance, endurance, and range of motion;
- Any treatment services, evaluations, or assessments which might utilize therapeutic exercises or the modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function;
- Other services, including supplies and equipment, determined by a physical therapist to be medically necessary and appropriate for a student's physical therapy; **and**
- Physical therapy services performed by a physical therapy assistant carrying out a therapy plan developed by the physical therapist. (He-W 589.04(s))

To be covered, physical therapy services must be provided either by a physical therapist who is a graduate of a program of physical therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed to practice in the state of NH or the state in which he or she practices, or by a physical therapy assistant as defined in RSA 328-A:2, VIII who is under the direction of a licensed physical therapist. (He-W 589.04(t))

Physical therapy services must be "medically necessary". The billable categories of physical therapy services include:

- Physical therapy, evaluation;
- Physical therapy, individual;
- Physical therapy, group; and
- Supplies and equipment necessary for the provision of covered physical therapy services. (He-W 589.04(u)-(v))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(s) Physical therapy services shall include:

(1) Any evaluations to determine a student's level of physical functioning, including performance tests to measure strengths, balance, endurance, and range of motion;

(2) Any treatment services, evaluations, or assessments which might utilize therapeutic exercises or the modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function;

(3) Other services, including supplies and equipment, determined by a physical therapist to be medically necessary and appropriate for a student's physical therapy; and

(4) Physical therapy services performed by a physical therapy assistant carrying out a therapy plan developed by the physical therapist.

(t) Physical therapy services shall be provided by:

(1) A physical therapist who is a graduate of a program of physical therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed to practice in the state of NH or the state in which he or she practices; or

(2) A physical therapy assistant as defined in RSA 328-A:2, VIII who is under the direction of a licensed physical therapist pursuant to (1) above.

(u) Physical therapy services shall be medically necessary.

(v) Billable categories of physical therapy services shall include the following:

(1) Physical therapy, evaluation;

(2) Physical therapy, individual;
(3) Physical therapy, group; and
(4) Supplies and equipment necessary for the provision of covered physical therapy services.

Informational Bulletin(s) – Physical Therapy Services

(None)

Psychiatric Services

Summary

To be covered by the Medicaid to Schools Program, psychiatric services must be "medically necessary" for the evaluation, assessment, diagnosis, and treatment of mental or emotional conditions. Psychiatric services must be provided either by a psychiatrist who is a physician licensed to practice in NH as defined in RSA 135-C:2, XIII, or the state in which he or she practices and either board certified or board eligible according to the most recent regulations of the American Board of Psychiatry and Neurology, Inc. or its successor organization, or an APRN with a psychiatric specialty pursuant to RSA 326-B:18. (He-W 589.04(w)-(x))

Billable categories of psychiatric services shall include the following:

- Psychiatric evaluation and diagnosis; and
- Psychiatric treatment. (He-W 589.04(y))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(w) Psychiatric services shall be medically necessary for the evaluation, assessment, diagnosis, and treatment of mental or emotional conditions.
(x) Psychiatric services shall be provided by:
(1) A psychiatrist who is a physician licensed to practice in NH as defined in RSA 135-C:2, XIII, or the state in which he or she practices and either board certified or board eligible according to the most recent regulations of the American Board of Psychiatry and Neurology, Inc. or its successor organization; or
(2) An APRN with a psychiatric specialty pursuant to RSA 326-B:18.
(y) Billable categories of psychiatric services shall include the following:
(1) Psychiatric evaluation and diagnosis; and
(2) Psychiatric treatment.

Informational Bulletin(s)- Psychiatric Services

(None)

Psychological Services

Summary

To be covered by the Medicaid to Schools Program, psychological services require an order and must be 'medically necessary' for the evaluation, diagnosis, treatment, and counseling of mental or emotional illnesses, symptoms, or conditions. In addition, to be covered, psychological services must be provided by any of the following providers:

- A psychologist who is a school psychologist or associate school psychologist certified by the state board of education in NH or in the state in which he or she practices and licensed by the NH board of psychologists or another state's board of psychology;
- A psychologist or associate psychologist licensed by the NH board of psychologists or licensed by another state's board of psychology;
- A physician;
- APRNs with a psychiatric specialty pursuant to RSA 326-B:18;
- Psychotherapists acting within the scope of his or her licensure; or
- A master licensed alcohol and drug counselor (MLADC) for co-occurring mental health and substance use disorders. (He-W 589.04(z)-(aa))

Billable categories of psychological services shall include the following:

- Psychological testing and evaluation;
- Psychodiagnostic testing;
- Psychological counseling, individual treatment;
- Psychological counseling, group treatment; and
- Family counseling, during which the student shall be present at 51% of the counseling session. (He-W 589.04(ab))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(z) Psychological services shall require an order and be medically necessary for the evaluation, diagnosis, treatment, and counseling of mental or emotional illnesses, symptoms, or conditions.
(aa) Psychological services shall be provided by:

(1) A psychologist who is a school psychologist or associate school psychologist certified by the state board of education in NH or in the state in which he or she practices and licensed by the NH board of psychologists or another state's board of psychology;
(2) A psychologist or associate psychologist licensed by the NH board of psychologists or licensed by another state's board of psychology;
(3) A physician;
(4) APRNs with a psychiatric specialty pursuant to RSA 326-B:18;
(5) Psychotherapists acting within the scope of his or her licensure; or
(6) A master licensed alcohol and drug counselor (MLADC) for co-occurring mental health and substance use disorders.

(ab) Billable categories of psychological services shall include the following:

(1) Psychological testing and evaluation;
(2) Psychodiagnostic testing;
(3) Psychological counseling, individual treatment;
(4) Psychological counseling, group treatment; and
(5) Family counseling, during which the student shall be present at 51% of the counseling session.

Informational Bulletin(s) – Psychological Services

Informational Bulletin Highlights:

- Coding
- Billing

Coding

1) **Procedure code 96101 has been deleted. What is the new code for this service?**

Because codes 96101 and 96150 have been deleted, use the following replacement CPT codes and their long descriptions for psychological testing:

96130: Psychological testing evaluation services by physician or psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.

96131: Psychological testing evaluation services by physician or psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).

96136: Psychological or neuropsychological test administration and scoring by physician or psychologist two or more tests, any method; first 30 minutes.

96137: Psychological or neuropsychological test administration and scoring by physician or psychologist two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

2) **What is the standard rate and unit measurement for the new psychological codes provided in the department's guidance document SFY2020-02?**

For procedure code 96130, the rate is $138.50 and the max unit is one (1).

Description (96139): Psychological testing evaluation services by physician or psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.

For procedure code 96131, the rate is $138.50 and the max unit is six (6)

Description (96131: Psychological testing evaluation services by physician or psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).

For procedure code 96136, the rate is $69.25 and the max unit is one (1)

Description (96136): Psychological or neuropsychological test administration and scoring by physician or psychologist two or more tests, any method; first 30 minutes.

For procedure coded 96137, the rate is $69.25 and the max unit is six (6)

Description (96137): Psychological or neuropsychological test administration and scoring by physician or psychologist two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).

These codes are subject to the rate increase and the updated rates will be issued in January 2020.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

Billing

1) **I have a School Psychologist who holds an Experienced Educator Certificate through the NH DOE and a Clinical Mental Health Counselor Cert. through Allied Health Professional. Does this mean that this person is not able to submit sessions for Medicaid reimbursement?**

The Office of Licensed Allied Health Professional does not certify clinical mental health counselors. If the individual holds a license as a clinical psychologist from the NH Board of Psychologists or holds a license as a clinical mental health counselor through the NH Board of Mental Health Practice, then Medicaid reimbursement can be sought for mental health services performed by them.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Mental Health Services Other Than Psychiatric and Psychological Services Including Substance Use Disorder

Summary

Mental health services, other than psychiatric and psychological services, shall:

- Be covered if they are medically necessary and ordered; and
- Include, but not be limited to:
  - Behavior management;
  - Individual counseling;
  - Group counseling;
  - Family counseling, during which the student shall be present at 51% of the counseling session; and
  - Crisis intervention. (He-W 589.04(ac))

Persons providing mental health services shall be:

- A psychologist who is a school psychologist or associate school psychologist certified by the state board of education in NH or in the state in which he or she practices and licensed by the NH board of psychologists or another state's board of psychologist;
- A psychotherapist or mental health practitioner as defined in RSA 330-A:2, VII and VIII, respectively;
- A psychologist licensed by the board of psychologists pursuant to RSA 329-B; or
- An APRN with a psychiatric specialty pursuant to RSA 326-B:18. (He-W 589.04(ad))

Substance use disorder (SUD) treatment and recovery support services shall be provided by the licensed qualified providers described in He-W 513, and in accordance with the requirements in He-W 513. (He-W 589.04(ae))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(ac) Mental health services, other than psychiatric and psychological services, shall:

(1) Be covered if they are medically necessary and ordered; and

(2) Include, but not be limited to:

a. Behavior management;

b. Individual counseling;

c. Group counseling;

d. Family counseling, during which the student shall be present at 51% of the counseling session; and

e. Crisis intervention.

(ad) Persons providing mental health services shall be:

(1) A psychologist who is a school psychologist or associate school psychologist certified by the state board of education in NH or in the state in which he or she practices and licensed by the NH board of psychologists or another state's board of psychologist;

(2) A psychotherapist or mental health practitioner as defined in RSA 330-A:2, VII and VIII, respectively;

(3) A psychologist licensed by the board of psychologists pursuant to RSA 329-B; or

(4) An APRN with a psychiatric specialty pursuant to RSA 326-B:18.

(ae) Substance use disorder (SUD) treatment and recovery support services shall be provided by the licensed qualified providers described in He-W 513, and in accordance with the requirements in He-W 513.

Informational Bulletin(s) - Mental Health Services Other Than Psychiatric and Psychological Services Including Substance Use Disorder

(None)

Rehabilitative Assistance

Summary

Rehabilitative assistance services shall include the following:

- Mobility assistance such as positioning, transfers, correct application of ankle-foot orthosis, bracing or orthotic devices, range of motion, fall prevention, safety risk precautions, and physical therapy carry-over tasks as directed by the licensed physical therapist;
- Communication assistance such as assistance with sign language, prompting to facilitate expressive and receptive language, assistance with AAC devices and other such devices that ameliorate communication limitations, and speech language carry-over tasks as directed by the licensed speech language pathologist;
- Assistance with the implementation of behavioral management plans to increase adaptive behavioral functioning and carry-over tasks as directed by the mental health practitioner or BCBA;
- Nutrition such as assistance with eating, cutting food, food preparation, and safe eating plan carry-over tasks as directed by the speech language pathologist or occupational therapist;
- Cueing, prompting, and guiding, when provided as part of the assistance with ADLs, communication, or behavior management;
- Assistance with adaptive or assistive devices when linked to the student's medical condition;
- Assistance with the use of DME when linked to the student's medical condition;
- Medication administration to the extent allowable under RSA 326-B and pursuant to Nur 404.07 when the rehabilitative assistant has been trained by a nurse in medication administration, and the nurse has delegated the task of medication administration to the rehabilitative assistant;
- Personal care services such assistance with ADL and IADL and assistance with occupational therapy, physical therapy, or speech language carry-over tasks;
- Carry-over of therapy skills training as delegated by a speech language pathologist, physical therapist, and occupational therapist;
- Observation and reporting of signs of distress in the student's medical condition as trained by a registered nurse;
- Implementation of safe eating plans and g-tube feedings as delegated by a registered nurse with applicable training;
- Maintaining a safe environment to assure the student's safety concerns are met for the student, other students and staff; and
- Any other remedial services, that are included in the student's care plan as medically necessary for the maximum reduction of a student's physical or mental disabilities excluding educational and social activities such as classroom instruction and academic tutoring. (He-W 589.04(af))

Additionally, rehabilitative assistants shall:

- Either:
  - Be certified pursuant to Ed 504.05 or Ed 504.06, requirements and certification for paraeducators;
  - Have qualifications determined by the department to be equivalent to the requirements for certification under Ed 504.05 or 504.06; or
  - Be other licensed clinicians; and
- If applicable for the tasks delegated to the rehabilitative assistant or if required by law have knowledge in the following areas:

- Personal care and nutrition;
- Infection control and universal precautions designed to prevent the transmission of infectious diseases;
- Safety and emergency procedures, including basic first aid and 911 protocols; and
- Proper lifting techniques. (He-W 589.04(ag))

Rehabilitative assistants shall provide rehabilitation assistance services in accordance with Ed 1113.12. and services shall be medically necessary and require an order. Provision of rehabilitative assistance services shall be reviewed by a licensed clinician designated by the enrolled school provider's care plan team every 30 days. Such review shall include review of the activities performed by the rehabilitative assistant and the effectiveness of the activities as observed by the rehabilitative assistant. As part of the review, the care plan team designated licensed clinician shall sign the documentation of the service transaction logs to attest that the service was actually provided and shall provide review and signature that the activities have been conducted in accordance with the. (He-W 589.04(ah)-(aj))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(af) Rehabilitative assistance services shall include the following:

(1) Mobility assistance such as positioning, transfers, correct application of ankle-foot orthosis, bracing or orthotic devices, range of motion, fall prevention, safety risk precautions, and physical therapy carry-over tasks as directed by the licensed physical therapist;

(2) Communication assistance such as assistance with sign language, prompting to facilitate expressive and receptive language, assistance with AAC devices and other such devices that ameliorate communication limitations, and speech language carry-over tasks as directed by the licensed speech language pathologist;

(3) Assistance with the implementation of behavioral management plans to increase adaptive behavioral functioning and carry-over tasks as directed by the mental health practitioner or BCBA;

(4) Nutrition such as assistance with eating, cutting food, food preparation, and safe eating plan carry-over tasks as directed by the speech language pathologist or occupational therapist;

(5) Cueing, prompting, and guiding, when provided as part of the assistance with ADLs, communication, or behavior management;

(6) Assistance with adaptive or assistive devices when linked to the student's medical condition;

(7) Assistance with the use of DME when linked to the student's medical condition;

(8) Medication administration to the extent allowable under RSA 326-B and pursuant to Nur 404.07 when the rehabilitative assistant has been trained by a nurse in medication administration, and the nurse has delegated the task of medication administration to the rehabilitative assistant;

(9) Personal care services such assistance with ADL and IADL and assistance with occupational therapy, physical therapy, or speech language carry-over tasks;

(10) Carry-over of therapy skills training as delegated by a speech language pathologist, physical therapist, and occupational therapist;

(11) Observation and reporting of signs of distress in the student's medical condition as trained by a registered nurse;

(12) Implementation of safe eating plans and g-tube feedings as delegated by a registered nurse with applicable training;

(13) Maintaining a safe environment to assure the student's safety concerns are met for the student, other students and staff; and
(14) Any other remedial services, that are included in the student's care plan as medically necessary for the maximum reduction of a student's physical or mental disabilities excluding educational and social activities such as classroom instruction and academic tutoring.

