RHODE ISLAND MEDICAID DIRECT SERVICES GUIDEBOOK FOR LOCAL EDUCATION AGENCIES (LEAs)

RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
September 2014

TABLE OF CONTENTS

IX. ADDENDA

I. INTRODUCTION

The Executive Office of Health and Human Services has developed provider manuals for all Medical Assistance Providers. This is a revision and replaces the Medicaid Direct Services Guidebook developed August 1, 2010, which replaces the Guidebook issued May 2008. Copies of this Guidebook, including Direct Services as well as Administrative Claiming are available on the EOHHS web site at:
http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/LocalEducationAgency.aspx

Highlights in the Guidebook include:

- **Background:** This section contains the RI General Law 40-8-18, Medicaid Overview, and the Role of Special Education.
- **Enrollment Information:** This section contains information about enrolling in the Medical Assistance Program, including the Medicaid Management Information System's (MMIS) Eligibility Verification and Medicaid Matching System.
- **Direct Service Claiming:** This section explains the basic standards required for HP ENTERPRISE SERVICES' (RI Medicaid Fiscal Agent) processing of billing forms, claim form completion, and claims reconciliation.
- **Services – Definitions and Record Keeping Guidelines:** This section contains information about services available for reimbursement by LEA providers.
- **Addenda:** This section contains additional information and forms.

The purpose of this guide is to assist Local Education Agencies (LEAs) in Rhode Island to enroll, implement and maintain a Medicaid reimbursement program for services provided by or for a Local Education Agency. The intent is to clarify the roles and responsibilities of the various school personnel involved in the direct services reimbursement program. These personnel include administrators, direct service providers and support staff. Responsibilities include: meeting all Medicaid documentation requirements; submitting the Certification of Local Funds on a quarterly basis; signing provider agreements; maintaining all other records used to support claims submitted for Medicaid reimbursement; and implementing self-audit procedures to ensure program integrity.

The content of the Guidebook includes: Medicaid provider enrollment; service definitions; provider qualifications; documentation guidelines; claim submittal information (including diagnosis and procedure codes used for claiming); claim reconciliation information; eligibility verification; and other policies and regulations affecting the program e.g., the Individuals with Disabilities Education Act (IDEA) Part B, the Rhode Island Board of Education Regulations Governing the Education of Children with Disabilities, the Family Educational Rights and Privacy Act (FERPA) the Health Insurance Portability and Accountability Act (HIPAA); and all provisions relative to the responsibilities of a Medicaid provider pursuant to Title XIX of the Social Security Act.

Common Acronyms

ACA:	Affordable Care Act
ADL:	Activities of Daily Living
AT:	Assistive Technology
CEDARR:	Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation
CIS:	Children's Intensive Services
CMS:	Center for Medicare and Medicaid Services
COTA:	Certified Occupational Therapy Assistant
CSHCN:	Children with Special Health Care Needs
DCYF:	Department of Children, Youth & Families
EDI:	Electronic Data Interchange
EOHHS:	Executive Office of Health and Human Services
EPSDT:	Early and Periodic Screening, Diagnostic, and Treatment
FAPE:	Free Appropriate Public Education
FERPA:	Family Educational Rights and Privacy Act
FFP:	Federal Financial Participation
HBTS:	Home Based Therapeutic Services
HIPAA:	Health Insurance Portability and Accountability Act
IADL:	Instrumental Activities of daily living (p. 53)
IDEA:	Individuals with Disabilities Education Act
IEP:	Individualized Education Program
IFSP:	Individual Family Service Plan
JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
LEA:	Local Education Agency
LRE:	Least Restrictive Environment
MA:	Medical Assistance
MHRH:	Mental Health Retardation and Hospitals
MMIS:	Medicaid Management Information System
NPI:	National Provider Identifier (part of the HIPAA 1996 requirements)
OT:	Occupational Therapy
PASS:	Personal Assistance Services & Supports
PES:	Provider Electronic Software
PHI:	Protected Health Information
PT:	Physical Therapy
PTA:	Physical Therapist Assistant
RA:	Remittance Advice
RIDE:	Rhode Island Department of Elementary and Secondary Education
RIGL:	Rhode Island General Law
SHL:	Speech, Hearing and Language
SLP:	Speech and Language Pathologist
SSA:	Social Security Administration
SSI:	Supplemental Security Income
TPA:	Trading Partner Agreement
TPL:	Third Party Liability

II. BACKGROUND

A. Rhode Island General Law 40-8-18

Congress has allowed schools and school districts to submit claims for federal reimbursement from state Medicaid programs for certain services since 1989. The State of Rhode Island enacted Rhode Island General Law (RIGL) 40-8-18 in 1992 (Addendum A). As amended in 2000, this general law enables LEAs to enroll as Early and Periodic Screening Diagnosis and Treatment (EPSDT) Providers with the Rhode Island Medical Assistance Program. Enrolling as a Medicaid provider allows an LEA to submit claims to receive the federal match for services provided within its programs and as identified through the special education process by the development and implementation of Individualized Education Programs (IEPs) to children who are Medicaid eligible. Since 2000, LEAs are also able to participate in Administrative Claiming, which allows them to draw down the federal funds for activities supporting the administration and outreach of the Medical Assistance Program.

Key Provisions of RIGL 40-8-18 include:

- Enrollment as a provider is voluntary
- LEAs include school districts, regional school districts, Public Charter Schools and The Metropolitan Career and Technical Center (The Met)
- Medicaid reimbursement is possible for certain direct services
- Medicaid reimbursement is possible for some administrative activities
- Payments made to the LEAs shall be used solely for educational purposes
- Federal funds must supplement, not supplant, local maintained fiscal effort to support education
- LEAs must comply with all provisions relative to the responsibilities of a Medicaid provider pursuant to Title XIX of the Social Security Act
- LEAs must provide the local/ state match through the certification of local funds in order to receive Federal Medicaid reimbursement for direct services

In addition, LEAs must review how services are funded before they submit claims for reimbursement and must follow these federal guidelines:

LEAs provide the state/local matching funds to support reimbursement from the federal Medicaid program. These matching funds cannot be federal funds; they must be of state or local origin or are federal funds authorized by Federal law to be used to match other federal funds. (42CFR 433.51)LEAs cannot submit claims for Medicaid reimbursement if the service or the service provider is paid through IDEA funds.

B. Medicaid

Medicaid is a Federal/State assistance program established in 1965 as Title XIX of the Social Security Act. State Medicaid programs are overseen by the Centers for Medicare and Medicaid Services (CMS) within the United States Department of Health and Human Services. State Medicaid programs are administered by each individual state to assist in the provision of medical care to children and pregnant women, and to needy individuals who are aged, blind, or disabled. [1] The federal and state governments jointly fund state Medicaid programs.

Medicaid programs pay for services identified in a plan, called the Medicaid State Plan, some of which are mandated by the Federal government and others that are optional and determined to be covered by each state. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The EPSDT program consists of two mutually supportive, operational components:

(1) assuring the availability and accessibility of required health care resources;

(2) helping Medicaid recipients and their parents or guardians effectively use these resources.[2]

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to seek out eligible recipients and inform them of the benefits of prevention and the health services and assistance available, and to help them and their families use health resources. It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.[3]

For more information, refer to CMS' June 2014 EPSDT Guide:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

Medicaid recipients usually pay no part of the cost of covered medical expenses, although a small co-payment is sometimes required. Medicaid eligibility is limited to individuals who fall into specified categories. The federal statute identifies over 25 different eligibility categories for which federal funds are available. These categories can be classified in six broad coverage groups:

- Children;
- Pregnant women;
- Adults in families without dependent children (The Affordable Care Act Medicaid expansion).
- Adults in families with dependent children;

- Individuals with disabilities;
- Individuals 65 or over.[4]

Medicaid should not be confused with **Medicare**, which is a Federal insurance program also administered by CMS. Medicare primarily serves people over 65, whatever their income. However, some categories of younger people who are disabled and dialysis patients may be eligible for Medicare.[5]

For more information about Medicaid, please refer to:
www.medicaid.gov or
www.eohhs.ri.gov
www.eohhs.ri.gov/Consumer/FamilieswithChildren.aspx

For more information about Medicare, please refer to:
www.medicare.gov

C: Medicaid in Rhode Island

The Medicaid Program in Rhode Island is called the Rhode Island Medical Assistance Program. Families and children in Rhode Island may become eligible for Medicaid by applying for coverage through the following: RIte Care, RIte Share, Supplemental Security Income (SSI), Katie Beckett or Adoption Subsidy. The majority of children covered by Medicaid are enrolled in a Managed Care Program through RIte Care, or through RIte Share. Most Children with Special Health Care Needs (CSHCN) receive their coverage through eligibility from SSI, Katie Beckett or Adoption Subsidy.

For more information, www.eohhs.ri.gov/Consumer/FamilieswithChildren.aspx

Services provided by LEAs through their special education programs will not cause other medically necessary services to be denied because special education services are provided in the Medicaid fee-for-service program. LEAs can therefore seek Medicaid reimbursement directly from the Rhode Island Medical Assistance Program. However, there should be coordination between a child's primary care physician/provider and the services provided by the LEA. Also important to note, that the reimbursement accessed by the LEAs *does not (with one potential exception) impact the family* because there is no additional cost to any family in terms of co-pays, premiums or lifetime service caps when LEAs submit claims to the Medical Assistance Program for services provided to eligible children. (Refer to Addendum R: IDEA Consent for Public Insurance)

LEAs should coordinate assistive technology (AT) device reimbursement with EOHHS to ensure that if an LEA submits a claim for an AT device, this will not impair the family's ability to access the device. If it will impact the family's ability to access the device through the child's Medicaid benefit, then the LEA should not submit a claim for reimbursement for that device.