(ag) Rehabilitative assistants shall:
(1) Either:
a. Be certified pursuant to Ed 504.05 or Ed 504.06, requirements and certification for paraeducators;
b. Have qualifications determined by the department to be equivalent to the requirements for certification under Ed 504.05 or 504.06; or
c. Be other licensed clinicians; and
(2) If applicable for the tasks delegated to the rehabilitative assistant or if required by law have knowledge in the following areas:
a. Personal care and nutrition;
b. Infection control and universal precautions designed to prevent the transmission of infectious diseases;
c. Safety and emergency procedures, including basic first aid and 911 protocols; and
d. Proper lifting techniques.

(ah) Rehabilitative assistants shall provide rehabilitation assistance services in accordance with Ed 1113.12.
(ai) Rehabilitative assistance services shall be medically necessary and require an order.
(aj) Provision of rehabilitative assistance services shall be reviewed by a licensed clinician designated by the enrolled school provider's care plan team every 30 days. Such review shall include review of the activities performed by the rehabilitative assistant and the effectiveness of the activities as observed by the rehabilitative assistant. As part of the review, the care plan team designated licensed clinician shall sign the documentation of the service transaction logs to attest that the service was actually provided and shall provide review and signature that the activities have been conducted in accordance with the care plan

Informational Bulletin(s) – Rehabilitative Assistance

Informational Bulletin Highlights:

- Ordering/Claiming/Documentation
- Qualifications/Training
- Covered Services
- Paraprofessionals

Ordering/Claiming/Documentation for Rehabilitative Assistance Services

1) **Who can order for rehabilitative assistance services?**

Most commonly, rehabilitative assistance is a multi-disciplinary function provided by a Rehabilitation Assistant or paraprofessional. Therefore, an order should come from a physician, physician's assistant, or APRN to cover all of the services involved. Alternatively, the school may determine it is more practical to obtain individual orders from multiple licensed clinicians to cover each service type, which is acceptable so long as every other licensed clinician is ordering within his or her scope of practice. In any instance that rehabilitative assistance is offered as a single-discipline service, such as behavior management provided by a psychologist or physical therapy offered by a physical therapist, that provider may be able to self-order, or provide the order for the Rehabilitation Assistant or paraprofessional.

Note: The order requirement is separate from the sign-off requirement. For sign off requirement, please refer to the guidance issued in January: 2020-05 Q9:

This informational bulletin section also appears in the Provider Qualifications section

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

2) **What needs to be done if it is found the para/rehabilitation assistant's order is incorrect after services were delivered?**

If you find that the order for para/rehabilitation assistant services was not executed by a Physician, APRN, physician assistant, or qualified treatment providers (when they are acting within the scope of their board license), then a new, correct order can be obtained and made retroactive as long as the service was in the 2019-2020 school year and the new order was written before December 31, 2020.

This informational bulletin section also appears in the Provider Qualifications section

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

3) **We have received questions on the oversight of rehabilitative assistant services. Who orders? Who supervises? Who signs off? May a professional supervise and review/signoff on the work a rehabilitative assistant does if the service is outside the professional's scope of practice?**

Who Orders?

Only licensed clinicians may order MTS services and those service orders must fall within the ordering clinician's scope of practice.

As individual care plans often include an array of multi-disciplinary, rehabilitative assistance services, schools may have different approaches to orders. The school may find it simpler to obtain one order from a physician, physician's assistant, or APRN, given the broad scope of practice of these clinicians. Or a school may obtain multiple orders from multiple licensed clinicians (e.g., physical therapist, speech therapist, occupational therapist, psychologist etc.), each ordering only those services that fall within their more limited scope of practice.

In any instance where rehabilitative assistance is offered as a single-discipline service, such as behavior management ordered by a psychologist or physical therapy ordered by a physical therapist, that provider may, within the scope of his or her practice, provide the order for the rehabilitative assistant or paraprofessional.

For additional information on scope of practice, see the Office of Professional Licensure and Certification's Medicaid to Schools Policy Guidance document SFY 2020-01 available at: https://www.oplc.nh.gov/documents/Medicaid -to-school-policy.pdf

Who Supervises?

As to who can supervise the services provided by a rehabilitative assistant, The Department in the SFY 2020-07 informational bulletin offered the following: "[t]he IEP/504/health care team needs to identify and designate a licensed clinician who will be responsible for oversight of the medical components of the IEP/504/health care plan and the carryover tasks delegated to the rehabilitative assistant." ***In other words, the individual supervising a rehabilitative assistant must be a licensed clinician***. The administrative rule states the following at He-W 589.04(aj)

> "Provision of rehabilitative assistance services shall be reviewed by another licensed clinician designated by the enrolled school provider's care plan team every 30 days. Such review shall include review of the activities performed by the rehabilitative assistant and the effectiveness of the activities as observed by the rehabilitative

assistant. As part of the review, the care plan team designated licensed clinician shall sign the documentation of the service transaction logs to attest that the service was actually provided and shall provide review and signature that the activities have been conducted in accordance with the care plan."

The Department has heard from various school districts and clinicians regarding repercussions on their licensure if they comply with He-W 589.04 (aj) as the "designated" licensed clinician supervising rehabilitative assistant services. These concerns relate to the fact that some rehabilitative assistants carry over the indicated treatment of multiple disciplines each day, some of which may be out of the scope of practice of the designated IEP/504/health care team member (licensed clinician) asked to supervise the rehabilitative assistant.

The decision for ***how*** to supervise a rehabilitative assistant is one that must be made on an individual basis and by each school district. Therefore, the task of defining the process for who supervises the services of a rehabilitative assistant is the responsibility of the school district.

The licensed clinician supervising does not have to be the person signing the service transaction logs (sometimes referred to as time in/time out logs). (see discussion below). However, if the person supervising is not signing the service transaction logs, then there must be detailed documentation in the student service records to indicate supervision review and sign off. This is required to ensure the services delivered are adequate, working, and do not need adjustment. This review and sign off must be done every 30 days.

Who Reviews/Signs-off

The sign-off, or review of, the rehabilitative assistant's service transaction logs (sometimes referred to as "time in/time out logs") is an attestation that the services were provided and conducted in accordance with the IEP, Section 504 plan, or individual health care plan. ***Currently, the individual signing off on the log must be a licensed clinician***. Again, the administrative rule states: "… As part of the review, the care plan team designated licensed clinician shall sign the documentation of the service transaction logs to attest that the service was actually provided and shall provide review and signature that the activities have been conducted in accordance with the care plan."

A note on case managers. Services that are provided under an IEP or Section 504 care plan and billed by schools to Medicaid are medically necessary services. A licensed clinician must supervise such services. Case managers are not licensed clinicians. Therefore, case managers may not supervise the rehabilitative assistants. At this time, the case manager may also not sign off on rehabilitative assistance service logs.

Documentation Provided by the Rehabilitative Assistant

The rehabilitative assistant must document their work in the student service record. Further information about documentation requirements are forthcoming.

Source: 2021-01; December 2020; Rehabilitative Assistance Services

4) What are acceptable co-signatures for rehabilitative assistant logs when there are no licensed clinicians on the team providing related services to the student?

The Department understands that not all tasks performed by a rehabilitative assistant are medical. However, rehabilitative services billed to Medicaid must be medical services. Therefore, a licensed clinician must order the rehabilitative assistance medical services. Additionally, a licensed clinician must supervise the activities being performed by the rehabilitative assistant. This clinician may only supervise within the scope of their practice.

Currently, the rule requires a licensed clinician to sign off on time in/time out. However, the Department is considering delinking supervision and sign off.

Source: 2021-01; December 2020; Rehabilitative Assistance Services

5) **Does the individual supervising the rehabilitative assistant need to be within "line of sight" in order to sign off on these activities? How often should the licensed clinician conduct a review?**

The rehabilitative assistant does not need to be within line of sight of the supervisor 100 % of the time. The School District is responsible for developing a process as to how supervision occurs, in line with scope of practice standards for the clinician.

The supervising, licensed clinician needs to conduct a review every 30 days, or more frequently as needed. The clinician may determine that supervision is warranted more often based on the severity of the recipient's functional limitation and the competency of the rehabilitative assistant. The licensed clinician must make a determination regarding the frequency of supervision on a case-by-case basis. Documentation of the supervision review must be part of the student's record and should include:

- Planned date of the session
- Whether the session was held (if not, reason for cancellation)
- The type of contact i.e. face-to-face, observation, telephone call
- Areas covered i.e. duties and expectations, skills development
- If applicable, list of trainings completed within past 30 days
- Issues identified, if any, and action to be taken
- Date of next session
- Signature of the supervising licensed clinician and date

Source: 2021-01; December 2020; Rehabilitative Assistance Services

Qualifications/Training for Rehabilitative Assistants

1) **Rehabilitative Assistant (RA) – Qualification and Training**

The supervising, licensed clinician should evaluate and document the RA's level of competency and develop trainings to ensure the ability of the RA to perform tasks outlined in the plan of care. Every 30 days the supervisor must evaluate the RA's performance of assigned tasks.

Documentation should include:

- Planned date of the session
- Whether the session was held (if not, reason for cancellation)
- The type of contact i.e. face-to-face, observation, telephone call
- Areas covered i.e. duties and expectations, skills development
- If applicable, list of trainings completed within past 30 days
- Issues identified, if any, and action to be taken
- Date of next session
- Signature of the supervising licensed clinician and date

Rehabilitative Assistants Providing Services Under a Behavioral Treatment Plan

RA's can provide services under the direction and supervision of a school psychologist or a Board-Certified Behavioral Analyst (BCBA). These services will be reimbursable if there is a medical component, a valid order, and the service is in the student's IEP, 504 plan, or healthcare plan.

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) **State precedent is that paraprofessional who do not hold a para 1 or 2 certificate have been allowed to document and provide services after a 2-week on-the-job training. Will this still be the case?**

The Department will be reviewing and will discuss with the Department of Education the certification requirements for paraprofessionals delivering rehabilitative assistance. The Department has been invited to observe the delivery of these services at three different schools and plans to do so during the month of December. At this time, the Department does not know what additional requirements, if any, paraprofessionals will need to have in order to deliver Medicaid coverable services. After the Department performs the field assessments, it will issue additional guidance.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

3) **Will rehabilitative assistants be able to deliver ABA services and receive the training to become an RBT? Will rehabilitative assistant services qualify for reimbursement?**

Rehabilitative assistance services delivered by qualified individuals to a Medicaid enrolled student and delivered pursuant to the administrative rule are qualified for Medicaid reimbursement, and these services are clearly listed as covered in the Medicaid to schools rule in He-W 589.04. If a rehabilitative assistant has an active certification as a Registered Behavior Technician (RBT), and if the RBT is supervised by a BCBA with a supervisory certification, then these services may qualify for Medicaid reimbursement as long as the student is Medicaid enrolled and the services are medically necessary. The Department's understanding is that many Rehab assistants currently carry out behavior treatment plans as outlined by BCBAs in the school setting, and these services will continue to be reimbursed. The national organization for BCBAs the Behavior Analysts Certification Board should be contacted for that information https://www.bacb.com/bcba/regarding training requirements for RBTs.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

4) **Can rehabilitative assistants apply to Medicaid to become a non-billing provider even if they do not have a license? Or will they always have to be checked manually via the Office of the Inspector General (OIG) list?**

No. Rehabilitative assistants may not apply for Medicaid provider status. School districts must check the OIG database for any identified sanctions for all non-enrolled Medicaid providers, including rehabilitative assistants.

Source: 2021-02; December 2020; Rehabilitative Assistance Services

5) **Can a guidance counselor bill as a rehabilitative assistant?**

An individual who is a guidance counselor cannot bill as a rehabilitative assistant unless that individual is acting as a rehabilitative assistant and providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj). [See He-W 589.05(h)(2) & (t).] A guidance counselor is not a recognized Medicaid treatment provider. Guidance counselor services may not be billed as a Medicaid service. However, if the individual, who is a guidance counselor, is employed from time to time as a rehabilitative assistant in accordance with He-W 589.04(ag) and performs 2 rehabilitative assistance services in accordance with He-W 589.04(af), then those services may be billed and reimbursed at the rehabilitative assistant rate.

Source: 2021-01; December 2020; Rehabilitative Assistance Services

6) **May rehabilitative assistants deliver ABA services**?

Yes. Qualified individuals may deliver rehabilitative assistance services pursuant to He-W 589.04. The Department's understanding is that rehabilitative assistants currently carry out behavior treatment plans under the direction and supervision of a school psychologist or a Board Certified Behavior Analyst (BCBA) in the school setting. Assuming so, these services will be reimbursable if there is a medical component, a valid order, and the service is in the student's IEP, 504 plan, or healthcare plan. An informational bulletin on ABA services in the school setting will be forthcoming.

Source: 2021-01; December 2020; Rehabilitative Assistance Services

7) **Will the Department provide training for rehabilitative assistant to become registered behavior technicians (RBTs)?**

No. The Department is unable to provide training for a rehabilitative assistant to become an RBT.

Source: 2021-01; December 2020; Rehabilitative Assistance Services

Covered Services for Rehabilitative Assistants

1) **Why does the policy guidance specify personal care services for rehabilitative assistants when the rule references more broad categories of services they deliver? Is it the state's intention to limit the scope of services that can be provided by them?**

The Department's intention is not to limit the scope of health care related services that can be provided by rehabilitative assistants, rather this was simply an example.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

2) **Is there an appropriate working definition of "personal care"?**

Personal Care Services are defined as a Medicaid coverable service that helps Medicaid recipients with everyday tasks. These tasks are called activities of daily living (ADLs) and assistance is needed due to an individual's injury, illness or disability. Examples of ADLs are grooming, eating, dressing, transferring, mobility, and toileting.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

Paraprofessionals

1) **I have been told that our vendor's para's do not hold a Para I or Para II NH certifications. Most of our vendor's para's have a high school diploma. With the recent updates to MTS, I am wondering if a "high school diploma" meets the qualifications for Medicaid reimbursement.**

At this time, no changes were made to the MTS rule regarding the qualifications or services being delivered by rehabilitation assistants. Schools seeking reimbursement for services delivered by rehabilitative assistants should at a minimum screen these individuals. This means performing monthly screening of the individuals for exclusions against the Office of Inspector General (OIG) exclusion and sanction database which is located at https://exclusions.oig.hhs.gov/.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Speech, Language, and Hearing Services

Summary

Speech, language, and hearing services are 'covered services' by MTS if they are services, supplies, or equipment ordered by a licensed audiologist or licensed speech-language pathologist to be 'medically necessary' for the evaluation, diagnosis, or treatment of speech, language, and hearing disorders which result in communication disabilities.

Speech language services include services performed by speech language assistants described below carrying out a therapy plan developed by the speech language pathologist. Speech, language, and hearing services must be provided by:

- An audiologist who is licensed to practice in NH by the board of hearing care providers or the state in which he or she practices;
- A speech-language pathologist who is either:
  - Licensed pursuant to RSA 326-F to practice in NH, which shall be considered equivalent to having met the requirements for the American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence in Speech-Language Pathology; or
  - Licensed in the state in which he or she practices and have one of the following:
    - A Certificate of Clinical Competence from the American Speech and Hearing Association;
    - Completed the equivalent educational requirements and work experience necessary for the certificate; *or*
    - Completed the academic program and is acquiring supervised work experience to qualify for the certificate; *or*
  - A speech-language assistant as defined in RSA 326-F:1, II-a working under the direction of a licensed speech-language pathologist. (He-W 589.04(ak)-(am))

Billable categories of speech, language, and hearing services include the following:

- Individual speech, language, or hearing evaluation;
- Speech, language, or hearing therapy, individual treatment;
- Speech, language, or hearing therapy, group treatment; and
- Supplies and equipment necessary for the provision of covered speech language and hearing services. (He-W 589.04(an))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(ak) Speech, language, and hearing services shall be covered services if they are services, supplies, or equipment ordered by a licensed audiologist or licensed speech-language pathologist to be medically necessary for the evaluation, diagnosis, or treatment of speech, language, and hearing disorders which result in communication disabilities.
(al) Speech language services shall include services performed by speech language assistants listed in (am) below carrying out a therapy plan developed by the speech language pathologist.
(am) Speech, language, and hearing services shall be provided by:

(1) An audiologist who is licensed to practice in NH by the board of hearing care providers or the state in which he or she practices;
(2) A speech-language pathologist who is either:

a. Licensed pursuant to RSA 326-F to practice in NH, which shall be considered equivalent to having met the requirements for the American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence in Speech-Language Pathology; or

b. Licensed in the state in which he or she practices and have one of the following:
(i) A Certificate of Clinical Competence from the American Speech and Hearing Association;
(ii) Completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Completed the academic program and is acquiring supervised work experience to qualify for the certificate; or
(3) A speech-language assistant as defined in RSA 326-F:1, II-a working under the direction of a licensed speech-language pathologist pursuant to (2) above.
(an) Billable categories of speech, language, and hearing services shall include the following:
(1) Individual speech, language, or hearing evaluation;
(2) Speech, language, or hearing therapy, individual treatment;
(3) Speech, language, or hearing therapy, group treatment; and
(4) Supplies and equipment necessary for the provision of covered speech language and hearing services.

Informational Bulletin(s) – Speech, Language, and Hearing Services

1) **The administrative rule states that there are covered services if ordered by a licensed audiologist or licensed speech pathologist but it also says that there shall be an order from a physician, APRN or PA. Could you clarify if a speech language pathologist licensed by the NH board is allowed to order services in the scope of their practice instead of a physician?**

The Department is seeking clarification from OPLC to further clarify those other licensed treatment providers who may, as permitted under their board licensure, order or prescribe services, what type of services are included under their scope of practice, and who they may supervise pursuant to their license. As the Department receives guidance and information from OPLC on the scope of licensed practitioner's licenses, the Department will issue new guidance and will modify the administrative rule accordingly. Our understanding based on recent conversations with the NH Speech-Language Pathology Governing Board is that the board believes speech-language services require an order but the Department is continuing to seek guidance from the board regarding speech-language pathologists' scope of practice as the Board is considering the scope of services being delivered in the school setting. As previously stated, OPLC is committed to issuing a guidance document related to scope of practice issues and plans to do so in December.

This informational bulletin section also appears in the Provider Qualifications section

Source: SFY 2020-04; November 2019; Billing and policy guidance document

2) **Since I am an SLP, I am most interested in the issues that affect SLPs in schools. Unfortunately, I haven't worked in schools since before Medicaid to Schools became available, so I don't know how the system has been working in NH. My questions are: Would a medical professional need to see the child in person to order services? And the big question - how do SLPs determine if the disability is medically based? There are disabilities that have no known cause, but research may find a reason in the future. Or - is the question whether the services are medically based?**

Per pages 5 and 6 of the SFY 2020-01 Office of Professional Licensure and Certification (OPLC) guidance, speech-language services performed by speech-language pathologists and assistants do not require an order. While these services do not require an order, the services must be medically based in order to qualify for Medicaid reimbursement, and this does not mean that a specific medical diagnosis or disability is required. To qualify for Medicaid reimbursement, the

services must be medically necessary which means that they are needed to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap or cause physical deformity or malfunction.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

3) **When billing speech evaluation it is entered as an event. This term will need to be defined in the billing manual or rule to clarify what constitutes an event. Can you tell us what constitutes an event?**

The CPT code description for speech evaluation is an event regardless of the time, number of encounters or dates of service it takes to complete the evaluation. This is a one-time reimbursement.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

4) **For a Speech-Language Pathologist-CFY with a provisional license through the State of NH, would they obtain their own NPI # or use the number of the SLP providing the "under the direction of"?**

A Speech-Language Pathologist-CFY, during their fellowship, cannot order services and therefore is not required to have an NPI for NH Medicaid purposes. Speech-Language Pathologist-CFY cannot enroll with NH Medicaid. Again, any provider providing services in a school setting must be screened monthly to ensure the provider is in good standing and able to provide services. This is the responsibility of the school is the provider is not actively enrolled with NH Medicaid.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI numbers

5) **Would it satisfy Medicaid requirements if the Speech/Language Professional were to meet with paraprofessionals as a group for 30 minutes once a month to discuss general information, but not specific students?**

No. This group meeting would not count towards monitoring, oversight, and supervision of the rehabilitative assistant because this meeting does not address the needs and progress of a specific student. This practice more clearly falls under training of the rehabilitative assistants.

Source: 2021-02; December 2020; Rehabilitative Assistance Services

Vision Services

Summary

To be covered by MTS, vision services must be 'medically necessary' for the prevention or rehabilitation of visual impairment or restoration of a student with a visual impairment to his or her best possible functional level and be provided by an optometrist, ophthalmologist, or optician. (He-W 589.04(ao))

Rule He-W 589.04 Covered Services and Provider Qualifications.

(ao) Vision services shall be medically necessary for the prevention or rehabilitation of visual impairment or restoration of a student with a visual impairment to his or her best possible functional level and be provided by an optometrist, ophthalmologist, or optician.

Informational Bulletin(s)- Vision Services

1) **Who can provide vision services, other than an optometrist or ophthalmologist?**

The Medicaid fee for service rule for vision services, He-W 565, states that ophthalmologists, optometrists, and opticians enrolled with NH Medicaid may receive reimbursement for Medicaid covered vision services.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)

Summary

EPSDT includes comprehensive and age-appropriate medical assessments and screenings of a student's physical and mental status, including vision and hearing screenings Services that are not covered or have coverage limits under the NH Medicaid state plan will be covered through the EPSDT benefit when 'medically necessary', coverable under Section 1905(a) of the Social Security Act, and requested in accordance with the requirements of He-W 546 as is explained below. Further training and information to be provided at a later date.

The following are examples of services that can be covered as EPSDT under the rules (He-W 546):

- Rehabilitative assistance services;
- Applied behavior analysis;
- Personal care services for individuals under the age of 21;
- Wrap around services;
- Case management services; and
- Other optional services listed in 1905(a) of the Social Security Act and not included in the NH Medicaid state plan or included as a covered service under this part. (He-W 589.04(ap)-(ar))

The following EPSDT services are **not** subject to the prior authorization requirements of He-W 546:

- Rehabilitative assistance services;
- Applied behavior analysis; and
- Personal care services for individuals under the age of 21. (He-W 589.04(as))

Any services not listed as covered under the NH Medicaid state plan or services with coverage limits shall be given independent review by the department for coverage based on medical necessity in accordance with the EPSDT benefit pursuant to He-W 546. (He-W 589.04(at))

He-W 589.04 Covered Services and Provider Qualifications.

(ap) EPSDT comprehensive and age-appropriate medical assessments and screenings of a student's physical and mental status, including vision and hearing screenings in accordance with the requirements pursuant to He-W 546.05.
(aq) Services that are not covered or have coverage limits under the NH medicaid state plan shall be covered through the EPSDT benefit when medically necessary, coverable under Section 1905(a) of the Social Security Act, and requested in accordance with the requirements of He-W 546.
(ar) Except as indicated in (at) below, the following shall be examples of services subject to the requirements of He-W 546:

(1) Rehabilitative assistance services;
(2) Applied behavior analysis;
(3) Personal care services for individuals under the age of 21;
(4) Wrap around services;
(5) Case management services; and
(6) Other optional services listed in 1905(a) of the Social Security Act and not included in the NH medicaid state plan or included as a covered service under this part.

(as) The following services shall not be subject to the prior authorization requirements of He-W 546:

(1) Rehabilitative assistance services;
(2) Applied behavior analysis; and
(3) Personal care services for individuals under the age of 21.

(at) Any services not listed as covered under the NH medicaid state plan or services with coverage limits shall be given independent review by the department for coverage based on medical necessity in accordance with the EPSDT benefit pursuant to He-W 546.

Informational Bulletin(s)- Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)

1) **Is there a separate CPT code related to EPSDT?**

There is no separate procedure code for EPSDT, rather schools will need to bill the applicable CPT code for the service being delivered. Early Periodic Screening Diagnosis and Treatment (EPSDT) is a distinct benefit under the Medicaid program which allows for students under the age of 21 to receive medically necessary services listed in Section 1905(a) of the Social Security Act regardless of whether the service is covered under the NH Medicaid State Plan. Attachment A lists the coverable services under the Social Security Act. Training will be provided to School Districts at a later time around the process for requesting services under provisions of EPSDT.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

Specialized Transportation

Summary

Specialized transportation can be covered by MTS as a billable service if transportation is listed in the student's IEP as a required service and the student is physically in the vehicle for the transportation.

Transportation is considered a 'required service' if:

- The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus; or
- The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the IEP;

The following transportation may be billed as an MTS service:

- Transportation to and from school only on a day when the student receives a Medicaid coverable service at school during the school day; and
- Transportation to and from a Medicaid coverable service in the community during the school day.

The Medicaid coverable service should be listed in the student's IEP as a required service. In addition to the documentation required by He-W 589.06, transportation providers must maintain a daily transportation log which includes the student's name, the date of service, clarification as to whether the student is being transported either one-way or round-trip, the total number of students in the vehicle both in the morning and the afternoon, the total miles traveled including morning and afternoon, the driver's name and the driver's signature. (He-W 589.04(au))

He-W 589.04 Covered Services and Provider Qualifications.

(au) Specialized transportation shall be a billable service as follows:

(1) Transportation shall be listed in the student's IEP as a required service and the student shall be physically in the vehicle for the transportation to be billable to medicaid;

(2) Transportation shall be considered a required service if:

a. The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus; or

b. The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the IEP;

(3) The following transportation may be billed as a medicaid service:

a. Transportation to and from school only on a day when the student receives a medicaid coverable service at school during the school day; and

b. Transportation to and from a medicaid coverable service in the community during the school day;

(4) The medicaid coverable service in (3)a. and (3)b. above shall be listed in the student's IEP as a required service; and

(5) In addition to the documentation required by He-W 589.06, transportation providers shall maintain a daily transportation log to include:

a. Student's name;

b. Date of service;

c. Clear indication that the student is being transported either one-way or round-trip;

d. The total number of students on the bus, both in the morning and the afternoon;

e. The total miles the bus traveled, both in the morning and the afternoon;
f. Driver's name; and
g. Driver's signature.