LEA staff may assist families with applications for Medical Assistance (MA). These activities can be documented for those districts participating in the time studies used for Medicaid

Administrative Claiming. The following are broad guidelines for school district staff to use when helping a family apply for MA:

(1) **RIte Care**: Eligibility is based on family income and is available for families who do not have insurance coverage. Refer by calling the Information Line at (401) 462-5300 or by calling the local EOHHS offices (Addendum B) or download an application for RIte Care from the EOHHS web site at http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/FamilieswithChildren.aspx

(2) **RIte Share**: Families whose income falls within certain federal guidelines and who have access to employer-sponsored insurance may be eligible for RIte Share. For more information, call the RIte Share Information line at (401)462-0311or download an application at http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/FamilieswithChildren.aspx

(3) **SSI:** Eligibility is based on the child's disability *and* the family's income for children aged birth to 18 years old. Eligibility for youth 18 years and older is based on youth's disability and youth's income and assets. To initiate an application or for more information call the Social Security Administration (SSA) at 1-800-772-1213, call a local SSA office (Addendum C) or refer to the Social Security web site at http://www.socialsecurity.gov/applyfordisability/

(4) **Katie Beckett:** Eligibility for children birth through 18 is based on a child's income and resources, disability and level of care.

For help with the application process, contact the EOHHS Katie Beckett Unit Social Caseworker at (401) 462-0760.
For clinical questions; contact EOHHS Public Health Nurse Consultant at (401) 462-6364.
For General Information, contact the EOHHS Info Line at (401) 462-5300.
For more information; refer to the EOHHS website at:
http://www.eohhs.ri.gov/Consumer/PeoplewithSpecialNeeds.aspx

(5) **Adoption Subsidy:** Children in Adoption Subsidy may qualify for RIte Care or RIte Share. The adoption subsidy program is administered through the Department of Children Youth and Families. For more information, please contact: (401) 528-3676.
For more information; refer to the DCYF website at:
http://www.dcyf.ri.gov/adoption.php

(6) **Health Source RI (the RI Health Care Exchange):** For families that are uninsured or may qualify for Medicaid, refer to RI's Health Care Exchange. The intake process through Health Source RI will screen applicants for Medicaid eligibility and will be able to advise individuals and families about the health insurance coverage available to them. www.healthsourceri.com/
1-855-840-HSRI (4774).

D: The Role of Special Education

IDEA Part B authorizes Federal funding to states in order to ensure that children aged 3-21 eligible for special education and related services receive a free appropriate public education (FAPE). FAPE is defined as the provision of special education and related services at no cost to the parents. FAPE however, does not relieve "an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a child with a disability."[6]

- Special Education is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education. Special education includes each of the following speech-language pathology services, or any other related service, if the service is considered special education rather than a related service under State standards; travel training; and vocational education."[7]

- Related services are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools and parent counseling and training. [Exception as noted §300.34 (b) regarding cochlear implants.] "[8]

LEAs must prepare an Individualized Education Program (IEP) for each child eligible, specifying all special education and related services needed by the child and annually review the IEP. For children transitioning from Early Intervention, through age 5, an Individualized Family Service Plan (IFSP) that meets IEP requirements may be used to meet these requirements [Section 300.323 (b) of IDEA].

The IEP team for each child with a disability must include: the parents of the child; not less than one regular education teacher of the child (if the child is, or maybe, participating in the regular education environment); not less than one special education teacher of the child, or where appropriate, not less than one special education provider of the child; a representative of the public agency who is qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities, and is knowledgeable about the general education curriculum, and is knowledgeable about the availability of resources of the public agency and has the authority to commit these resources; an individual who can interpret the instructional implications of evaluation results, who may be a member of the team described already; at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; and whenever appropriate, the child with a disability.

Beginning at age 14, the LEAs must invite the child with a disability if the purpose of the IEP meeting is to discuss post-secondary goals. LEAs must invite, with parental permission or student permission (if at age of majority), a representative of any participating agency that is likely to be responsible for providing or paying for transition services. [9]

The IEP details the specific special education and related services that are to be provided to the child. Each IEP must include a description of how the child's progress will measured and when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided.[10]

Documentation of services in the IEP is an important component of Federal Medicaid requirements, the development of the IEP and the provision of special education and related services are guided by the application of the Individuals with Disabilities Education Act (IDEA) and the Rhode Island Board of Education Regulations Governing the Education of Children with Disabilities. In developing the IEP, the team should focus on the RI Common Core State Standards and other standards of the general education curriculum that all students, including students with disabilities, are required to meet. For more information on the IEP please visit; www.ride.ri.gov/StudentsFamilies/SpecialEducation/IEPIndividualEducationProgram.aspx.

A state Medicaid program can pay for those health-related services that are specified in the Federal Medicaid statute, as identified by the IEP Team and documented in an IEP, and determined to be medically necessary by the state Medicaid agency.[11] The Centers for Medicare and Medicaid Services (CMS) require that services submitted for reimbursement by Medicaid must be documented in the IEP, CMS does not dictate where or how these services need to be documented in the IEP.

The Rhode Island Executive Office of Health and Human Services utilizes the following definition for medical necessity/medically necessary:

> "Medical, surgical or other services required for the prevention, diagnosis, cure or treatment of a health-related condition, including such services necessary to prevent a decremental change in either medical or mental health status." Within federal and state Medicaid program requirements regarding allowable services and providers, LEAs can seek reimbursement from the Medicaid program for these health-related services when provided to children enrolled in Medicaid. [12]

Before accessing Medicaid reimbursement, the LEAs must obtain written, informed parental consent in adherence with the requirements of the RI Board of Education Regulations Governing the Education of Children with Disabilities §300.154 (d) (2) (iv) (A). (http://www.ride.ri.gov/StudentsFamilies/SpecialEducation/SpecialEducationRegulations.aspx) For a sample copy of the IDEA Parental Consent to Access Public Benefits or Insurance e.g. Medicaid, please visit: http://www.ritap.org/medicaid/idea-parental-consent-access-public-benefits-or-insurance-eg-medicaid.

III. LEAs ENROLLING AS AN EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) PROVIDER

A. Local Governing Authority Approval

It is recommended that the local governing authority of each LEA approve its enrollment as a provider because the receipt of Medicaid funds has fiscal impact. The local governing authority can include the school committee, selectmen, town council, or a Board of Directors.

B. The Rhode Island Executive Office of Health and Human Services/Local Education Agency Interagency Provider Agreement

In order to enroll as Medical Assistance providers, LEAs must complete, sign and return two original copies of the EOHHS/LEA interagency provider agreement. Upon receipt of the two original signed copies, the Director of the Executive Office of Health and Human Services signs each copy and then returns one completed copy to the LEA and maintains one completed copy for its records. This is a multi-year provider agreement and when it expires, two original copies of a new EOHHS/LEA Interagency Provider Agreement will be sent to each LEA for completion and return to EOHHS following the process described above. Copies of the Provider Agreement, both unsigned and signed, are available from EOHHS by contacting Jason Lyon at *(401) 462-7405 or* Jason.Lyon@ohhs.ri.gov

C. Certification of Funds Requirement

The LEAs provide the state/local match for all Medicaid direct service claims submitted for approval and receive the federal financial participation (FFP) rate for each claim approved. In order for LEAs to draw down this federal match, they must submit Certification of Funds letters quarterly in accordance with the EOHHS/LEA Interagency Provider Agreement. The FFP is subject to change each federal fiscal year and is in effect for the period between October 1 and September 30 for each year.

The Certification of Funds letter must state that the LEA certifies that there are sufficient state/local and/or private money being used as a match for the Federal Medicaid reimbursements. A sample Certification of Funds letter is in Addendum K. Each LEA must submit a Certification of Funds letter for the following dates:

March 31	September 30
June 30	December 31

D. HP ENTERPRISE SERVICES Provider Enrollment Process

1. Provider Enrollment Packet

HP ENTERPRISE SERVICES (HP) is the fiscal agent for EOHHS and its Medical Assistance Program. HP is responsible for the enrollment, assignment of provider numbers, claims processing and reconciliation for all RI Medical Assistance Providers.

HP ENTERPRISE SERVICES can be reached by calling:

- 1-401-784-8100 for local and long distance calls
- 1-800-964-6211 for in-state toll calls or border community calls
- Or by accessing its website https://www.eohhs.ri.gov/secure/logon.do

Some of the information LEAs can request from HP ENTERPRISE SERVICES includes:

- Provider Enrollment Packet (including LEA Linkage Form)
    - Provider Application
    - Provider Agreement form
    - Provider Disclosures
    - Provider Exclusion Letter
    - W-9 Form
    - Trading Partner Agreement Form (TPA)
    - Provider Addendum G – The Glossary
    - Electronic Funds Transfer (EFT) Form.
- Electronic Data Interchange Trading Partner Agreement (TPA)
- A copy of the HIPAA compliant Provider Electronic Solutions Software (PES)

The Medicaid Direct Services Guidebook for Local Education Agencies Available on the EOHHS web site at http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/LocalEducationAgency.aspx

The provider enrollment packet must be submitted to HP ENTERPRISE SERVICES and approved by EOHHS *before* an LEA submits claims for reimbursement. HP ENTERPRISE SERVICES will enroll each LEA, utilizing the National Provider Identifier (NPI) number assigned by the NPI Enumerator. LEAs will need two NPI provider numbers; one to be used for district employees; and one to be used for contracted providers.

The National Plan and Provider Enumeration System (NPPES) is the contractor hired by CMS to assign and process the NPIs, to ensure the uniqueness of the health care provider, and generate the NPIs. Providers can apply at the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

- **Individual Provider Number** is used as the billing provider number to claim services provided by individuals employed by the LEA.
- **Group Provider Number** is used as the billing provider number to claim services provided by individuals contracted by the LEA. In addition, LEAs must include the performing provider number for the provider that actually

provided the service in the appropriate field on the claim.