Informational Bulletin(s) – Specialized Transportation

1) **Do Districts need transportation to also be ordered/signed off by a physician? Even if transportation does not specifically need a physician's authorization, to determine if transportation can be billed do the services need to have the physician's authorization on file to be fully considered a billable Medicaid services, therefore allowing transportation to be billed?**

Transportation services do not need to be ordered or signed off by a physician in order for them to be billable but they do need to be noted in the IEP. Per the administrative rule, He-W 589.04(av)(2)-(3):

(2) Transportation shall be considered a required service if:

a. The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus; or

b. The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the IEP;

(3) The following transportation may be billed as a Medicaid service:

a. Transportation to and from school only on a day when the student receives a Medicaid coverable service at school during the school day; and

b. Transportation to and from a Medicaid coverable service in the community during the school day;

Source: SFY 2020-05; January 2020; Billing and policy guidance document

Non-Covered Services

Introduction

If a service is "non-covered", it is not "covered" or recognized as a billable service by the Medicaid program. Non-covered services are not eligible for reimbursement.

Summary

The following are 'non-covered services' and are not be eligible for reimbursement:

- Services not listed in a student's care plan;
- Services that are not coverable under the Social Security Act and for which no FFP is available for said service;
- Services performed by unqualified individuals pursuant to the Social Security Act, or services delivered by provider types not approvable under the Social Security Act to provide Medicaid services;
- Consultations, visits, trainings, meetings, or discussions between healthcare providers or individuals in which the student was not physically present for at least 51% of the time;
- Services which are non-covered pursuant to rules in He-W 500 and are not covered under EPSDT;
- Supported employment such as vocational goals and job tasks;
- Services which are solely educational, remedial education, or vocational instruction or tutoring;
- Services performed by educators or individuals who are not healthcare clinicians such as teachers of the visually impaired or deaf unless:
    - The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;
    - The individual is a rehabilitative assistant providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj); or
    - The individual currently holds a certification as a BCBA;
- Leisure and social activities that are non-medical;
- General supervision of a student as required for any student based on the student's development and for non-medical reasons;
- Services that are solely personal care services delivered by a legally responsible family member pursuant to 42 CFR 440.167;
- Performance of tasks for the sole purpose of assistance with completion of educational assignments;
- Services under a CMS NH Medicaid waiver;
- Medicaid state plan services only provided under the 1915(i) provisions of the Social Security Act;
- Day care;
- Teaching parenting skills;
- Review of records, documentation development, or report writing;
- Attending meetings, including individualize education program meetings and IEP team meetings;
- Parent consultations, contacts, or trainings;
- School guidance counselor services unless:
    - The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;

- The individual is a rehabilitative assistant providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj); or
- The individual currently holds a certification as a BCBA;

- Services by individuals not having a current license for the practice specialty area for the service area being provided; and
- Services requiring the technical or professional skill that a state statute or regulation mandates shall be performed by a health care clinician licensed or certified by the state. (He-W 589.05(a)-(v))

Rule He-W 589.05 Non-Covered Services.

The following shall be non-covered services and shall not be eligible for reimbursement:
(a) Services not listed in a student's care plan;
(b) Services that are not coverable under the Social Security Act and for which no FFP is available for said service;
(c) Services performed by unqualified individuals pursuant to the Social Security Act, or services delivered by provider types not approvable under the Social Security Act to provide medicaid services;
(d) Consultations, visits, trainings, meetings, or discussions between healthcare providers or individuals in which the student was not physically present for at least 51% of the time;
(e) Services which are non-covered pursuant to rules in He-W 500 and are not covered under EPSDT;
(f) Supported employment such as vocational goals and job tasks;
(g) Services which are solely educational, remedial education, or vocational instruction or tutoring;
(h) Services performed by educators or individuals who are not healthcare clinicians such as teachers of the visually impaired or deaf unless:
(1) The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;
(2) The individual is a rehabilitative assistant providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj); or
(3) The individual currently holds a certification as a BCBA;
(i) Leisure and social activities that are non-medical;
(j) General supervision of a student as required for any student based on the student's development and for non-medical reasons;
(k) Services that are solely personal care services delivered by a legally responsible family member pursuant to 42 CFR 440.167;
(l) Performance of tasks for the sole purpose of assistance with completion of educational assignments;
(m) Services under a CMS NH medicaid waiver;
(n) medicaid state plan services only provided under the 1915(i) provisions of the Social Security Act;
(o) Day care;
(p) Teaching parenting skills;
(q) Review of records, documentation development, or report writing;
(r) Attending meetings, including individualize education program meetings and IEP team meetings;
(s) Parent consultations, contacts, or trainings;
(t) School guidance counselor services unless:
(1) The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;

(2) The individual is a rehabilitative assistant providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj); or
(3) The individual currently holds a certification as a BCBA;
(u) Services by individuals not having a current license for the practice specialty area for the service area being provided; and
(v) Services requiring the technical or professional skill that a state statute or regulation mandates shall be performed by a health care clinician licensed or certified by the state.

Informational Bulletin(s) – Non-Covered Services

(None)

Provider Enrollment: Program Integrity Requirements

Introduction:

The following guidance on provider enrollment was prepared by the Program Integrity Unit of NH Medicaid on or about December 2019, to assist provider enrollment in the Medicaid to Schools program. The guidance was provided in the form of a power point presentation and is summarized below.

Enrolling with NH Medicaid is a crucial component of billing for Medicaid services. This section provides an overview of the enrollment process.

Definitions:

Rule: N/A

Informational Bulletin(s) – Provider Enrollment

School/Provider Enrollment

- All schools must be enrolled Medicaid providers.
- To be covered by Medicaid, an order prescribing the covered service is generally needed from a Physician, APRN, or physician assistant or other licensed treatment providers practicing within their scope of board licensure. These providers will need to be enrolled in Medicaid either as a provider of physician services or as an ordering, referring, prescriber only provider (does not bill Medicaid).
- To bill for Medicaid covered services, schools need to complete a group application, signed provider participation agreement, and application signature page. At the completion of the process, a unique Medicaid Identification number is sent to the provider which is 7 digits.
- An 11-digit National provider Identification number (NPI) is required and a taxonomy that identifies the services is required on the application or re-validation.
- All employed school professionals who provide the covered Medicaid service, need to be enrolled in Medicaid and affiliated to the school enrollment as a non-billing individual. This includes PT, OT, APRN, or MD.
- All enrolling providers will undergo a federally mandated comprehensive screening before their application is approved and the state will complete monthly screening of the school and affiliated professionals.
- The schools must keep copies of the appropriate service provider qualifications (copy of licensure or documentation of credentials) on file and for non-enrolled staff to screen monthly on the LEIE/OIG exclusion site for any sanctions/exclusions.
- Completed applications should list the managing employee for the school, usually the Superintendent, and delegate authorized users that can access the MMIS if needed with changes.
- All providers will be required to revalidate every five years by completing a new application and submit signature pages and the state will complete a full screening as part of the revalidation process.

National Provider Identifier (NPI) and Taxonomy Code

- When applying for an NPI, providers must designate the taxonomy code(s) that best represents their provider type, classification, and area of specialization. The taxonomy code is a federally established 10-character alphanumeric code that health care professionals use to identify their unique specialty areas. The code set is a combination of federally defined

provider type and provider specialty that are self-declared by health care providers during the NPI enrollment process.[1]

- **251300000X**; is the current taxonomy in the enrollment record in MMIS for Local Education Agencies (LEA)
- Local Education Agency (LEA) healthcare taxonomy code - **251300000X**
  - Website to check Taxonomy code: https://npidb.org/taxonomy/
  - Website to check NPI number: https://npiregistry.cms.hhs.gov/

How to Submit Claims for Payment

- There are three ways to submit claims for payment:
  1. The school may submit claims directly to the MMIS system portal and with this option a training session with Conduent staff is available to review the submission of claims data directly into the portal under your current Medicaid provider number.
  2. The school may utilize a software system to submit their billing which requires a trading partner application be completed for that entity. This is termed a "self" trading partner application and another provider ID number is issued.
  3. If one school will be billing for other districts, a trading partner application is submitted with a billing agent agreement for each location, an 835-application remittance advice if the school wants an 835, and a list all affiliations in the application using the Medicaid provider ID numbers of the schools.
- **Third Party Administrators (TPA):** If the school will be using a third-party billing administrator/agent, the school must have the following agreements executed:
  - A "trading partner application" needs to be completed by the entity. The application needs to list all service locations by Medicaid ID number.
  - A billing agent agreement for each school,
  - A signor agreement and billing agent authorization for each affiliated school.
- 835 or the Electronic Remittance Advice (ERA) is the electronic transaction that provides claim payment information.
- If the school determines not to continue with the trading partner or TPA, a letter from managing employee(superintendent) of the school needs to be sent to MMIS(Conduent) informing of the change.

Requirements for Enrolling Order, Referring or Prescribing Providers (ORP)

- Code of Federal Regulations 455:401(b) states that Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan to be enrolled as participating providers.
- The Affordable Care Act requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.
- If a provider does not currently participate with NH Medicaid but may order, refer, or prescribe to Medicaid members, they must now be enrolled to ensure that the billing provider will be paid for service.

[1] To find updated NH Medicaid Billing Manuals, please refer to NH MMIS Health Enterprise Portal at https://nhmmis.nh.gov/portals/wps/portal/BillingManuals

- **As a billing provider, the NPI of the ORP must be included on all claims when billing for service.**
- As of September 1, 2019, a shortened application is available to providers to enroll for ORP if not currently enrolled, and during the phase-in period claims will not deny.
- To be covered by Medicaid, an order prescribing the covered service is generally needed from a Physician, APRN, or physician assistant or other licensed practitioner practicing within their scope of board licensure. All children should have a primary care provider and this provider will need to be Medicaid enrolled to order services.

Requirements for the Enrolled School Provider

- Federally mandated screening of NPI verification, LEIE/OIG, licensure, or certifications are done by the state at time of enrollment, during revalidation and every month at the state level of enrolled providers.
- The schools are responsible to screen employees that are providing Medicaid medical services that they employ or contract with to provide services. (i.e. BCBA individuals that are not enrolled in Medicaid)
- It is the school's responsibility to validate that all ORP providers are Medicaid enrolled with provider number and NPI to ensure they are screened by State.

Federal Screening Requirements

- All providers are required to take the following steps to ensure Federal and State program integrity screening:
  - If the school will be using school employee professionals to provide the covered Medicaid service, all screenings will be responsibility of the school for licensure or certification and OIG screenings.
  - If the school is contracting with an individual to provide the covered Medicaid services, all screenings will be responsibility of the school for licensure or certification and OIG screenings.
  - If the school contracts with outside professional groups to perform the services, the group entity is responsible for completing the screenings required of the furnishing/rendering provider and informing the school of any changes. Schools are responsible to ensure the contracted group is performing the required screening.
  - Schools are required to perform screenings upon hire or upon entering into a contract and every month there after until the school no long employs or contracts with the person.
  - Schools are required to search the employee or contractor name on the HHS-OIG list of excluded Individuals and entities (LEIE) website monthly to validate their eligibility for Federal programs.

What to do if the school finds a sanctioned provider

- If the school finds a sanctioned provider, then they need to discontinue using this provider for Medicaid services.
- Immediately report to NH Medicaid any exclusion information discovered. This information should be sent in writing and should include the individual or business name, provider identification number, and what, if any, action has been taken to date. This should be sent to:

  DHHS-Program Integrity
  129 Pleasant St. Thayer Building
  Concord, NH 03301

Or email: programintegrity@dhhs.nh.gov

What Happens after Enrollment for Billing Process?

- Local education agencies may be reimbursed by NH Medicaid for health services provided by the school employed providers or the school contracted employees who provide medically necessary healthcare services for Medicaid enrolled children services.
- The LEA should ensure that:
  - The appropriate services are added under the school's assigned LEA National Provider Identifier (NPI) (nursing, therapies, behavioral health are some examples).
  - Effective September 1, 2021, all ordering providers must have a Medicaid provider ID and NPI. The ordering provider's NPI must be on all claims for services.
  - The LEA meets its responsibility to keep information current in the MMIS, submitting change forms when staff change or superintendent, monitoring the 835 for claims submitted and what was paid or not, and maintaining staff files at school with current information and monthly LEIE screenings.

Medicaid to Schools Enrollment

- All schools must be enrolled Medicaid providers.
- To be covered by Medicaid, an order prescribing the covered service is generally needed from a Physician, APRN, or physician assistance or other licensed treatment providers practicing within their scope of board licensure. These providers will need to be enrolled in Medicaid either a provider of physician services or as an ordering, referring, prescriber only provider (does not bill Medicaid)
- If the school will be utilizing the primary care physician of the Medicaid members on the order sheet, validation will need to be done that those practitioners are enrolled in Medicaid and the practitioner's Medicaid provider name and National Provider Identifier must be present on the claims.
- If the school will be using school employee professionals to provide the covered Medicaid service, that employee will need to be enrolled in Medicaid and affiliated to the school enrollment. All screenings will be responsibility of the school for licensure or certification and OIG screenings.
- If the school will be contracting with outside professional groups to perform the ordered services, the group entity is responsible for completing the screenings required and informing the school of any changes.
- For the schools to bill for covered services using a third party billing agent, billing agent authorization and billing agent agreement needs to be completed and affiliated to the third party trading partner enrollment. (ie: School district to engage MSB for billing of services must complete authorization and agreement form to be submitted to the Medicaid management information system by the third party agent.)
- For schools to bill utilizing a third party software system, a "self" trading partner application is required to be submitted for enrollment and identification of the software for testing purposes is required and notice to remove affiliation from other third party billing agents.

Informational Bulletin(s) – Provider Enrollment

Informational Bulletin Highlights:

- Enrollment
- NPI Numbers

Enrollment

1) **Participation in the Medicaid to Schools Program**

   Participation in the Medicaid to Schools Program (MTS) is at the discretion of the Local Education Authority (LEA) or School Administrative Unit (SAU). Districts will become the enrolled Medicaid Providers and if applicable, identify their contracted, trading partner third party billing agent***. Note: If the school uses a third party billing agent, the school must complete and submit a Third Party Billing Agreement to MMIS***.

   Enrolled Districts are eligible for reimbursement of Medicaid, covered medical services in a child's plan of care. Districts may collect up to 50% of their actual cost or 50% of the published Medicaid rate, ***whichever is less.***

   Source: SFY 2020-07; May 2020; Operational Policy Clarifications

2) **My superintendent does not want to provide a social security number with the Medicaid enrollment package. Are schools required to submit the superintendent's social security number on the provider application?**

   Yes, disclosure of a school superintendent's social security number is required for enrolling in the Medicaid program because superintendents fall under the definition of a 'managing employee', which is a type of employee that federal law mandatorily requires social security number submission as part of Medicaid enrollment.

   Federal law states that "the Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures: The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity)." 42 CFR 455.104. A 'managing employee' is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency." 42 CFR 455.101 The superintendent of a school district certainly falls into the definition of an administrator of an entity (school provider) that receives Medicaid funds.

   The Department will collaborate with the NH School Administrators Association, the NH Association of School Principals, and the NH Department of Education to help support the understanding of this requirement to provide a superintendent's social security number as part of Medicaid enrollment.

   Source: SFY 2020-06; January 2020; Billing and policy guidance document

3) **Some staff have started the process of enrolling in NH Medicaid and have been asked to complete a Provider Participation Agreement. Is this necessary and if not, how can it be reversed so that the process is done correctly?**

   Yes, any provider enrolling with NH Medicaid is required to sign a Provider Participation Agreement.

   Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI numbers

4) **Is there some way for staff to confirm if they were previously enrolled as a NH Medicaid provider?**

Go to the www.nhmmis.nh.gov portal and open the quick link labeled "Find a Healthcare Provider." This will open a search page where you can search for a provider. If a provider is actively enrolled, the page will display name, address, and phone number. Providers that have enrolled as ordering only providers, or inactive providers, will not be displayed. You will need to contact Conduent for those providers. The Provider Relations Call Center is available to you Monday through Friday, from 8:00AM to 5:00PM at 1-866-291-1674

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI numbers

NPI Numbers

4) **Please confirm that for the NPI and NH Medicaid application, the location of service would be the district office rather than each individual school location and the contact person would be the Medicaid Coordinator or the Superintendent.**

An NPI application does not require "service location" or "contact person." A NH Medicaid non-billing or individual application does require these fields. On the NH Medicaid application, you can enter either the school district office or the school that the provider spends the majority of their time. The NPI application states: "If you have more than one practice location, select one as the "primary" location." The service location on the NH Medicaid application should coincide with the primary practice location submitted on your NPI application. There is a section in the NH Medicaid application where you can affiliate all "groups," i.e., schools, the provider works with. The contact person should be a person associated with the primary practice. The applicant should consult with the schools to determine which Medicaid Coordinator or other staff member will be their contact.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

5) **Do all providers need to be enrolled with Medicaid as "non-billing" individuals?**

At present, NH Medicaid does not require rendering providers or providers directly providing the service to be enrolled with NH Medicaid or to be noted on the claim form. In the future, should NH Medicaid require the rendering provider be identified on the claim form, then all individual providers giving services or their supervising provider will be required to submit their NPI on claims. NH Medicaid will inform the school districts of any billing requirement changes in the future along with transition period if that should happen.

NH Medicaid does require ordering providers to be enrolled and to be identified on claim form. An order must be obtained from an individual capable of ordering the services under their license.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

6) **We are an out of district provider. We have obtained physician orders for all of our related and medical (nursing) services. All of our providers have NPI numbers. Do they need to be Medicaid Enrolled providers as well?**

Beginning in the 2021-2022 school year, the ordering provider must be enrolled with NH Medicaid.

For the 2020-2021 school year, if the provider is not enrolled with NH Medicaid, then the school is responsible for ensuring the provider has been properly licensed and screened. If the provider is enrolled with another State Medicaid program, then the school is still responsible for ensuring the provider meets licensure and screening criteria and the school must provide supporting documentation of this upon request and audit.

This informational bulletin section also appears in Covered Services section

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

7) **For our group of providers that technically do not need an order (i.e. PT and Speech) does this mean they do not need the NPI number?**

NH Medicaid cannot require any provider to obtain an NPI. For those providers in which an order is not required, NH Medicaid does not require rendering providers or providers directly providing the service to be enrolled with NH Medicaid or to be noted on claim form with an NPI. In the future, should NH Medicaid require the rendering provider be identified on the claim form, then all individual providers giving services, or their supervising provider, will be required to submit their NPI on claims. NH Medicaid will inform the school districts of any billing changes in the future along with a transition period if that should happen.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

8) **Are non-ordering providers required to enroll in NH Medicaid, or is it just suggested for the benefit of LEIE checks? If not, will they be required to do so in the future, and if so, within what timeframe? If so, will their information also be added to claims, or will only the ordering provider's NPI, etc. be necessary?**

At present, NH Medicaid does not require rendering providers or providers directly providing the service to be enrolled with NH Medicaid or to be noted on claim form. In the future, should NH Medicaid require the rendering provider be identified on the claim form, then all individual providers giving services, or their supervising provider will be required to submit their NPI on claims. NH Medicaid will inform the school districts of any billing changes in the future along with transition period if that should happen. If a provider is not enrolled with NH Medicaid, then the schools must ensure a rendering or ordering provider has an active proper license and is screened monthly through LEIE website to ensure the provider is in good standings to provide or order services.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

9) **Is there a way to send Conduent a list of providers to have validated as active NH Medicaid in one form, rather than having to look up each provider individually in the provider search? Some schools have several physicians they need to verify are enrolled to make sure they can order school services.**

Yes, the schools can send a list to Conduent and Conduent will send the list back indicating if the provider is active or not with NH Medicaid. Conduent cannot give Medicaid provider IDs or any other provider information. The list must be in excel and must include provider name and NPI. If you have a NH Medicaid ID, then please add that to the excel list. NH Medicaid ID is not required for the look up. Please e-mail the spreadsheet to NHproviderrelations@conduent.com. Ensure you state that this is for a Medicaid to School provider. Conduent will return the list noting if the person is currently active with NH Medicaid.

Source: SFY 2021-01; July 2020; Medicaid Provider Enrollment and NPI Numbers

10) **How long will it take to get an NPI number? When I got to the DHHS website to lookup my providers credentials, it brings me to Allied health. How can I find my providers credentials? When can we expect the next phase of rulemaking to begin? How long is it expected to take to reach full compliance?**

To obtain an NPI number, an online application can be submitted, and the number will be emailed to you within 24 hours. For more information about the application process and how to apply go to this CMS website: https://www.cms.gov/Regulations-andGuidance/Administrative-Simplification/NationalProvIdentStand/apply and review the application information found on

the Department's MTS website: https://www.dhhs.nh.gov/ombp/Medicaid/mts/providers.htm.
To find a provider's credentials or whether they are enrolled with NH Medicaid , a search can be performed on the MMIS portal at https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome. Select "How to Find a Provider" under the Directories tab at the top of the page.
Provider credentials for the individuals in NH can also be located online:

- https://nhlicenses.nh.gov/Verification/Search.aspx, search criteria: Profession select from Allied Health (OT/PT/SLP, OTA, PTA, SLA), Hearing Care, Medicine, Mental Health, Nursing, Nursing Assistant, Psychology, or other MTS related profession
- https://www.nbcot.org/ for the National Board for Certification in OT to verify affiliation
- https://www.asha.org/certification/cert-verify/ to verify ASHA affiliation
- https://www.bacb.com/page/100155/ for certification of BCBA, RBT

The next rulemaking phase will begin as soon as the current rulemaking process has concluded with the Joint Legislative Committee on Administrative Rules hearing the proposed He-W 589 rule on February 21, 2020. The Department plans to enter into rulemaking over the next year to address various aspects of the benefit to align it fully with the NH Medicaid state plan.
Source: SFY 2020-05; January 2020; Billing and policy guidance document

Documentation and Payment for Services

Introduction

Documentation of services rendered by enrolled providers include critical requirements to both preserve the record of services provided to students through the Medicaid to Schools program and verify appropriate billing and reimbursement for services rendered.

Summary

Documentation and Payment for Services includes:

- Overview of billing and reimbursement
- Billing for Physical Therapy, Occupational Therapy, and Speech-Language Therapy Services
- Billing for Rehabilitative Services
- Billing for Transportation Services
- Overview of documentation
- Parental Consent
- Record Retention

Overview of Billing and Reimbursement

Summary

Reimbursement to enrolled school providers shall be the lesser of the following:

- One half of the actual cost, or
- The rate established by the department, in accordance with RSA 161:4, VI(a).

Enrolled school providers must bill by unit of service, using the current procedural code for the service delivered, and submit claims for payment that include the actual cost of the service to the department's fiscal agent.
Enrolled school providers must submit claims for Medicaid covered services consistent with the MTS rules and federal Medicaid law. (He-W 589.06(a)-(c))

Rule He-W 589.06 Documentation and Payment for Services.

(a) Reimbursement to enrolled school providers shall be the lesser of the following:
(1) One half of the actual cost, or
(2) The rate established by the department, in accordance with RSA 161:4, VI(a),
(b) Enrolled school providers shall bill by unit of service, using the current procedural code for the service delivered, and submit claims for payment that include the actual cost of the service to the department's fiscal agent.
(c) Enrolled school providers shall submit claims for medicaid covered services consistent with this rule and with federal medicaid law pursuant to 42 CFR 455, 42 CFR 456, 42 CFR 431, and 42 CFR 1001.

Informational Bulletin(s) – Overview of Billing and Reimbursement

Informational Bulletin Highlights:

- Procedure Codes/Documentation
- Group v. Individual Session Billing
- Time of Sessions
- Other

Procedure Codes/Documentation

1) **Service Documentation Requirements**

Providers are required to maintain documentation of:

- Student's current Care Plan (IEP, 504, or healthcare plan)
- Copy of order from a physician, physician assistant, APRN, or other licensed clinician
  - Order must be within the clinician's scope of practice
- Evidence of credentials and/or licensure of all staff delivering medical services
- Evidence of service implementation:
  - Invoices
  - Mileage logs
  - Transaction logs (which must include the following):
    - Name(s) of the student(s) and the medical assistance ID number
    - Date(s) of service
    - Location of service
    - Type of service
    - Name of service provider
    - Signature of service provider

- Number of service units delivered
- Start and stop time of delivered services
- If service was provided to one child or in a group setting (include how many in group regardless of Medicaid eligibility)
- School calendar
- School attendance records
- Parental consent to access Medicaid
- Rate-setting methodology
- 30 Day Review documentation (if applicable)

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) **The Department has received the following questions on procedure codes and the billing of certain codes:**
   a) *Are there new CPT codes for OT and PT? We are currently using the following codes: 95730 OT and 97799 PT with a modifier for individual and a HQ for group service. Also we have quite a few students who go to Crotched Mountain and on their logs for Occupational Therapy and Physical Therapy they have changed the CPT code from what we have in Easy Medicaid to 97110TMGO for OT and 97110TMGPU for PT. Can you please clarify what codes we should be using?*
   b) *We are seeking clarification on the calculations for group billing. Do you divide the provider's rate by the number of students in a group, or bill each student at the full provider rate? Do you divide the provider's rate by the number of students in a group, or bill each student at the full provider rate?*
   c) *Can you confirm allowable billing codes for schools for behavioral health services as well as billing unit size and provider types?*
   d) *When will updated CPT codes/standard rates for categories of billing be available? How will they be announced and/or to whom will they be sent?*
   e) *Will NH Medicaid use the following codes for behavioral health services: 96130-TM 1st hour psychological testing; 96131-TM additional psychological testing hours; 96132-TM 1st hour neuropsychological testing; 96133-TM additional neuropsychological testing hours; 96136-TM 1st 30 minutes testing 2 or more tests; 96137-TM additional 30 minutes.*

The Department's Medicaid Finance Unit applied a 3.1% rate increase for all approved CPT codes, effective January 1, 2020. Revised fee schedules and billing manual will be posted on the MMIS portal at: https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

3) **How will the group CPT codes be designated? Will there be a lower rate attached to a HQ modifier and will that suffice to prorate the number of participants in the group?**

A procedure code for a group for the therapies (PT/OT/ST) has only been identified for speech therapy at this time.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

4) **Question on first paragraph in the administrative rule, it says that this is not meant to mandate that services must be provided by school district but some of these services are medically necessary and mandated by an MD. Those do need to be done by schools. Is this meant to say they're not required to seek reimbursement?**

Yes, the first paragraph in the rule (He-W 589.01 Purpose) states that requesting federal financial participation (Medicaid reimbursement) "for Medicaid services is **optional** for school

districts" and that "(p)articipation in Medicaid is **discretionary** on the part of school districts and school administrative units." While participation is optional for schools, in order to seek Medicaid reimbursement for Medicaid covered services, schools must comply with all federal and state Medicaid law.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

5) **How will districts be notified when a code changes?**

The Department will issue a provider notice of code changes to the NH Department of Education for distribution to the Superintendents of Schools and others in the local school districts. Additionally, as indicated in question #1 above, the MMIS portal can be accessed for code information at: https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

6) **Are there maximum units per service?**

Yes, procedure codes do have maximum units. These units; however, are under review. The Department will issue guidance once it has completed its review. A provider notice will be sent to the Superintendents of Schools for distribution to the local school districts. This notice will also be posted to MMIS website (see question #2 above for a link to the MMIS portal).