2. LEA Linkage Process and Linkage Form

In order to identify those services that are provided by staff employed by the LEA and those provided by contracted providers, each LEA should use its individual provider number to claim services provided by district employees and should use its group number to claim services provided by contracted individuals or agencies. In addition to using its group provider number for contracted services, each LEA must include an assigned performing provider number for the contracted entity.

If an LEA contracts with any service provider, including a day or residential program, and wants to seek reimbursement for these or any contracted services, then the LEA needs to initiate the enrollment and/or linkage of the contracted provider. To accomplish this, both the LEA and the contracted provider need to complete the LEA Linkage Form (Addendum J). The new linkage form has fields for the NPI and taxonomy of the contracted provider. These are required fields. Linkage forms will be returned unless the NPI and taxonomy are complete. In addition to the LEA Linkage form the provider must also attach a copy of the original CMS approval letter establishing the NPI.

The Linkage form has two purposes: (1) it enrolls and assigns performing provider numbers to providers who are contracted by LEAs to provide services and (2) it links the performing provider to the LEA's group provider number. LEAs and their contracted provider must complete this form before the LEA submits claims for services provided by the contracted provider. It is not necessary for LEAs to enroll its employees.

While it is permissible to photocopy the form and fill in standard information, the signatures must be original and the form must be dated. Any forms submitted without original signatures or improperly dated will not be processed. In addition to the LEA Linkage Form, the provider must also attach a copy of the original CMS approval letter assigning the NPI.

3. Electronic Data Interchange Trading Partner Agreement (TPA)

Effective October 16, 2003, all Medicaid providers, including LEAs, must utilize HIPAA compliant software. Providers in Rhode Island may use HP ENTERPRISE SERVICES' free software, Provider Electronic Solutions (PES), or software that has completed HIPAA compliance testing with HP ENTERPRISE SERVICES. Another component for HIPAA compliance is an Electronic Data Interchange (EDI) Trading Partner Agreement.

Each billing provider, clearinghouse, or billing service that directly exchanges electronic data with HP ENTERPRISE SERVICES **must** complete and sign the Trading Partner Agreement (TPA). Once an LEA forwards a TPA to HP ENTERPRISE SERVICES, HP ENTERPRISE SERVICES will then forward an identification number and password to be used to access information on the EOHHS web portal. The web portal can be utilized

to send claims, receive remittance advices, verify recipient eligibility, check on claims status, check the message center and to verify remittance payment.

An LEA must list its Individual *and* Group Billing Provider numbers on its TPA. RI Medicaid providers who utilize a Third Party (a billing company) to exchange data with HP ENTERPRISE SERVICES, must identify the transactions that the Third Party is authorized to perform on their behalf, and indicate consent by an authorized signature on the TPA.

If an LEA contracts with a billing company that will share or receive information electronically with HP ENTERPRISE SERVICES, then the billing company needs to complete a TPA and the LEA needs to sign it in the appropriate place. It is possible that an LEA, a billing company or both will have a signed TPA on file with HP ENTERPRISE SERVICES. If you have any questions about completing the TPA, please contact the HP ENTERPRISE SERVICES Coordinator at (401) 784-8014.

LEA Instructions for Completing a Trading Partner Agreement

Original signatures are required on any TPA sent to HP ENTERPRISE SERVICES. Photo copied or faxed agreements *will not* be accepted. Information for completing the TPA:

- Page 1 (Provider's Full Name): fill in the name of the LEA (trading partner)
- Page 2 (2.2): fill in the LEA's (trading partner's) information
- Page 6(6.1): Please check one if the LEA will be submitting claims or leave blank if the LEA is just signing up for eligibility verification
- Page 6 and 7 (Check off all that apply): LEAs or their billing companies can check off the following:

Yes	Eligibility Search
Yes	Claim Status Search
Yes	Remittance Advice (RA) on the Web

Yes	837 Professional	Yes*	277 Unsolicited Claim Status
N/A	837 Institutional	Yes	999 Functional Acknowledgement
N/A	837 Dental	Yes*	835 Remittance Advice
Yes	270 Eligibility Inquiry	Yes	271 Eligibility response
Yes	276 Claim Status Inquiry		
N/A	NCPDP 5.1 Batch		

*Only one entity per provider may receive the electronic version of the 277 Unsolicited Claim Status (pended claims reports) and the 835 Remittance Advice.

LEAs that contract with a billing company to submit claims need to decide if the LEA *or* the billing company will have access to the electronic remittance advice and pended

claims reports. If the billing company will have access to this information, then the TPA filled out by the billing company will have these items checked off. HP ENTERPRISE SERVICES will continue to provide a PDF version of the Remittance Advice.

LEAs utilizing billing companies, may want to execute a TPA for eligibility verification capabilities. LEAs that want their billing company to perform this function must complete the TPA and check off 270 Eligibility Inquiry and 271 Eligibility Response.

- Page 7: (Specify software) Unless the LEA or its billing company has created or purchased new HIPAA compliant software, the Provider Electronic Solutions should be checked
- Page 7: Method of transmission: The LEA needs to list any and all methods of transmission for the activities, e.g., Internet, website, modem, or DSL
- Page 7: list the person who should be contacted if there is a problem with an electronic claim being transmitted
- Page 7: for LEAs with two billing numbers, please list the assigned group provider number and the assigned individual provider number separately. An LEA must sign the authorized signatures in the section, *even if* the LEA contracts with a billing company to submit its claims
- Page 7: the trading partner, the LEA or its billing company, must sign here

E. Eligibility Verification

Medicaid Providers can verify Medicaid eligibility through the EOHHS web portal or the HP Customer Service Help Desk. An enrollment verification number for that date of service is provided which should be maintained by LEAs as proof for eligibility on that date.

EOHHS Web Portal Eligibility Verification System

Providers who want to utilize the EOHHS web portal to verify recipient eligibility must complete a Trading Partner Agreement with HP ENTERPRISE SERVICES through the portal. To access the web, providers need to use an assigned Identification (ID) number and password, and know the recipient's Medical Assistance ID (MID) number, usually a social security number. Eligibility verification on the web portal may be accessed for a recipient up to 365 days from the date of service. If a provider's current TPA does not include eligibility verification, it can submit a Trading Partner Agreement ID Change/Add Form to add eligibility verification.

To access the EOHHS web portal eligibility verification system providers need to:

- Complete a TPA and select Eligibility Search
- Receive a Trading Partner ID and password from HP ENTERPRISE SERVICES
- Access the EOHHS web site at: https://www.eohhs.ri.gov/secure/logon.do
- Enter their Trading Partner ID and password
- Choose from the list of options that appear (these will vary and depend on those selected on the TPA)
- Select "Eligibility"

Other enhancements available to providers on the EOHHS web site include:

- Claim Status (the information contained on the Remittance Advice, which is processed two times a month)
- Prior Authorization Status
- Remittance Advice Amount
- Message Board
- National Drug Code (NDC) list (pharmacy providers)

HP Customer Service Help Desk

In addition to our on-line assistance, Representatives from the RI Medicaid Customer Service Help Desk (CSHD) are dedicated to answering your inquiries on the above topics or other various questions.

To expedite your calls on eligibility and claim status, please have your information readily available:

- National Provider Identifier (NPI) or Medicaid Provider Legacy Number
- Client Medicaid ID
- Date of Service for your inquiry

The Medicaid Customer Service Help Desk is available Monday-Friday from 8:00 AM to 5:00 PM. The local and long-distance number is (401) 784-8100 and the in-state toll call and border community number is 1-800-964-6211.

F. Medicaid Matching System

In March 2004, HP ENTERPRISE SERVICES began a process that provides LEAs or their billing agencies the Medical Assistance Identification Number of identified students. This process is provided 3 times per year in March, July, and November. LEA's interested in participating in the data match are required to submit files by the 15th of March, July and November. HP ENTERPRISE SERVICES then processes and returns the information to the LEA by the end of the same month. If an LEA misses a month in the cycle then the LEA needs

to wait until the next request date to submit information to HP ENTERPRISE SERVICES.

In order to access information from HP ENTERPRISE SERVICES to provide a Medicaid match for eligible students, an LEA must have a signed provider agreement on file with EOHHS as well as having up to date certification of funds letters on file with EOHHS. The Data Match is used to provide LEAs with the Medical Assistance Identification Number of Medicaid eligible students; however, this does not guarantee eligibility. Each LEA is responsible for verifying student eligibility for Medical Assistance coverage for the date of service of each claim submitted for reimbursement. Eligibility can be verified using Web Eligibility Inquiry System processes described in section E-"Eligibility Verification".

Instructions for submitting data for a data match, to be provided up to three times a year:

On a CD or encrypted email, format the following information in a password protected comma or tab-delineated text file:

- Recipient Last Name
- Recipient First Name
- Recipient Initial
- Date of Birth (ccyymmdd format)
- Town Code (If needed back in HP ENTERPRISE SERVICES data match file)

Important data formatting requirements:

- Data should be in the order listed above
- Do not include periods, commas, or hyphens, etc. in the names
- Do not include column names in the file
- Please provide the names in uppercase letters

HP ENTERPRISE SERVICES processes the file against the Medicaid Management Information System (MMIS) recipient data evaluating each record for an exact match based on recipient first name, last name, and date of birth. For each record with a match, the following information is written to a text file and returned to the submitter by encrypted email:

- Recipient Last Name
- Recipient First Name
- Recipient Initial
- Date of Birth (ccyymmdd format)
- Code (from input file)
- Social Security Number

For more information about this process, please contact Karen Murphy at HP ENTERPRISE SERVICES by calling at (401) 784-8004 or by e-mailing at: karen.murphy3@hp.com.