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

7) **Will there be procedure codes for students with an IEP versus students without an IEP?**

Yes, modifiers will be added to the current MTS procedure code set to distinguish billing for students with IEPs versus those without an IEP for reporting purposes. A provider notice will be sent to the Superintendents of Schools for distribution to the local school districts once the new modifiers have been loaded into the MMIS claims system. This notice will also be posted to the MMIS website (see question #1 above for a link to the MMIS portal).

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Group v. Individual Session Billing

1) **Group vs. Individual Billing Sessions**

Services can only be billed if there is an order and the service is required in the healthcare plan. The mode of services must match what is in the healthcare plan. ***Ex- if the plan calls for a group service, you cannot bill for individual services.***

Individual services can only be billed when individual services are included in the plan of care. Group services can only be billed when group services are included in the plan of care.

As previously described in guidance document SFY 2020-02 published September 2019, group therapy consists of simultaneous treatment to two or more students who may or may not be doing the same activities. If the therapist is dividing attention among the students, providing only brief, intermittent personal contact, or giving the same instruction to two or more students at the same time, then it is appropriate to bill for each student one unit of group therapy. In this instance, the students do not receive one on one treatment; therefore, it is appropriate only to bill the group code.

Currently the only Current Procedural Terminology (CPT) code that is setup with a group rate is 92508 TM HQ, which is treatment of a speech language, voice communication and/or auditory processing disorder group, 2 or more individuals. The Department will be establishing group codes for physical therapy and occupational therapy, and when established, a provider

notice will be sent to the Superintendents of Schools and other stakeholders in the local school districts for distribution.

Maintaining documentation of the Medicaid services delivered to support the claims billed is a condition of enrollment with NH Medicaid. Thus, keep in mind that each student in the group should have unique documentation of the service delivered, including a description of the group session, and how the session contributed to the student's IEP or care plan treatment goals in compliance with 42 CFR 431.07 and NH Administrative Rules He-W 520.03.

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) **When a procedure code exists for a group rate, can the school district just bill the rate associated with this code regardless of the number of students served as long as there is more than one? Or do they have to determine how many students received the service and pro-rate the code? When a procedure code does not have a group modifier, how should billing work?**

Group therapy consists of simultaneous treatment to two or more students who may or may not be doing the same activities. If the therapist is dividing attention among the students, providing only brief, intermittent personal contact, or giving the same instruction to two or more students at the same time, then it is appropriate to bill for each student one unit of group therapy. In this instance, the students do not receive one on one treatment; therefore, it is appropriate only to bill the group code.

Currently the only Current Procedural Terminology (CPT) code that is setup with a group rate is 92508 TM HQ which is treatment of a speech language, voice communication and/or auditory processing disorder group, 2 or more individuals. The Department will be establishing group codes for physical therapy and occupational therapy, and when established, a provider notice will be sent to the NH Department of Education for distribution to the Superintendents of Schools and others in the local school districts. The MMIS portal can be accessed for code information at https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome

Maintaining documentation of the Medicaid services delivered to support the claims billed is a condition of enrollment with NH Medicaid. Thus, keep in mind that each student in the group should have unique documentation of the service delivered, including a description of the group session, and how the session contributed to the student's IEP or care plan treatment goals in compliance with 42 CFR 431.07 and NH Administrative Rules He-W 520.03.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

3) **Sometimes a student needs a group setting service according to their IEP, but because of the make-up/availability of other students for that student, the sessions are sometimes (or often), in reality, individual sessions. In an instance where the IEP says they are supposed to have a group sessions, but they are the only one in the group that day, how should school districts ultimately document for those services with Medicaid (group of 1? individual service?)**

The student's IEP or written care plan is the source document for MTS billing used to support the medical necessity of the services for which the school sought reimbursement. If group sessions were indicated in the IEP, then the procedure code for the group session can only be billed even if practically speaking the student was served individually.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Time of Sessions

1) **Rounding up or Rounding down?**

When billing for transportation mileage, it is acceptable to round up. ***For example, 18.6 miles can be rounded to 19 miles.*** When billing for other services, the following rules apply:

The Department has modeled its billing instructions, particularly the 8-minute criteria, on the standards for Medicare billing established by the Centers for Medicare and Medicaid (CMS).

This means, for any single timed CPT code in the same day measured in 15-minute units, school districts should bill one 15-minute unit for treatment greater than or equal to 8 minutes up to and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, up to and including 37 minutes, then 2 units should be billed. See the table below:

Number of minutes	Number of 15-minute units that can be billed
Fewer than 8 minutes	No units can be billed
8 minutes up to 22 minutes	1 unit
23 minutes up to 37 minutes	2 units
38 minutes up to 52 minutes	3 units
53 minutes up to 67 minutes	4 units
68 minutes up to 82 minutes	5 units
83 minutes up to 97 minutes	6 units
98 minutes up to 112 minutes	7 units
113 minutes up 127 minutes	8 units

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) **What are the typical approved timeframes for billing a 15-minute versus a 30-minute service? What if the service provided was 18 minutes, can the school bill 30 minutes? Or should they bill 15 minutes? Is there a standard timeframe utilized for determining how to bill?**

After reviewing industry standards on the billing and documentation of services using 15-minute units, the Department has modeled its billing instructions, particularly the 8-minute criteria, on the standards for Medicare billing established by the Centers for Medicare and Medicaid (CMS).

That means, for any single timed CPT code in the same day measured in 15-minute units, school districts should bill one 15-minute unit for treatment greater than or equal to 8 minutes up to

Number of minutes	Number of 15-minute units that can be billed
Fewer than 8 minutes	No units can be billed
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68 minutes up to 82 minutes	5 units
83 minutes up to 97 minutes	6 units
98 minutes up to 112 minutes	7 units
113 minutes up 127 minutes	8 units

and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, up to and including 37 minutes, then 2 units should be billed. See the table below:

The 8-minute criteria remains the same for treatment times in 30, 45 and 60-minute increments.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Billing for Physical Therapy, Occupational Therapy, and Speech-Language Therapy Services

Summary

Enrolled school providers must follow the following rules when submitting claims for physical, occupational, and speech-language therapy:

- Only units of direct treatment performed by a physical therapist, occupational therapist, SLP, a physical therapy assistant, occupational therapy assistant, or speech-language assistant shall be billed, meaning the time the therapist or physical therapy assistant, occupational therapy assistant, or speech-language assistant spends providing direct treatment to one student;
- Therapists working as a team to treat one or more students shall not each bill separately for the same or different service provided at the same time to the same student; and
- If a student requires co-treatment simultaneously by 2 therapists, the total number of units shall be divided between the therapists and billed separately by each therapist to equal the total time the student was receiving actual therapy services. (He-W 589.06(e))

He-W 589.06 Documentation and Payment for Services.

(e) Enrolled school providers shall submit claims for physical, occupational, and speech-language therapy services in accordance with the following:

(1) Only units of direct treatment performed by a physical therapist, occupational therapist, SLP, a physical therapy assistant, occupational therapy assistant, or speech-language assistant shall be billed, meaning the time the therapist or physical therapy assistant, occupational therapy assistant, or speech-language assistant spends providing direct treatment to one student;

(2) Therapists working as a team to treat one or more students shall not each bill separately for the same or different service provided at the same time to the same student; and

(3) If a student requires co-treatment simultaneously by 2 therapists, the total number of units shall be divided between the therapists and billed separately by each therapist to equal the total time the student was receiving actual therapy services.

Informational Bulletin(s) – Billing for OT, PT and Speech Language Services

1) **If a student receives rehab aide services to carryover OT, Speech, PT, Behavior, do all related services providers then have to sign off monthly on these services?**

No, the IEP team needs to identify and designate a licensed clinician who will be responsible for oversight of the medical components of IEP plan and the carry-over tasks delegated to the Rehabilitative aide. The administrative rule states the following at He-W 589.04(aj)

> "Provision of rehabilitative assistance services shall be reviewed by another licensed clinician designated by the enrolled school provider's care plan team every 30 days. Such review shall include review of the activities performed by the rehabilitative assistant and the effectiveness of the activities as observed by the rehabilitative assistant. As part of the review, the care plan team designated licensed clinician shall sign the documentation of the service transaction logs to attest that the service was actually provided and shall provide review and signature that the activities have been conducted in accordance with the care plan."

Source: SFY 2020-07; May 2020; Operational Policy Clarifications

2) **Is it now correct that a related service licensed professional (OT/PT/SPL) can no longer recommend through signing for OT/PT/SPL or rehab assistance services, a doctor must now sign?**

The Department is seeking clarification from the Office of Professional Licensure and Certification (OPLC) to further clarify those other licensed treatment providers who may, as permitted under their board licensure, order or prescribe services, what type of services are included under their scope of practice, and who they may supervise pursuant to their license. In its regular rulemaking proposal, the Department will clarify the definition for "order" to include those licensed treatment practitioners 2 2020 –03 Medicaid to Schools Responses to Questions Received 10.2019 whose scope of license permits ordering services to be consistent with federal and state law, and will clarify in further rulemaking those providers who may supervise rehabilitative assistants.

As previously stated in guidance 2020-02, an order prescribing the Medicaid covered service is generally required from a Physician, APRN, or physician assistant for the services to be reimbursable by NH Medicaid; however, some qualified medical treatment providers may order services if state statute allows them to do so, and when they are acting within the scope of their board license. If your provider has unique circumstances or training, please contact OPLC to discuss the circumstance with the applicable licensing board. A list of contacts for each board can be accessed at this website: https://www.oplc.nh.gov/contactus/contact-your-board.htm. The main phone number to the OPLC is (603)-271-2152.

Source: SFY 2020-03; October 2019; Billing and policy guidance document

3) **Where can I find Out of District Medicaid reimbursement forms for our therapists to complete for our NH districts?**

Currently there is not a form for this. You should check with each of the school districts to determine how they want to be invoiced for services provided by qualified and licensed therapists.

Source: SFY 2020-03; October 2019; Billing and policy guidance document

4) **How will the group CPT codes be designated? Will there be a lower rate attached to a HQ modifier and will that suffice to prorate the number of participants in the group?**

A procedure code for a group for the therapies (PT/OT/ST) has only been identified for speech therapy at this time. The Department is identifying a corresponding procedure code for a group for physical therapy and occupational therapy. These procedure codes will be released with the revised fee schedule in January 2020.

Source: SFY 2020-04; November 2019; Billing and policy guidance document

5) **Speech evaluations are the only active CPT codes within Medicaid-to-Schools that have the designation of "per event" for billing. In school setting, evaluations typically are conducted over multiple days and in multiple sessions. Is the event/evaluation to capture a one-time reimbursement for the evaluation as a whole, no matter how long it takes to complete?**

The CPT code description for a speech evaluation is an event regardless of the time it takes to complete the evaluation. This is a one-time reimbursement.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Billing for Rehabilitative Services

Summary

Enrolled school providers may only bill the MTS program for covered service time provided simultaneously by more than one licensed clinician and a rehabilitative assistant when the following requirements are met:

- If rehabilitative assistance is provided simultaneously with another covered service, the rehabilitative assistance shall be billed in addition to the covered service; or
- If rehabilitative assistance is provided by more than one rehabilitative assistant simultaneously, each assistant's service shall be billed separately. (He-W 589.06(f))

He-W 589.06 Documentation and Payment for Services.

(f) Enrolled school providers shall only bill covered service time provided simultaneously by more than one licensed clinician and a rehabilitative assistant as follows:

(1) If rehabilitative assistance is provided simultaneously with another covered service, the rehabilitative assistance shall be billed in addition to the covered service; or

(2) If rehabilitative assistance is provided by more than one rehabilitative assistant simultaneously, each assistant's service shall be billed separately.

Informational Bulletin(s) – Billing for Rehabilitation Services

1) **Can related service licensed professionals (OT/PT/SLP) sign off on rehab assistant billing once a doctor has ordered the service?**

The individual within the school setting who is providing supervision or direction to the rehab assistant may continue to sign off on the billing and the service logs describing the services delivered, the number of hours or minutes for the services delivered, the dates of service, the start and stop times, etc. Keep in mind that Medicaid requires unique documentation of the service delivered, including a description of the services performed, amount of time it took to perform them, and how the services contributed to the student's IEP or care plan treatment goals in compliance with 42 CFR 431.07 and NH Administrative Rules He-W 520.03. Some qualified treatment providers have qualifications permitting supervision within the scope of their board licensure. Further clarification is being sought from OPLC regarding which qualified medical treatment providers may supervise rehabilitative assistants as part of the scope of their board licensure, and the Department will issue guidance in the future.

Source: SFY 2020-03; October 2019; Billing and policy guidance document

2) **If a rehabilitative assistant is supporting a student with health-related needs (such as helping to bridge the gap with communication, i.e., carry-over speech tasks), is that billable service?**

Yes. Rehabilitative assistance services include carry-over tasks. Carry-over tasks are billable if ordered by a licensed clinician as medically necessary services and part of an IEP or Section 504 or health care plan.

Source: 2021-02; December 2020; Rehabilitative Assistance Services

3) **Please clarify how Related Service Providers and Rehab Assistants document shared time? Could you confirm that the following is correct (assuming the medical needs of these services are clearly outlined in the IEP)?**

a.) A Rehab Assistant and a Related Service Provider can document for full time spent with students.

b.) Two service providers that are OT/PT/SLP/ etc.; have to split the total time in ½ while working with the same student.

A rehabilitative assistant would not likely be performing personal care services while a student is receiving treatment services. A more likely scenario would be that a student is scheduled for one hour of speech therapy, and the rehab assistant is in attendance during the treatment session, but the speech language session is interrupted for toileting. The speech-language provider would bill three units of therapy and the rehab assistant would bill one unit of service. Therapy treatment providers conducting treatment as a team would split the total time spent with the student and bill separately. Keep in mind that Medicaid requires unique documentation of the service delivered, including a description of the services performed, amount of time it took to perform them, and how the services contributed to the student's IEP or care plan treatment goals in compliance with 42 CFR 431.07 and NH Administrative Rules He-W 520.03.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Billing for Transportation Services

Summary

In calculating the cost for transportation, the enrolled school providers may first aggregate the following actual costs related to the trip:

- Fuel;
- Insurance;
- Driver's salary and benefits;
- Salary and benefits of other persons working on the bus;
- Depreciation, and
- Maintenance

The aggregated actual costs is then divided by the total number of miles for the trip both ways, and then divided by the total number of students on the bus, regardless of the students' Medicaid eligibility, to determine the cost per mile per student. (He-W 589.06(g)-(h))

He-W 589.06 Documentation and Payment for Services.

(g) In calculating the cost for transportation, the enrolled school providers may include the following actual costs related to the trip:

(1) Fuel;
(2) Insurance;
(3) Driver's salary and benefits;
(4) Salary and benefits of other persons working on the bus;
(5) Depreciation, and
(6) Maintenance.

(h) The total cost calculated in (g) above shall then be divided by the total number of miles for the trip both ways, and then divided by the total number of students on the bus, regardless of the students' medicaid eligibility, to determine the cost per mile per student.

Informational Bulletin(s) – Billing for Transportation Services

1) **Reimbursement for Medically Necessary Transportation:**

Pursuant to He-W 589.04 (au), specialized transportation may be billed to Medicaid when specific conditions are met.

Specialized transportation may be billed without a specific transportation order if on the day the transportation is provided, a Medicaid covered, medically necessary service was provided to the student and the provisions of He-W 589.04 (au) are met. *Please note, the medical service on the day of the transportation must be pursuant to an ordered, or self-ordered, billable service.*

Pursuant to He-W 589.04 (au), specialized transportation may be billed to Medicaid when specifics conditions are met.

- Transportation must be specifically included in the student's current Care Plan (IEP, 504, or healthcare plan) as a required service. The plan must clearly state the transportation needs and reason transportation is required;
- The student must be physically present in the transportation vehicle; and
- An ordered, Medicaid qualified service must be delivered on the day of transportation.
- One of the following provisions must be met:

- The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus; or
- The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the IEP; or
- The student requires a person to accompany them on the bus as outlined in the Care Plan

Source: December 18, 2020; Reimbursement for Medically Necessary Transportation

2) Specialized transportation – is the entire trip billable to Medicaid regardless of whether the student is on the vehicle or not / Does specialized transportation need to be included in the IEP?

No changes in the transportation policy were made in the current MTS emergency rule. Pursuant to He-M 1301.04, the transportation must be listed in the IEP and the student must be on the bus for the specialized transportation to be paid. The rule states that:

(at) Specialized transportation shall be a billable service as follows:

(1) Transportation shall be listed in the student's IEP as a required service;

(2) Transportation shall be considered a required service if:

a) The child requires transportation in a vehicle specially adapted to serve the needs of the disabled child, including a specially adapted school bus; or
b) The child resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the IEP;

(3) The following transportation may be billed as a Medicaid service:

a) Transportation to and from school only on a day when the student receives a Medicaid coverable service at school during the school day; and
b) Transportation to and from a Medicaid coverable service in the community during the school day;

(4) The Medicaid coverable service in (3)a. and (3)b. above shall be listed in the student's IEP as a required service.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Overview of Documentation

Summary

Enrolled school providers must maintain unique documentation in accordance with these guidelines as well as with He-W 520 for the delivered services in each student's individual record. Required documentation includes:

- A copy of the care plan and, if an IEP, evidence of implementation of the IEP as required by Ed 1109.04(b);
- The name of the student, the medical assistance ID number, and documentation demonstrating receipt of each unit of the covered service;
- The names, qualifications, and credentials of all performing providers for each service delivered for which the school sought FFP;
- The documentation of the qualifications, names, and signatures of persons directing or supervising the individuals providing the covered services if direction or supervision is required under this part or applicable law, and the date of supervisory approval.
- Date(s) of each service delivered and the location where the services were performed;
- The type of covered service provided and a description of each service provided;
- The duration of the provision of the each covered service, number of units performed, and the number of minutes for each delivered service;
- The start and stop times of the delivered services, and whether there was a break in services or time away by the performing provider;
- Indication whether the services were delivered in a group setting or individually;
- Indication of whether the student was actually present for the service and indication whether the student was present for at least 51% of the time;
- In the case of group services, documentation of the number of participants in the group who received the covered service regardless of the participants' Medicaid eligibility;
- A copy of a physician's or other licensed clinician's order if required; and
- Documentation of the qualifications and the handwritten signature of the individual(s) attesting to the medical non-academic nature of the covered rehabilitative assistance services. (He-W 589.06(d))

He-W 589.06 Documentation and Payment for Services.

(d) Enrolled school providers shall maintain unique documentation in accordance with He-W 520 and this part for the delivered services in each student's individual record, with such documentation to include:

(1) A copy of the care plan and, if an IEP, evidence of implementation of the IEP as required by Ed 1109.04(b);
(2) The name of the student, the medical assistance ID number, and documentation demonstrating receipt of each unit of the covered service;
(3) The names, qualifications, and credentials of all performing providers for each service delivered for which the school sought FFP;
(4) The documentation of the qualifications, names, and signatures of persons directing or supervising the individuals providing the covered services if direction or supervision is required under this part or applicable law, and the date of supervisory approval.
(5) Date(s) of each service delivered and the location where the services were performed;
(6) The type of covered service provided and a description of each service provided;
(7) The duration of the provision of the each covered service, number of units performed, and the number of minutes for each delivered service;

(8) The start and stop times of the delivered services, and whether there was a break in services or time away by the performing provider;
(9) Indication whether the services were delivered in a group setting or individually;
(10) Indication of whether the student was actually present for the service and indication whether the student was present for at least 51% of the time;
(11) In the case of group services, documentation of the number of participants in the group who received the covered service regardless of the participants' medicaid eligibility;
(12) A copy of a physician's or other licensed clinician's order if required; and
(13) Documentation of the qualifications and the handwritten signature of the individual(s) attesting to the medical non-academic nature of the covered rehabilitative assistance services.

Informational Bulletin(s) – Overview of Documentation

(None)

Parental Consent

Summary

Informed parental consent must be obtained prior to the enrolled school provider billing the student's Medicaid. (He-W 589.06(i))

He-W 589.06 Documentation and Payment for Services.

(i) In accordance with 34 CFR 300.154 (d)(2)(iv), Ed 1120.08, and 42 CFR 300.154(d)(2)(v), informed parental consent shall be obtained prior to the enrolled school provider billing the student's Medicaid.

Informational Bulletin(s) – Parental Consent

1) **When would parents sign off on Medicaid reimbursement and how long would it be in effect? Would parents receive statements?**

School districts do need to get informed parental consent to bill NH Medicaid. NH statutes (NH RSA167:3-k, III(b)2 and RSA 186-C, II(d)3) require informed parental consent but do not indicate the frequency of obtaining parental consent. Federal regulation, 42 CFR 300.154(d)(2)(v)4 requires parental consent and notification prior to accessing a student's Medicaid benefits for the first time and annually thereafter. The Department is still seeking clarification regarding the federal regulation's application to the frequency of obtaining parental consent and notification, and its impact to students relocating to another school district. The Department will issue additional guidance in the future. The Department does not send out explanation of benefits to parents, but individuals can request billing records and claim records from the Department and from their child's school.

Source: SFY 2020-05; January 2020; Billing and policy guidance document

2) **If districts already have a one-time consent on file and the student has not changed District of Liability, does parental consent need to be received every time a student's IEP services changes (yearly and/or whenever an amendment takes place)? Does parental consent need to be received when a student moves from one school district to another?**

School districts do need to get informed parental consent to bill NH Medicaid. NH statutes (NH RSA167:3-k, III(b)1 and RSA 186-C, II(d)2) require informed parental consent but do not indicate the frequency of obtaining parental consent. Federal regulation, 42 CFR 300.154(d)(2)(v)3 requires parental consent and notification prior to accessing a student's Medicaid benefits for the first time and annually thereafter.

Source: SFY 2020-02; September 2019; Billing and Policy Guidance

Record Retention

Summary

Enrolled school providers must maintain records in support of claims submitted for reimbursement for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced in the 6-year period, whichever is longer.

As applicable, the creation, storage, retention, disclosure, and destruction of documentation required must also comply with all federal and state privacy and security laws and rules including the substance use disorder patient records regulations pursuant to 42 CFR Part 2 (to the extent applicable), Family Educational Rights and Privacy Act, and the Health Insurance Portability and Accountability Act of 1996. (He-W 589.06(j)-(k))

He-W 589.06 Documentation and Payment for Services.

(j) Enrolled school providers shall maintain records in support of claims submitted for reimbursement for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced in the 6-year period, whichever is longer.
(k) As applicable, the creation, storage, retention, disclosure, and destruction of documentation required by this part shall comply with all federal and state privacy and security laws and rules including the substance use disorder patient records regulations pursuant to 42 CFR Part 2, Family Educational Rights and Privacy Act, and the Health Insurance Portability and Accountability Act of 1996.

Informational Bulletin(s) – Record Retention

(None)

Audit Process

Informational Bulletin(s) – Audit Process

1) Audit Process

MTS audits are federally mandated. There are two (2) units within the NH Department of Health and Human Services that conduct audits. The Financial Compliance Unit (FCU) monitors for claims and rule requirements. The Program Integrity (PI) Unit audits claims with anomalies for fraud waste and abuse.

When the FCU conducts an audit, student selection is random. The process is begun by an Engagement letter mailed to the Special Education Director including the date of review, student(s) selected (for whom services were billed) and documents necessary for review.

Requested Documents & Information:

- Student's Healthcare Plan for audited school year
- Credentials of Providers and Supervising Professionals
- Service transaction logs
- School year calendar, including:
  - Unscheduled closings (i.e. snow days, flooding, etc.)
  - Early release days, delayed start or early dismissals
  - Teacher conference days
  - Actual last of day of school
- Attendance records (daily not period attendance)
- Parental consent to access Medicaid & written notification of parental rights
- Referrals, orders, recommendations as required
- Rate-setting methodology
- Copies of 30-Day Review documentation (if applicable)

A *Preliminary Findings letter* will be mailed to the SAU Superintendent. The SAU is given 30 days to respond with additional documentation or additional or corrected information. Then a Final Findings letter will be issued. The SAU will be given an additional 30 days to respond with further documentation and/or information and an opportunity to appeal due to disagreement with the findings. Finally, a *Conclusion letter* is issued.

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

2) Common findings – Billing and Documentation Errors to Avoid

Below are common errors found in provider billing and documentation:

- No provider signature on log or signature was photocopied and used on multiple logs
- Billed the wrong procedure code
- Overbilled the number of units actually delivered
- Billed 15 minutes of service as 30 minutes
- Several school districts billed the same service
- Service was billed under the wrong school district
- Service was billed twice
- Logs were not submitted
- Billed for services not included on logs
- Provider credentials were not submitted
- Provider not qualified

- Parental Consent not submitted or dated after service delivery

Source: SFY 2021-03; December 2020; Billing and Auditing Guidance

Utilization Review and Control

Summary

The department's program integrity unit will monitor utilization of medical services delivered in schools to identify, prevent, and correct potential occurrences of fraud, waste, and abuse. Pursuant to the fraud and abuse laws, the department must recoup state and federal Medicaid payments if an enrolled school provider fails to comply with applicable rules or fails to maintain supporting records demonstrating covered services were provided. (He-W 589.07(a)-(b))

He-W 589.07 Utilization Review and Control.

(a) The department's program integrity unit shall monitor utilization of medical services delivered in schools to identify, prevent, and correct potential occurrences of fraud, waste, and abuse in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 1001, and He-W 589.
(b) The department shall recoup state and federal medicaid payments as permitted by 42 CFR 455, 42 CFR 447, and 42 CFR 456 for an enrolled school provider's failure to comply with these rules and to maintain supporting records in accordance with He-W 520 and He-W 589.

Informational Bulletin(s) – Utilization Review and Control

(None)

Other Information

Other information includes:

- Documentation of Expenditure of Non-Federal Funds
- Waivers
- Telehealth
- Federal Medical Assistance Percentages (FMAP)

Informational Bulletin(s) - Other

1) **Many of the questions submitted by the schools are focused on operational issues. Does the Department plan to conduct trainings?**

Given the number of questions related to billing, services, enrollment, and documentation requirements, the Department plans to provide training and technical assistance to schools. The first training session will be focused on Medicaid enrollment and is being finalized. The Department will post the date, time, and location for the training on the MTS webpage and will issue an email to the stakeholders once a date, time, and location have been finalized. Additionally, the Department plans to conduct regular quarterly training and technical assistance sessions with interested schools

Documentation of Expenditure of Non-Federal Funds

Summary

The enrolled school provider must provide documentation annually regarding all services rendered under the MTS program. Such documentation must:

- Demonstrate that:
  - The percentage of federal medical assistance reimbursed, as required by section 1905(b) of the Social Security Act, does not exceed 50% of the actual cost of covered services claimed under Medicaid; and
  - In no case are services that are reimbursable under Medicaid, but paid by other federal funding, claimed by the enrolled school provider under NH Medicaid;
- Be reviewed and signed by the enrolled school provider's superintendent;
- Be submitted to the department no later than October 30 of each year for the preceding fiscal year period; and
- Be accompanied by a completed form "Documentation of Expenditure of Non-Federal Funds" (2/2020) for a specific July 1 through June 30 time period which includes an attestation signed and dated by the superintendent stating;

  "*I hereby certify that all Medicaid funds paid to the above named districts under He-W 589, Medical Assistance Services Provided by Educational Agencies for the period July 1, xxxx through June 30, xxxx have been supplemented with LEA/SAU and/or non-federal funds to total 100% of the cost of services rendered and that the Medicaid reimbursement does not exceed 50% of the total cost of the services rendered.*" (He-W 589.08(a)-(b))

He-W 589.08 Documentation of Expenditure of Non-Federal Funds.