G. Reference Materials

Visit the EOHHS website for Billing and Program Information:
http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation.aspx

- **Program Information:** Refer to the E-Learning Center for general information about the Medical Assistance Program, including provider and recipient information
- **General Billing Information: :** Refer to the Billing and Claims page for the basic standards required for HP ENTERPRISE SERVICES' processing of billing forms
- **Claim Preparation Instructions:** Refer to the Billing and Claims page for claim form completion instructions for specific provider types

IV. DIRECT SERVICES CLAIMING

A. Free Care Principle

An important requirement within Medicaid is the issue of free care. Under the free care principle, Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. An important exception to the free care requirement is services provided through IDEA. Section 1903 (c) of the Social Security Act prohibits the Department of Health and Human Services from refusing to pay or otherwise limit payment for services provided to children with disabilities that are funded under the IDEA through an IEP or IFSP.[13]
LEAs are able to submit claims for reimbursement from Medical Assistance for Medicaid beneficiaries even though they do not charge for services provided through Special Education. Although services are exempt from the free care rule, LEAs still need to pursue any liable third party insurers.[14]

B. Third Party Liability (TPL)

Under Medicaid law and regulations, Medicaid is generally the payer of last resort. A third party is any individual, entity or program that is or may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services. Congress intended that Medicaid pay for health care only after a beneficiary's other health care resources were accessed.[15]

Even though services provided through IDEA are exempt from the free care principle, LEAs must comply with TPL policies. What this means for LEAs in Rhode Island, is that districts or their billing companies must submit claims to third party insurers for those children with other insurance coverage. If the district receives a denial of payment from the third party insurer for the claim, then the district or its billing company can submit the claim to HP ENTERPRISE SERVICES for payment. There are exceptions to the provisions of Medicaid as the payer of last resort that allows Medicaid to be the primary payer to another Federal or Federally funded program and these include Medicaid-covered services listed on a Medicaid eligible child's IEP/IFSP. Medicaid will pay primary to IDEA.[16]

Federal regulatory requirements for third party liability (TPL) are explicated in Subpart D of 42 CFR 433. It should be noted that Section 433.139 (c) provides: "If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule."

C. Claims Preparation Activities

1. Pre-Claiming Activities

Once an LEA has enrolled as a provider, it should consider the following activities prior to submitting a claim:

- Designate a person responsible for overseeing Medicaid activities which include:
  - Formatting and submitting Data Match requests to HP to verify Medicaid eligibility
  - Creating provider log forms
  - Providing staff training
  - Completing LEA/OHHS Provider Linkage Forms and returning to HP ENTERPRISE SERVICES for processing
  - Verifying student Medicaid eligibility (through Web Portal)
  - Verifying student attendance for dates of services claimed
  - Creating a system for filing and securing records
  - Identifying reimbursable services through IEP reviews
  - Verifying the student's primary special education disability to use as the diagnosis on claims
  - Establishing a system for log collection
  - Requesting tuition breakdown from day and residential program providers (for more detailed information refer to pages 46-49)
  - Requesting monthly attendance reports from day and residential program providers
  - Obtaining informed parental consent to access Medicaid funds pursuant to IDEA and RI Regulations
  - Submitting Quarterly Certification of Funds letter to the State Medicaid Agency
  - Reviewing claims documentation periodically
  - Reviewing Remittance Advice to track claims activity and respond accordingly
  - Participating in Medicaid reviews/audits conducted by state or federal officials

- LEAs may choose to contract with a billing company that will provide some or all of these activities

2. Use of Billing Companies

LEAs that contract with billing companies to submit claims on their behalf should be aware that the LEA is liable for those claims submitted by the billing company. Please note the following taken from the Rehabilitation Provider Manual:

> "Providers [LEAs] using billing companies for Electronic Media Claims (EMC) or hardcopy claims must ensure that the claims are handled properly. HP ENTERPRISE SERVICES processes claims received from billing companies according to the same policies applied to claims prepared under the direct supervision of the provider. This includes policies on the timely submission of claims. Accuracy of information and timely submission are the provider's [LEA's] responsibility."

3. Record Keeping Requirements

LEAs must adhere to record keeping requirements prescribed by the Executive Office of Health and Human Services in conjunction with the Centers for Medicare and Medicaid Services (CMS) for the records used to support a Medicaid claim. *LEAs should refer to* ***Addendum D****: "Medicaid Self-Audit Matrix" and* ***Addendum L****: "Provider Log Guidelines"* for more detailed information about proper documentation for each service. LEAs must adhere to the State of Rhode Island record retention schedule that requires LEAs to maintain Medicaid reimbursement records for 10 years.[17]

LEAs are responsible for maintaining all required documentation for each claim submitted. The types of documentation needed to support Medicaid claims includes, but is not limited to:

- Primary Special Education Disability
- Individualized Education Programs (IEPs)
- Procedure/activity note (encounter note)
- Progress notes
- Provider logs or contact sheets
- Student attendance records
- Provider Certification/Licensure
- Evaluations
- Individualized Health Plans (nursing services)
- Treatment or care plans (Expanded Behavioral Health and case management)
- Yearly tuition breakdown for day and residential programs
- Invoices (assistive technology devices, day or residential treatment programs, contracted services…)

4. Provider Log Guidelines

The following is intended to guide in the development, dissemination and collection of provider logs used by Local Education Agency staff and/or contracted personnel. The purpose of these logs is to provide the basis for submitting a claim to the Medical Assistance Program for the services provided to students. For a sample log, refer to **Addendum L**. Provider logs for physical therapy, occupational therapy, speech and language therapy and counseling services may be generated from the Special Education Census maintained by each LEA. *Refer to the sample log and instructions for logs generated from the census are in* ***Addendum L****, "Special Education Census Generated Provider Logs".*

Provider Log Recommendations:

- Create user-friendly log sheets with instructions
- Include staff in the design process

- Establish cycle for logs submitted electronically or returned to central office (daily, weekly, monthly, quarterly…)
- Provide staff training for completing logs, including written instructions
- Decide how to file the logs e.g., by service provider, by service, by student records
- Use individual student logs in adherence to confidentiality requirements of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA)

Minimum *information required by EOHHS and CMS.*

- Logs must be legible
- Provider Name and Signature
  - Includes supervisor signature for paraprofessional logs e.g., PCAs, PTAs, COTAs.
- Type of service provided
- Group or Individual setting
- Place of service (school, home, "walk-in"(preschool services, child outreach, other)
- Length of encounter (must include start time and end time or start time and encounter duration e.g. end time 9:30 or 20 minutes duration)
- Student's name
- Date of service
- Description of Service-including activity/procedure note for each date of service and supplemented by quarterly progress note, or as often as otherwise educationally/medically necessary.
- For more detailed information, including definitions, refer to **Addendum D** and **Addendum L**:

5. Claiming Activities

The following is a list of activities or considerations that LEAs or a billing company should consider when preparing claims for reimbursement:

- Verify student Medicaid eligibility
  - Staff can verify eligibility through the EOHHS Web Portal via computer
- Transfer log information to claim form
- Verify student's primary special education disability as reported in the census for special education. (This is to be used as the diagnosis for most claims submitted; exceptions are noted in recordkeeping requirements and in

Addendum D *Medicaid Self-Audit Matrix*.)

- Submit claims within 365 days of the date of service (HP ENTERPRISE SERVICES processes claims approximately every two weeks)
- Develop a system for the dissemination and collection of logs to and from school staff and/or contracted providers
- Ensure contracted providers are enrolled and linked to the LEA's group number (Refer to LEA Linkage Process, p. 14
- Provide training to staff on how to complete service logs
- Establish a system for submitting claims to HP ENTERPRISE SERVICES
- Claims can be submitted on a daily, weekly, monthly, or quarterly basis
- Processing timeline is determined when claims are received by HP ENTERPRISE SERVICES
- Services supported through other federal funds, e.g. IDEA cannot be submitted for reimbursement
    - The LEA needs to identify services provided through federal grants and ensure that these are not submitted for reimbursement. For example, if IDEA Part B funds are used to support the salary of a Speech-Language Pathologist (SLP), then a district cannot submit claims for services provided by this SLP.
- Verify student attendance
- Verify parental consent form is on file

LEAs should submit claims for services actually provided to the child. (Although it is possible that the LEA may pay for services not provided to the child through a contract with e.g. a nursing agency or a day or residential treatment, claims may be submitted for only those services received by the child.)

6. Span Date Policy

Span dating is the ability to span the "From" and "Through" dates of service *within a calendar month* for the same service on a claim. It is important to understand how to span date in order to format a claim properly. There are three types of span dating available:

- Span date for services whose units are designated as a day, e.g. Day and Residential treatment services
- Span date for claiming services whose units are designated in minutes, ½ hour or one hour or for a completed service.
- Span date for evaluations captured in multiple units

Span Date Policy for Day or Residential Services: To span date within a calendar month for services where units are based on days in attendance, list the first day of the month as the "from" date of service and the last day of the month as the "through" date of service e.g., 01012014 through 01312014. For the number of units, fill in the number of days the child *attended* that program for that calendar month. A district may pay the full tuition *regardless* of days in attendance for a day program or residential treatment. Medicaid will reimburse only for those services *provided* to the eligible student which includes actual days attended.

Span Date Policy for Distinct services: To span date within a calendar month for services whose units are based on 15 minute units, half-hour units, hour units, or completed service units, the "from" and "through" date of service must be for consecutive days for the same procedure code.

Span Date Policy for Certain Evaluations: To span date for multiple meetings with a child to conduct the following evaluations: Physical Therapy, Occupational Therapy, Speech Therapy, Assistive Technology and Orientation and Mobility; utilize the from and through dates of services *within* a calendar month for the date of the initial meeting and date of the last meeting to conduct an evaluation e.g. From 09/03/14 through 09/24/14 and fill in the number of units to those that correspond to the provider log documenting the evaluation e.g., 6 units. The amount should be the unit amount listed in Addendum O of the Guidebook for each specific evaluation.

D. Quality Assurance

Quality Assurance (QA) practices are a very important component of a responsible Medicaid claiming program. These practices will help to ensure that LEAs are submitting claims that are supported by all required documentation. The following technical assistance documents have been developed to assist LEAs in developing their QA practices:

- **Addendum D: Medicaid Self-Audit Matrix**
- **Addendum E: Sample On-Site Technical Review Tool**
- **Addendum G: Glossary of Terms**

Quality Assurance Template

Districts are required to submit a QA Medicaid Action Plan to EOHHS following the template provided in Addendum F. Understanding that some of the information may change periodically, the district must submit these changes to EOHHS so that the Medicaid Action QA Plan on file with EOHHS is up to date and accurate. It is not necessary to submit an entirely new plan, districts can forward just the section(s) with the modifications. For example, if a contact person for the district changes, then the district would need to submit just a new sheet with the change in contact person(s) and not the whole Medicaid Action QA Plan.

Documentation availability and accessibility are critical elements of a QA Plan to ensure that anyone-district staff or auditors-have timely access to the files used to support a claim. Claims documentation requirements do not specify that all documentation to support a claim be maintained in one central file so districts should catalog the person responsible for document maintenance and where the documents are stored.

Another critical element of a solid QA plan is the development of internal controls for the periodic review of required documentation. Some documentation should be reviewed monthly while others may need to be reviewed annually. The following are recommended intervals for period review of the required documentation for services provided by employers as well as contracted providers:

- Student attendance records: verify prior to billing
- Diagnosis Codes: verify with the Special Education Census at initial claiming and on-going through Census updates for student's primary disability for special education eligibility
- Activity Notes: monthly spot checks
- Progress Notes: quarterly spot checks
- Provider Service Logs: monthly spot checks
- Provider Certification/Licensure: maintain file for all service providers for current school year.
    - staff/employers, including Teacher Assistants providing PCA services
    - contractors
- Transportation Logs: monthly spot checks
- Treatment Plans: monthly spot checks
- HP ENTERPRISE SERVICES Remittance Advice: monthly reviews.

Medicaid Self-Audit Matrix

This form has been created to provide districts with a list of the required documentation for each service, including procedure codes. LEAs should use the matrix as a starting point to identify the records required to support Medicaid claims *prior* to submitting a claim for that service because the required documentation varies by service.

Sample On-Site Technical Review Tool

This is a companion document to the Matrix and is the tool used by EOHHS to verify claims documentation during its annual LEA reviews. As part of their comprehensive QA Plan, districts should perform regular reviews (self-audits) to check the documentation on file for paid claims. While districts can develop their own tools for self-audits, it is recommended that they use this sample tool since it is the one used by EOHHS. The value to the district to conduct periodic self-audits includes:

- Identifying an individual provider who is not documenting a claim properly
- Identifying groups of providers who are not documenting claims properly
- Identifying a broad systemic error that is causing claims to be paid inappropriately

    - Districts should conduct self audits any time a new system or procedure is in place, e.g. new billing software, change of billing agent, new provider logs, new services, new IEP forms etc.
- Verifying units on paid claims to those on provider logs
- Ensuring that individual provider documentation is available to the district either through staffing or contract changes
- Verifying that an accurate procedure code is used for each service, including modifiers, as needed.
    - **Auditors will disallow a paid claim for a service that has been provided and properly documented *if* it is not the service that was billed, *even* if the service billed was for a lesser reimbursement than the service that should have been billed**
- Identifying and correcting a problem with paid claims before an auditor discovers the error, including submitting a paid claim correction form for any claim billed in error. See Addendum M for HP's Paid Claim Correction Form or an Electronic Replacement or Void (available through the EOHHS web portal) may be submitted with the correct claim information. Any specific questions regarding claims adjustments can be made to HP at 784-8100 or Karen Murphy, HP LEA Provider Representative, at 401-784-8004 and/or karen.murphy3@hp.com.

Glossary of Terms

Districts should use this document to understand the headers on the Matrix and Self-Audit Tool.

E. Claims Reconciliation Activities

An important element in maintaining a Medicaid billing system is the reconciliation of claims submitted for payment. Claims submitted for payment to the Medicaid Management Information System (MMIS) are paid, denied or suspended. All providers *should* reconcile their claims to the claims reconciliation information contained in the Remittance Advice. Remittance Advice is processed twice a month and it is recommended it be reviewed by LEAs on a monthly basis.

RAs are generated for every provider that has claims processed in a cycle and active providers will receive an RA in each claims financial cycle. RAs can be accessed on the EOHHS web portal for those providers ***OR*** their billing companies as authorized through an Electronic Data Interchange Trading Partner Agreement. (Please refer to TPA information on page 14-15.)

Claims Reconciliation Guidance:

- Paid claims *should not* be resubmitted (the system will deny payment as a "duplicate claim"). Denied claims *may be* resubmitted with the corrected information and will be considered a new claim
- If an LEA determines that a paid claim has been paid incorrectly, then either

*Claims Adjustment Form (*Addendum M) or an Electronic or an Electronic Replacement or Void (available through the EOHHS web portal), may be submitted with the correct claim information

- LEAs should monitor any suspended claims, waiting for them to pay or deny before reconciling or resubmitting with corrected information. If claims suspend for several months, then the LEA should contact a provider representative at HP ENTERPRISE SERVICES.

More detailed information about claims reconciliation can be referenced in the Rehabilitation Provider Manual. HP ENTERPRISE SERVICES also posts Provider Updates monthly, typically with the first RA of the month and updates can be accessed on the EOHHS web site at: http://www.eohhs.ri.gov/News/ProviderNewsUpdates.aspx These updates include important information for providers that can include billing and reconciliation policy as well as provider training opportunities.

V. SERVICES: DEFINITIONS, QUALIFIED PERSONNEL AND RECORD KEEPING REQUIREMENTS

Special Education Medicaid Reimbursable Services

LEAs may submit claims for certain services provided by staff and/or contracted providers as authorized by the EOHHS. The Individualized Education Program (IEP) Team identifies the need for most of these services. The exceptions include the following: an evaluation identified as reimbursable by EOHHS that is used to determine initial eligibility for special education is an allowable claim; and certain expanded behavioral health services identified outside the IEP process. Expanded behavioral health includes individual and group counseling sessions provided by psychiatrist, psychologists and social workers or mental health counselor. This section includes a list of services that can be submitted for reimbursement, their definitions, qualified personnel and record keeping requirements. The provider qualification and documentation requirements are the same for employees and contracted providers.

Physical Therapy Service Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Physical Therapy Service Definitions:

Physical Therapy

Physical Therapy includes services provided by a licensed Physical Therapist or by a licensed Physical Therapist Assistant working under the supervision of a licensed Physical Therapist**. Providers include employees and contracted staff.**

Physical Therapy Evaluation

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services to provide additional data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS for this service
- A Physical Therapist, licensed by the Rhode Island Department of Health, provides a physical therapy evaluation
- It is an individual service

Individual Physical Therapy w/Licensed Physical Therapist

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for services is documented in the child's Individualized Education Program (IEP)
- The child is Medicaid eligible
- A licensed Physical Therapist provides an individual physical therapy session to a student
- The individual therapy needs to last the minimum time required by EOHHS for this service
- It is an individual service

Individual Physical Therapy Program

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for services is documented in the child's IEP
- The child is Medicaid eligible
- A licensed Physical Therapist Assistant (PTA) working under the supervision of the licensed Physical Therapist provides individual therapy to a student
- The individual therapy needs to last the minimum time required by EOHHS for this service
- It is an individual service

Physical Therapy Program-Group

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for services is documented in the child's IEP
- The child is Medicaid eligible
- *Either* a licensed Physical Therapist *or* a licensed Physical Therapist Assistant (PTA) provides therapy in a small group setting
- The group therapy needs to last the minimum time required by EOHHS for this service
- A claim for group therapy can be made for each Medicaid eligible student in the group

Physical Therapy Record Keeping Requirements:

All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

Evaluation

- The completed evaluation and Evaluation Team Report must be maintained for initial evaluations
- The IEP, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide data for the IEP Team
- A log indicating the time the therapist spent evaluating the student (time to write the evaluation report is calculated in the rate)

- Student attendance records
- Staff licensure

Individual *or* Small Group Services Provided by a licensed Physical Therapist *or* a licensed Physical Therapist Assistant (PTA):

- Primary special education disability
- The child's IEP
- Procedure/Activity Note for each encounter
- Progress notes
- Provider logs
- Student attendance records
- Staff licensure

Occupational Therapy Service Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Occupational Therapy Service Definitions:

Occupational Therapy

Occupational Therapy includes: improving, developing or restoring functions impaired or lost through illness, injury or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; and preventing, through early intervention, initial or further impairment or loss of function.[18] **Providers include employees and contracted staff.**

Occupational Therapy Evaluation

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services or to provide additional data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS for this service
- An Occupational Therapist, licensed by the Rhode Island Department of Health, provides an occupational therapy evaluation
- It is an individual service

Individual Occupational Therapy w/Licensed Occupational Therapist

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for services is documented in the child's IEP
- The child is Medicaid eligible
- A licensed Occupational Therapist provides an individual occupational therapy session to a student
- The individual therapy lasts the minimum time required by EOHHS for this service
- It is an individual service

Individual Occupational Therapy Program

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for the service is documented in the child's IEP
- The child is Medicaid eligible
- A Certified Occupational Therapy Assistant (COTA) working under the supervision of the licensed Occupation Therapist provides individual therapy to a student
- The individual therapy lasts the minimum time required by EOHHS for this service
- It is an individual service

Occupational Therapy Program-Group

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for services is documented in the child's IEP
- The child is Medicaid eligible
- *Either* a licensed Occupational Therapist *or* a Certified Occupational Therapy Assistant (COTA) provides therapy in a small group setting
- The group therapy needs to last the minimum time required by EOHHS for this service
- A claim for group therapy can be made for each Medicaid eligible student in the group

Occupational Therapy Record Keeping Requirements:

All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

Evaluations

- The completed evaluation and the Evaluation Team Report must be maintained for initial evaluations
- The IEP, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide data for the IEP Team
- A log indicating the time the therapist spent evaluating the student (time to write the evaluation report is calculated in the rate)

- Student attendance records
- Staff licensure

Individual *or* Small Group Services Provided by the Licensed Therapist *or* a Certified Occupational Therapy Assistant (COTA)

- Primary special education disability
- The child's IEP
- Procedure/Activity Note for each encounter
- Progress notes
- Provider logs
- Student attendance records
- Staff licensure

Speech Hearing And Language (SHL) Therapy Service Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Speech Hearing and Language (SHL) Therapy Service Definitions:

Speech Hearing and Language Services

Includes: identification of children with speech or language impairments; diagnosis and appraisal of specific speech or language impairments; referral for medical or other professional attention necessary for the habilitation of speech or language impairments; provision of speech and language services for the habilitation or prevention of communicative impairments; and counseling and guidance of parents, children and teachers regarding speech and language impairments.[19] Providers include employees and contracted staff.