(a) The enrolled school provider shall provide documentation annually regarding all services rendered pursuant to these rules.
(b) Such documentation shall:
(1) Demonstrate that:
a. The percentage of federal medical assistance reimbursed, as required by section 1905(b) of the Social Security Act, does not exceed 50% of the actual cost of covered services claimed under medicaid; and
b. In no case are services that are reimbursable under medicaid, but paid by other federal funding, claimed by the enrolled school provider under NH medicaid;
(2) Be reviewed and signed by the enrolled school provider's superintendent;
(3) Be submitted to the department no later than October 30 of each year for the preceding fiscal year period; and
(4) Be accompanied by a completed form "Documentation of Expenditure of Non-Federal Funds" (2/2020) for a specific July 1 through June 30 time period which includes an attestation signed and dated by the superintendent stating;
"I hereby certify that all medicaid funds paid to the above named districts under He-W 589, Medical Assistance Services Provided by Educational Agencies for the period July 1, xxxx through June 30, xxxx have been supplemented with LEA/SAU and/or non-federal funds to total 100% of the cost of services rendered and that the medicaid reimbursement does not exceed 50% of the total cost of the services rendered."

Informational Bulletin(s) – Documentation of Expenditure of Non-Federal Funds

1) **When completing the documentation of expenditure of non-federal funds form, do we use the remittance advice (RA) date or the date of the check when counting funds?**

The check date is the date of receipt of Medicaid funds. You can also log onto the provider portal at https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome and access the message center to confirm the payment date.

Source: SFY 2020-03; October 2019; Billing and policy guidance document

Telehealth

Informational Bulletin(s) - Telehealth

1) **Definition:**

Definition of Telehealth and Terms*: Telehealth is the use of telecommunications technologies for remote delivery of medical services. Telehealth is used to facilitate live contact directly between an individual/individual's family and a provider.*

Originating Site*: An originating site is the physical location where the child/child's parent/guardian are located during the telehealth visit. There are no restrictions on location of originating sites. Medicaid payment is not made to the originating site even if the site is other than the child's home/ residence.*

Distant Site*: The distant site is where the Medicaid to School's provider is physically located during the telehealth visit. Providers may render telehealth services from their private residence (remote site) instead of having to come into the school. Confidentiality and privacy protections however still apply. The address on the claim should reflect the address of the billing provider not the address of the performing provider conducting the telehealth service.*

Source: May 2020; NH Medicaid to Schools Supplemental Fact Sheet COVID-19 Preparedness and Response

2) **Eligible Provider Types:**

All services provided via telehealth must be within the provider's professional scope of practice and He-W 589.04. The following provider types are eligible to provide telehealth services:

- Occupational Therapists (OTs)
- Physical Therapists (PTs)
- Speech and Language Pathologists (SLPs)
- Rehabilitation Assistants
- Psychologists
- Board Certified Behavior Analysts (BCBAs)
- School Physicians
- Psychiatrists
- Advanced Registered Nurse Practitioners (APRNs) and Registered Nurses (RNs)
- Licensed alcohol and drug counselors (LADC) and master licensed alcohol and drug counselors (MLADC) per He-W 513
- Psychotherapists and Mental Health Practitioners

Providers who are not recognized as a qualified Medicaid treatment providers, i.e. School Guidance Counselors, are not eligible to receive Medicaid reimbursement for telehealth services. NH Medicaid enrolled providers located and enrolled in another state must get a NH temporary emergency license if they plan on practicing in New Hampshire or offering telehealth to any resident living in New Hampshire the per the COVID-19 Governor's Emergency Order #15. https://www.governor.nh.gov/news-media/emergencyorders/documents/emergency-order-15.pdf

3) **What is Billable?**

Any direct service that would have previously been rendered and Medicaid covered as face-to-face may now be rendered via telehealth. This includes both medical services as well as behavioral health services. Follow up with students on home activities that normally would

have been done face- to- face would be considered direct services. Work that Rehabilitation Assistants are doing remotely in support of students such as sensory exercises, teaching communication skills or other such medically related activities in support of the student's plan of care would be billable. Notification to NH Medicaid to transition an individual from face- to- face direct treatment to telehealth visits is not required.

4) **What is Non-Covered?**
   - Indirect services specifically services that include preparation time for telehealth telecommunications visits are not covered.
   - Supervision of other licensed staff such as OT assistants and ST assistants is not covered.
   - Reimbursement under transportation to deliver medical equipment to students is not covered

5) **Consent for Treatment via Telehealth and Documentation Requirements:**

Verbal consent by the student's parent or guardian to a telehealth visit should be documented in the provider's visit documentation note. Consent may also be obtained via email or text. All other documentation requirements remain in effect.

6) **Telehealth Reimbursement and Billing**

NH Medicaid pays the same rate as if the service was provided face- to- face. Billing for the service delivered should identify the CPT codes typically used for in-person visits with the addition of the GT modifier and place of service 02 (telehealth) to the claim form. The use of the GT modifier and the 02 place of service are for all Medicaid to Schools covered procedure codes both medical and behavioral health. Medicaid is not adopting a different set of procedure codes specific to telehealth.

Please use the current list of billing codes provided by the Bureau of Developmental Services. These codes have been increased by 3.1% effective 1/1/2020. NH Medicaid is not implementing the proposed new codes listed in the draft billing manual discussed in February 2020 until the next 2020-2021 school year.

7) **Key Takeaways**
   - OTs, PTs, SLPs providers may conduct telehealth visits for Medicaid even though Medicare does not recognize these provider types for telehealth services.
   - Applicable State practice acts for non-physician practitioners remain in effect relative to provision of telehealth services.
   - The expansion of telehealth services is not intended to expand the scope of services provided by Medicaid. Services not paid for by Medicaid currently will not be paid for under telehealth.
   - Per guidance issue by the Office of Civil Rights (OCR) eligible telehealth providers may use poplar applications that allow video chats including Apple FaceTime, Facebook Messenger Video chat, Google Handouts video or Skype.
   - Visits with both video and audio are the preferred method of providing telehealth services. However, audio-only services may be billed in the same manner.

If you have questions about this notice, please submit your questions to the Department's Medicaid to Schools mailbox at MTS@dhhs,nh.gov. Further informational bulletins may be issued as telehealth implementation continues during this state of emergency

Source: May 2020; NH Medicaid to Schools Supplemental Fact Sheet COVID-19 Preparedness and Response

8) Telehealth

In administering telehealth services, providers are required to:

- Maintain documentation
- Document consent
- Only medical telehealth services are reimbursable under Medicaid
    - *Ex. Reimbursable nursing care is the medical service authorized for the student. The nurse cannot perform or bill for academic support/remote learning during the medical service.*

Questions about this informational bulletin can be sent to: MTS@dhhs.nh.gov Please reference informational bulletin SFY 2021-02 in the subject line.

Appendix

Exhibit A: Specific State or Federal Statutes the Rule Implements

From: He-W 589 Medical Assistance Services Provided by Education Agencies

Rule	***Specific State or Federal Statutes the Rule Implements***
He-W 589.01	*RSA 171-A:6, RSA 135-C:1; RSA 186-C:25 & 29; RSA 167:3-k*
He-W 589.02	*RSA 171-A:6, RSA 135-C:1, 42 CFR 483.106*
He-W 589.03	*RSA 171-A:6, RSA 135-C:1, 42 CFR 483.106*
He-W 589.04	*RSA 186-C:25; 42 CFR 440.230; 42 CFR 456.3; 42 USC 1936d(r)*
He-W 589.05	*42 CFR 440, Subpart A*
He-W 589.06	*RSA 186-C:25; 42 CFR 447.15; 42 CFR 447*
He-W 589.07	*RSA 171-A:6; RSA 135-C:1, 42 CFR 483.132; 42 CFR 455; 42 CFR 456*
He-W 589.08	*RSA 171-A:6; 135-C:1; 42 CFR 483.132*
He-W 589.09	*RSA 171-A:6; 135-C:1: 42 CFR 483.132*

Exhibit B: Medicaid to Schools Provider Chart

Provider Type	Can Order *Always must be within the scope of practice	Can Supervise (if so, who)	Statute
Advanced Practice Registered Nurse (APRN)	Yes	Yes can supervise the following: LNA LPN LADC (by Psychiatric APRN) Rehab Assistant	RSA 326-B:11, 326-B:14, I; 330-C: 11, II
Audiologist	Yes	No	RSA 137-F:2
Board Certified Behavior Analyst (BCBA)	No	Must meet supervision requirements from the Behavior Analyst Certification Board (BACB) ; Yes can supervise the following: Rehab Assistant or Registered Behavior Technician (RBT)	Federal statute 42 CFR 444.130(c) EPSDT Provisions §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
Certified Recovery Support Worker	No	No	RSA 330-C:13
Clinical Mental Health Counselors (CMHC)	Yes, within the scope of practice can order mental health services	Yes can supervise the following: CSW CMHC Rehab Assistant	RSA 330-A:19 330-A: 18, III 330-A: 19, III 330-C: 11, II
Clinical Social Workers	Yes, within the scope of practice can order mental health services	Yes can supervise the following: CMHC Rehab Assistant	330-C: 11, II RSA 330-A:19, III
Dentist	Yes, can order dental services	Yes can supervise the following: Dental Hygienists Dental Assistants LPN	RSA 317-A:20 RSA 326-B: 2, IX,(b)
Dental Hygienist	No	No	RSA 317-A:21-c
Dietitian	No.	No	RSA 326-H:6
Licensed Alcohol and Drug Counselor (LADC)	No, only MLADC can order (*see* below)	No	RSA 330-C:11, II
Licensed Nursing Assistant (LNA)	No	No	RSA 326-B:14

Source: https://www.dhhs.nh.gov/ombp/medicaid/mts/documents/mts-provider-order-chart.pdf

Appendix

Provider Type	Can Order *Always must be within the scope of practice	Can Supervise (if so, who)	Statute
Licensed Practical Nurse (LPN)	No	Yes can supervise the following: LNA Rehab Assistant	RSA 326-B: 2, IV; RSA 326-B:13 RSA 326-B: 14
Master Licensed Alcohol and Drug Counselor (MLADC)	Yes, for alcohol and drug counseling services	Yes can supervise the following: LADC	RSA 330-C:10; RSA 330-C: 11, II
Medication Nursing Assistant (MNA)	No	No	RSA 326-B:2, VI;
Occupational Therapist	Yes, for services to individuals with non-medically related conditions to provide prevention, wellness, and education services Cannot order for services to individuals with medically related conditions. Requires an order from a physician, physician assistant, chiropractor, APRN, optometrists, or any other qualified health care professional who is authorized to order health care services.	Yes can supervise the following: Occupational Therapy Asst. Rehab Assistant	RSA 326-C:1, II, IV
Occupational Therapy Assistant	No	No	RSA 326-C:1, IV
Optometrist	Yes	No	RSA 327:1, IV
Physical Therapist	Yes, can order physical therapy services	Yes can supervise the following: Physical Therapist Assistant Physical Therapy Aides Rehab Assistant	RSA 328-A:2, VII, VIII, X
Physical Therapist Assistant	No	No	RSA 328-A:2, VIII, X
Physical Therapy Aide	No	No	RSA 328-A:2, X
Physician	Yes, within the scope of their practice	Yes can supervise the following: Physician Assistants LPN RN Rehab Assistant	RSA 329:1

Source: https://www.dhhs.nh.gov/ombp/medicaid/mts/documents/mts-provider-order-chart.pdf

Provider Type	Can Order *Always must be within the scope of practice	Can Supervise (if so, who)	Statute
Physician Assistant (PA)	Yes, as delegated by the supervising physician	No	RSA 328-D:1
Psychiatrist	Yes	Yes can supervise the following: PA, and Rehab Assistant	RSA 135-C:2. RSA 135-C: 51
Psychologist	Yes, for psychology services	Yes can supervise the following: Rehab Assistant	RSA 329-B:2, IX
School Psychologist-Doctoral or School Psychologist-Specialist	Yes, for psychology services	Yes can supervise the following: Rehab Assistant	RSA 329-B:15-a
Psychotherapist	No	Yes can supervise the following: Rehab Assistant	RSA 329-B:2, XI
Recreational Therapist	Yes, for services to individuals with non-medically related conditions to provide prevention, wellness, and education services. Cannot order for services to individuals with medically related conditions	No	RSA 326-J:1, II
Registered Nurse (RN)	No	Yes can supervise the following: LNA, and LPN Rehab Assistant	RSA 326-B: 2, IV; RSA 326-B:13, I RSA 326-B: 14, I
Rehabilitative Assistant	No	No	He-W 589.04(ag)
Respiratory Care Practitioner	No	No	RSA 326-E:4
Speech Language Pathologist	Yes	Yes can supervise the following: Speech Language Assistant Rehab Assistant	RSA 326-F:1, II-a, III
Speech Language Assistant	No	No	RSA 326-F:1, II-a

Source: https://www.dhhs.nh.gov/ombp/medicaid/mts/documents/mts-provider-order-chart.pdf