Audiology

Includes: the identification of children with a hearing loss; determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing; provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation; creation and administration of programs for prevention of hearing loss; counseling and guidance of children, parents, and teachers regarding hearing loss; and determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.[20] Providers include employees and contracted staff.

Speech Hearing and Language Evaluation

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services or to provide additional data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS for this service
- A speech language evaluation is provided by a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education or by a Speech-Language Pathologist licensed by the Rhode Island Department of Health
- A hearing evaluation is provided by an audiologist licensed by the Rhode Island Department of Health

- It is an individual service

Individual Speech, Hearing and Language with a Speech Language Pathologist (SLP)

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's IEP
- The child is Medicaid eligible
- A Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education or a Speech-Language Pathologist licensed by the Rhode Island Department of Health provides an individual speech or hearing session to a student
- The individual therapy needs to last the minimum time required by EOHHS for this service
- It is an individual service

Individual Hearing Therapy with a Licensed Audiologist

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's IEP
- The child is Medicaid eligible
- An audiologist licensed by the Rhode Island Department of Health provides an individual session to a student
- The individual therapy needs to last the minimum time required by EOHHS for this service
- It is an individual service

Individual Speech, Hearing and Language Program

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's IEP
- The child is Medicaid eligible
- A paraprofessional, working either under the supervision of a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education or under the supervision of a Speech-Language Pathologist licensed by the Rhode Island Department of Health provides an individual speech or hearing session to a student

- The individual therapy needs to last the minimum time required by EOHHS for this service
- It is an individual service

Speech Hearing and Language Therapy Program/Group

A claim for group therapy can be filed for each Medicaid eligible student in the group. This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's IEP
- The child is Medicaid eligible
- Speech Hearing and Language therapy is provided in a small group setting by a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education, or a Speech-Language Pathologist licensed by the Rhode Island Department of Health *or*
- Speech Hearing and Language therapy is provided in a small group setting by an audiologist licensed by the Department of Health
- Speech Hearing and Language therapy is provided in a small group session by a paraprofessional working under the supervision of a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education, or under the supervision of a Speech-Language Pathologist licensed by the Rhode Island Department of Health
- The group therapy needs to last the minimum time required by EOHHS for this service
- A claim for group therapy can be made for each Medicaid eligible student in the group

Speech Hearing and Language Therapy Record Keeping Requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

Evaluations

- The completed evaluation and the Evaluation Team Report must be maintained for initial evaluations
- The IEP, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide data for the IEP Team
- A log indicating the time the therapist spent evaluating the student (time to write the evaluation report is calculated in the rate)
- Student attendance records
- Staff certification/licensure

Individual *or* Small Group Services Provided by an appropriately credentialed therapist *or* by an appropriately credentialed paraprofessional working under the supervision of the Speech Language Pathologist

- Primary Special Education disability code
- The child's IEP
- Procedure/Activity Note for each encounter
- Progress notes
- Provider logs
- Student attendance records
- Staff licensure/certification

Orientation and Mobility (O & M) Service Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Orientation and Mobility (O & M) Service Definition:

(1) Services provided to blind or visually impaired children by qualified personnel to enable those students to attain systemic orientation to and safe movement within their environments in school, home, and community; and

(2) Includes teaching children the following, as applicable:
   a) Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., using sound at traffic light to cross street);
   b) To use the long cane or a service animal to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision;
   c) To understand and use remaining vision and distance low vision aids; and
   d) Other concepts, techniques, and tools.

Orientation and Mobility Evaluations

An evaluation for Orientation and Mobility services includes:

(1) The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;

(2) Medical history as it relates to the current course of therapy;

(3) The beneficiary's current functional status (functional baseline);

(4) The standardized and other evaluation tools used to establish the baseline and to document progress;

(5) Assessment of the student's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment;

(6) Assessment of the student's cognitive skill level (e.g., ability to follow directions,

including auditory and visual, comprehension); and

(7) Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.

Orientation and Mobility Record Keeping Requirements: All records used to support a claim must be maintained at least 10 years from date of service. ***Refer to Addendum D Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to Addendum L for provider log requirements.***

Evaluations

- The completed evaluation and Evaluation Team Report must be maintained for initial evaluations
- The IEP, the completed evaluation and documentation of the IEP Team evaluation report/decisions must be maintained for re-evaluations or for evaluations used to provide data to the IEP Team
- A log indicating the time the therapist spent evaluating the student (time to write the evaluation report is calculated in the rate)
- Student attendance records
- Staff certification/licensure

Services provided by a certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)

- Primary Special Education disability code
- The child's IEP
- Procedure/Activity Note for each encounter
- Progress notes
- Provider logs
- Student attendance records
- Staff licensure/certification

Psychological Evaluations: Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Definition of Evaluation Services:

Evaluation services include administering psychological and educational tests, interpreting assessment results.[21]

Psychiatric Evaluation by a Board Certified Psychiatrist

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine initial eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services or is used to provide data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS
- A Board certified psychiatrist provides a psychiatric evaluation
- It is an individual service

Record keeping requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations
- The IEP, the child's primary special education disability, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide additional data for the IEP Team
- Child's attendance records
- Staff licensure

Psychological Evaluation by a Licensed Clinical Psychologist

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine initial eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special

education or related services or is an evaluation to provide data for the IEP Team

- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS
- A Licensed Clinical Psychologist provides a psychological evaluation
- It is an individual service

Record keeping requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations
- The IEP, the child's primary special education disability, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide data for the IEP Team
- Child's attendance records
- Staff licensure

Evaluation by a Social Worker or a Licensed Mental Health Counselor

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The evaluation is used to determine initial eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services or to provide additional data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS
- A LICSW, Licensed Certified Social Worker, - Certified School Social Worker, or a Licensed Mental Health Counselor[1]provides a clinical assessment or Mental Health evaluation
- It is an individual service

Record keeping requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

[1] Licensed Mental Health Counselor approved as of September 29, 2008

- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations

- The IEP, the child's primary special education disability, the completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or for evaluations used to provide additional data for the IEP Team
- Child's attendance records
- Staff licensure/certifications

Counseling Definitions and Record Keeping Requirements

*Refer to **Addendum O** for procedure code, rate and diagnosis code list.*

Definition of Counseling Services:

Counseling services include interpreting assessment results; obtaining, integrating, and interpreting information about child behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies as they relate to the child's learning.[22]

Counseling services can be provided by the following providers:
A Board Certified Psychiatrist, Licensed Clinical Psychologist, a Licensed Social Worker, a LICSW, Certified School Social Worker or a Licensed Mental Health Counselor[2] as identified through the IEP process for individual, individual w/Parent present or small group sessions. Providers include employees and contracted staff.

Individual, Individual with Parent present or small group counseling by a Board Certified Psychiatrist, a Licensed Clinical Psychologist, a Licensed Social Worker, LICSW or a Certified School Social Worker or a Licensed Mental Health Counselor.

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's IEP
- The child is Medicaid eligible
- A qualified professional, listed above, provides an individual, Individual w/Parent present or small group counseling session
- The counseling session needs to last the minimum time required by EOHHS
- A claim for group therapy can be made for each Medicaid eligible student in the group

Record Keeping Requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Child's primary special education disability
- Child's IEP
- Procedure/activity note for each encounter
- Progress Notes
- Provider's logs
- Child's attendance records
- Staff licensure/certification

[2] Licensed Mental Health Counselor approved as of September 29, 2008

Expanded Behavioral Health Counseling Services and Record Keeping Requirements

*(Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.)*

Definition of Expanded Behavioral Health Services:

Expanded Behavioral Health Counseling includes planning and managing a therapeutic plan of psychological services, including psychological counseling for children; and developing positive behavioral intervention strategies.

A Board Certified Psychiatrist, Licensed Clinical Psychologist, a Licensed Social Worker, LICSW, Certified School Social Worker, or a Licensed Mental Health Counselor[3] may provide individual, individual w/Parent present or small group counseling as identified through a Treatment Plan. Providers include employees and contracted staff.

*Refer to **Addendum P** for a sample Treatment Plan.* Districts can use this sample to meet documentation requirements or they can use other forms to document this service as long as the district documentation meets the required elements in ***Addendum L*** including provider signature.

Expanded Behavioral Health Individual, Individual with Parent Present or Small Group Counseling by a Board Certified Psychiatrist, a Licensed Clinical Psychologist, a Licensed Social Worker, LICSW, Certified School Social Worker, or a Licensed Mental Health Counselor.

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for service is documented in the child's Expanded Behavioral Health Treatment Plan
- The child is Medicaid eligible
- A qualified professional, listed above, provides an individual, individual w/Parent present or small group counseling session
- The counseling session needs to last the minimum time required by EOHHS
- A claim for group therapy can be made for each Medicaid eligible student in the group
- The student has a valid IEP

Record Keeping Requirements: All records used to support a claim must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum P** for Sample Treatment Plan.*

- Child's Individual Treatment Plan (**Addendum P**)
- Child's IEP

[3] Licensed Mental Health Counselor approved as of September 29, 2008

- Procedure/Activity note for each encounter
- Progress notes
- Provider logs
- Child's attendance records
- Staff licensure/certifications

Nursing Services Definitions and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Nursing Services Definitions:

> **LEAs may submit claims for individual skilled nursing services, provided to eligible students for *non-routine* services. Non-routine services include the special needs of children enrolled in special education who have tracheostomies, catheters, ventilators and other medically necessary services. This can include the one-to-one nursing services provided during transportation to and from school as well as the one-to-one services provided during the school day. These services are designed to enable a child with a disability to receive FAPE as described in the child's IEP.[23] Providers include employees and contracted staff.**

This service may be submitted for reimbursement from Medicaid when the following criteria are met:

- The need for nursing services is described in the IEP (or the Individualized Health Care Plan) If service is described in IHP then a current IEP must also be present
- The child is Medicaid eligible
- Certified School Nurse Teacher, Registered Nurse or Licensed Practical Nurse provides individual nursing services
- The session needs to last the minimum time required by EOHHS
- This is an individual service

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Primary Special Education disability
- Child's IEP
- Individualized Health Care Plan (per RI School Health Regulations) if the IEP does not detail the nursing services needed by the student
- Procedure/Activity note for each encounter
- Progress notes
- Provider logs
- Child's attendance records
- Physician's Orders
- Licensure/Certification

Day Program Treatment Definition and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Day Program Treatment Definition:

The IEP team may decide that in order for a child to receive the services identified in the IEP, the child will receive his/her education and related services in an "out of district" program. These are known as day programs because the child does not live at the facility, but continues to live at home and is transported daily to the day program. LEAs may submit claims for services provided by other LEAs or by school programs approved by RIDE known non-public programs.

Prior to the start of each school year, or prior to the enrollment of a child in a day program, the LEA must request the following information from the Day Program provider:

- The yearly tuition for the program *and*
- A breakdown of the daily cost of the program (known as tuition) into daily educational costs *and* into daily treatment costs
- A copy of the agencies Single Audit (performed by an Independent Certified Public Accountant) or other documentation that sufficiently details the agencies methodologies for calculating treatment costs prior to the start of the school year.

In order to calculate the daily educational costs and daily treatment costs, the Day Program Provider should use the following formula:

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days or 230 days, this amount equals the daily rate
- The daily rate then needs to be broken down into "daily treatment costs" and "daily educational costs"
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following services:

  Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services, evaluations
- This daily treatment rate is the unit rate used for reimbursement of this service and must be calculated in accordance with OMB Circular A-87 Cost Principles for State, Local, and Indian Tribal Government Agencies

  LEAs that contract with Day Programs are responsible for ensuring that the calculation rates for treatment cost are consistent with requirements outlined within this guidebook.

The school district must also request from the Day Program Provider attendance reports for each

calendar month a student attends the Day Program. The district may only submit claims for the number of days within each calendar month that a child attends the Day Program. The district may span date for the entire calendar month and use the total number of days the child attends the program that month as the units billed. To calculate the total rate, multiply the number of days in attendance that calendar month by the daily treatment rate. If a child requires services beyond those included in the annual tuition costs of the Day Program, which are not factored into the tuition/costs of the Program, then a Day Program may submit logs for these services in order for the LEA to submit claims for these services. For example, a child may require a personal care attendant or non-routine nursing care or additional therapies that are not part of the program.

Claims for day programs may be submitted for reimbursement from Medicaid when the following criteria are met:

- A certified day program provides services as identified by the child's IEP
- The child is Medicaid eligible
- Documentation of the daily education and daily treatment costs
- Child's attendance records are maintained

Day Program Record keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Primary special education disability
- Child's IEP
- Progress notes
- Student Attendance reports
- Daily tuition rates (broken down by treatment and educational costs)
- Program Certification/licensure
- Tuition rate, including purchase orders or invoices

Residential Treatment Definition and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Residential Treatment Definition:

The IEP team may decide that in order for a child to receive the services identified in the IEP, the child will receive his/her education and related services in a Residential Treatment program. These are known as Residential programs because the child lives at the facility. LEAs may submit claims for the treatment services provided by Residential Programs.

Prior to the start of each school year, or prior to the enrollment of a child in a Residential program, the LEA must request the following information from the Residential Program:

- The yearly tuition for the program *and*
- A breakdown of the daily cost of the program (known as tuition) into daily educational costs *and* into daily treatment costs *and* into daily room and board costs
- A copy of the agencies Single Audit (performed by an Independent Certified Public Accountant) or other documentation that sufficiently details the agencies methodologies for calculating treatment costs

In order to calculate the daily educational costs, daily treatment costs and daily room and board, the Residential Program Provider should use the following formula:

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days, 230 days or 365 days; this amount equals the daily rate
- The daily rate then needs to be broken down into "daily treatment costs", "daily educational costs" and "daily room and board costs"
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following services:

  Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services, evaluations
- This daily treatment rate is the unit rate used for reimbursement of this service and must be calculated in accordance with OMB Circular A-87 Cost Principles for State, Local, and Indian Tribal Government Agencies

LEAs that contract with Residential Treatment programs are responsible for ensuring that the calculation rates for treatment cost are consistent with the requirements outlined within this guidebook.

- Room and board costs are those costs for providing food and shelter for the child in this program. *If* the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits a Residential Facility, *then* the costs for room and board are also reimbursable

The school district must also request from the Residential Program Provider monthly attendance reports for each calendar month a student attends the Program. The district may only submit claims for the number of days within each calendar month that a child attends the Program. The district may span date for the entire calendar month and use the total number of days the child attends the program that month as the units billed. To calculate the total rate, multiply the number of days in attendance in that calendar month by the daily treatment rate. *If* the facility is JCAHO accredited, *add* the treatment rate and the room and board rate then multiply this combined rate by the number of days in attendance for that calendar month.

If a child requires services beyond those included in the annual tuition costs of the Residential Program, which are not factored into the tuition/costs of the Program, then a Residential Program may submit logs for these services in order for the LEA to submit claims for these services. For example, a child may require a personal care attendant or non-routine nursing care or additional therapies that are not part of the program.

Residential Treatment Program services may be submitted for reimbursement from Medicaid when the following criteria are met:

- A residential treatment program provides the services as identified by the child's IEP
- The child is Medicaid eligible
- Documentation of the daily education, treatment and room and board costs
- Child's attendance records are maintained

Residential Program Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Primary special education disability
- Child's IEP
- Progress notes
- Student Attendance reports
- Daily tuition rates (broken down by treatment and educational costs)
- Program Certification/licensure
- Tuition rate, including purchase orders or invoices

Transportation Definition and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Transportation Definition:

The Rhode Island Medical Assistance program will pay each trip, when transportation is provided to and/or from school based services for children under IDEA when both of the following conditions are met:

1) The child receives transportation to obtain a Medicaid-covered service (other than transportation), and
2) Both the Medicaid-covered service and the need for transportation are included in the child's IEP or IFSP
3) The transportation is provided in accordance with all applicable federal and state laws
4) **Providers include employees and contracted staff.**

On any day conditions are met, Medicaid payment for transportation to and from school is available.
If a child receives a Medicaid-covered IDEA service at an off-site facility during the school day, the cost of transportation from the school to the facility and back to the school would be reimbursable.[24]

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

Documentation includes:

- The child's primary special education disability
- Transportation must be listed as a related service on the IEP
- Provider logs include the following:
  - Student's name
  - Date of service
  - Type of service
  - Provider Name and signature
- Student attendance records

Case Management Services Definition and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Case Management Definition:

According to 42 CFR 440.169(a), *case management services* means:

> " . . . services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with §441.18 of this chapter. "

According to 42 CFR 440.169(b), *targeted case management services* means:

> ". . . case management services furnished without regard to the requirements of §431.50(b) of this chapter (related to statewide provision of services) and §440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan."

According to 42 CFR 440.169(d), the services that case managers provide that are eligible for Federal matching funds include:

> "(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
>
> (i) Taking client history.
>
> (ii) Identifying the needs of the individual, and completing related documentation.
>
> (iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
>
> (2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
>
> (i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
>
> (ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
>
> (iii) Identifies a course of action to respond to the assessed needs of the eligible individual.
>
> (3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including

activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan. (4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(I) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers."

According to 42 CFR 440.169(e), case management may include:

". . .. contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs."

Claims should be fully documented and should include date of service, name of recipient, nature, extent or units of service and place of service. Providers include employees and contracted staff.

Other relevant Federal regulatory requirements under 42 CFR 44.18(a) include:

- Individuals must be free to choose any qualified Medicaid provider within the specified geographic area identified in the Medicaid State Plan when obtaining case management services.
- Case management services, including targeted case management services, may not be used to restrict the individual's access to other Medicaid-covered services.
- An individual may not be compelled to receive case management services.

- It is not permissible to condition receipt of case management services, including targeted case management services, on the receipt of other Medicaid services or to condition receipt of other Medicaid services on the receipt of case management services (or targeted case management services)

Case Management Record Keeping Requirements: Records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements. Districts must have a Case Management plan for any student for whom case management is sought for reimbursement. Refer to **Addendum H** for Sample Case*

Management Plan with Definitions

- Rhode Island Medicaid Program also requires case management to be listed in the child's IEP

The Federal regulations at 42 CFR 441.18(a)(7) require providers to document case records for all individuals receiving case management services, these elements should be included on provider logs:

> "(i) The name of the individual.
> (ii) The dates of the case management services.
> (iii) The name of the provider agency (if relevant) and the person providing the case management service.
> (iv) The nature, content, length of time (include start time and end time or start time and length of service) of the case management services received and whether goals specified in the care plan have been achieved.
> (v) Whether the individual has declined services in the care plan.
> (vi) The need for, and occurrences of, coordination with other case managers.
> (vii) A timeline for obtaining needed services.
> (viii) A timeline for reevaluation of the plan."

Personal Care Definition and Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Personal Care Definition:

Services provided by a Personal Care Attendant (PCA), including by employees or contracted staff, in the school setting and identified in a child's Individualized Education Program (IEP) include assistance with eating, personal hygiene, and other activities of daily living, including assistance provided to support the child in his/her educational setting, as identified through the IEP the level of support needed, by a student to receive FAPE in the least restrictive environment. Some students may require the 1:1 assistance provided by a personal care attendant for the entire duration of the school day, while other students may require intermittent support during specific times or activities during the day. Some students may require assistance for transitioning from one area of the school to another, others may require assistance with toileting or feeding and others may require these services for the entire school day. The logs maintained by the personal care attendant should indicate when the PCA provided the 1:1 intervention during the course of the school day.

The following information was adapted from the CMS's State Medicaid Manual section on Personal Care Services (10-99, 4480, Rev. 73, 4-495).

Personal Care Services include a range of assistance provided to students with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a student) or cuing so that the student performs the task by him/herself. Such assistance most often relates to performance of Activities of Daily Living (ADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a licensed health care professional are not considered personal care services.

IADLs: Instrumental activities of daily living include activities associated with independent living necessary to support the ADLs (e.g., use of the telephone, ability to do laundry, and shopping).
Cognitive Impairments: A student may be physically capable of performing ADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task.

Physical Impairments: A student may be physically incapable of performing ADLs because of an impairment that affects mobility or activities of daily living. These impairments can include blindness, hearing impairments, cerebral palsy, and traumatic brain injury for example. Students with such disabilities may require assistance in navigating their educational environment and with other ADLs.

Personal Care service is reimbursable by an LEA when the following criteria are met:

- The need for services is documented appropriately in the child's IEP
- The child is Medicaid eligible
- A Personal Care Assistant (PCA) working under the supervision of the classroom teacher or other appropriately credentialed staff in the school setting provides one to one assistance to a student
- The individual assistance needs to be provided in the minimum time required by EOHHS for this service

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Child's primary special education disability
- The child's IEP
- Procedure/activity note for each encounter
- Provider logs
    - These must be legible and signed by both the PCA and the Supervisor
- Student attendance records
- Staff certification/licensure
    - This includes provider qualifications, certification, licensure…for *both* the PCA and the Supervisor (who co-signs the provider log)

Assistive Technology (AT) Service and Assistive Technology Device Definitions *and* Record Keeping Requirements

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

A. Assistive Technology Service

Definition:

An Assistive Technology Service is any medically necessary service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. **Providers include employees and contracted staff.** The term includes:

- The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children with disabilities
- Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing or replacing assistive technology devices
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs
- Training or technical assistance for a child with a disability or, if appropriate, that child's family
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers or other individuals who provide services to employers or who otherwise are substantially involved in the major life functions of that child[25]

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Child's primary special education disability
- The child's IEP
- Procedure/activity note for each encounter being billed as an AT service
- The completed evaluation and Evaluation Team Report must be maintained for initial evaluations, *if* an AT evaluation is being submitted as an AT service
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained for re-evaluations or to provide additional data for the IEP Team, *if* an evaluation is being submitted as an AT service
- Student attendance records, when appropriate, e.g. a child does not need to be in attendance the day a device is being serviced or repaired

- Certification/licensure
- Provider service logs

B. Assistive Technology Device

Definition:

An Assistive Technology Device is any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified, or customized, that is medically necessary and is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, or the replacement of such device.[26]

Each LEA must ensure that assistive technology devices or services are made available to a child with a disability if required as part of the child's special education, related services or supplementary aids and services and on a case by case basis the use of school-purchased assistive technology devices in the child's home or in other settings is required *if the child's IEP Team* determines the child needs access to those devices in order to achieve FAPE.

However, under Medicaid rules, if a child's Medicaid benefits are accessed to purchase a piece of equipment, including assistive technology, the equipment *belongs* to the child and must be available for the child's use outside the school setting.

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions. Refer to **Addendum L** for provider log requirements.*

- Child's primary special education disability
- The child's IEP
- Completed Evaluation stating need for device
- Invoice for the device must be maintained and include the following information:
    - Date of invoice
    - Type of device
    - Cost of the device

Child Outreach: Screening and Re-Screening

*Refer to **Addendum O** for provider qualifications, procedure code, rate and diagnosis code list.*

Service definition:

A. Screening:

All school departments in Rhode Island provide Child Outreach Screening services for children aged 3-5 years old. Trained staff provides these screenings and they assess a child's development. Screening components include hearing, vision, speech and developmental skills. Providers include employees and contracted staff.

B. Re-screening:

Children are asked back for a re-screening if an area of concerns arises after the initial screening. The re-screening includes any areas of concern and is provided by trained staff.

In order to submit a claim for reimbursement, the following criteria must be met:

- The child must be Medicaid eligible
- The screening/re-screening must be conducted under a screening program approved by RIDE

Record Keeping Requirements: All records must be maintained at least 10 years from date of service. *Refer to **Addendum D** Medicaid Self-Audit Matrix for recordkeeping requirements and definitions.*

- V705 is used as diagnosis code
- A copy of the completed screening or re-screening

VI. ROLES AND RESPONSIBILITIES FOR SCHOOL ADMINISTRATORS

District administrators should be aware that Medicaid revenues and expenses must be reported to the RIDE as part of district fiscal reporting requirements (e.g. Onsite). Responsibilities for school administrators, including Superintendents, Business Managers, and Directors of Special Education may include:

- Signing the Interagency Provider Agreement with the Executive Office of Health and Human Services
- Certifying Local Funds each quarter
- Creating or selecting log forms for service providers
- Organizing/providing staff training for completion of logs
- Overseeing a system for log distribution, collection and maintenance
- Providing or arranging staff training for necessary claims documentation
- Overseeing a Quality Assurance Process
- Conducting Self-Audit Activities
- Reviewing paid claims periodically for proper documentation
- Reconciling Remittance Advice (paid, denied and suspended claims)
- Maintaining Record Retention System
- Establishing and maintaining a process for obtaining Parental Consent to Access Medicaid Funds
- Updating District Medicaid Corrective Action Plan as needed (Addendum F)

VII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

The Departments of Education and Health and Human Services have issued joint guidance on the application of FERPA and HIPAA for LEAs. To access: www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf
Background:

The law known as "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996 (PL 104-91) which was passed to promote more standardization and efficiency in the health care industry. LEAs in Rhode Island need to be aware of HIPAA law and policy as it affects covered entities because under HIPAA definitions, LEAs are considered "Hybrid Entities". The following is intended to give LEAs a basic understanding of HIPAA requirements as well as the requirements of the Family Educational Rights and Privacy Act (FERPA), the federal act that regulates the privacy of school records. Please refer to the HIPAA FAQ in Addendum Q or the EOHHS web site at http://www.eohhs.ri.gov/Home.aspx or the HIPAA web site at www.hhs.gov/ocr/privacy/ for more information about HIPAA.

HIPAA

HIPAA is comprised of two parts: the Portability Component and the Accountability Component. The Accountability Component applies to "Covered Entities" and includes Administrative Simplification which has four parts: the Electronic Transactions and Code Sets Standards Requirements; the Privacy Requirements; the Security Requirements; and the National Identifier Requirements. These have their own implementation dates, including dates for most providers and dates for small providers. Small providers are defined as providers who receive less than $5, 000,000.00 in annual receipts. Based on direct service claiming for Medicaid reimbursement, all LEAs in Rhode Island are considered small providers by definition.

Electronic Transactions and Code Sets

All providers, including LEAs, must comply with this standard by October 16, 2003. National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every provider who does business electronically to use HIPAA compliant software and uniform health care transactions, code sets, and identifiers. Transactions and code sets standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically.

Privacy Requirements

April 14, 2003 was the deadline for compliance with the privacy standards by covered entities. Small providers, those with annual receipts of less than $5,000,000, must be compliant by April 14, 2004. The Privacy Regulations cover the privacy of protected health information in oral, written or electronic format maintained by covered entities. The privacy requirements *limit the release* of protected health information without the individual's knowledge and consent.

Security Requirements

April 25, 2005 is the deadline for compliance with the security standards for most providers. Small providers have until April 25, 2006 to become compliant with the security components.

The Security Regulations pertain to the security of protected health information in electronic format maintained by covered entities. The security regulations outline the minimum administrative, technical, and physical safeguards required to prevent unauthorized access to protected health care information *either* stored or transmitted electronically.

National Identifier requirements

May 23, 2007 is the deadline for most providers and small providers have until May 23, 2008 to become compliant with this requirement. HIPAA requires that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The National Plan and Provider Enumeration System (NPPES) is the contractor hired by CMS to assign and process the NPIs, to ensure the uniqueness of the health care provider, and generate the NPIs. Providers can apply at the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

The Family Educational Rights and Privacy Act (FERPA) and HIPAA

FERPA: FERPA is a federal law that applies to an educational agency or institution to which funds have been made available under any program administered by the Secretary of Education (this includes all LEAs). FERPA lists the requirements for the protection of privacy of parents and students with respect to educational records maintained by the LEA. Based on an analysis of applicable HIPAA Privacy Regulations, it has been determined that education records which are subject to FERPA are exempt from HIPAA Privacy Regulations.

Specifically, Section 164.501 of the HIPAA Privacy Regulations defines *Protected Health Information* as:

> "Individually identifiable health information (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media: (ii) Maintained in any medium described in the definition of *electronic media* at § 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) *Protected health information* excludes individually identifiable health information in: (i) Education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer." [34 C.F.R. 164.501, Definitions]

A careful analysis of applicable HIPAA Privacy Regulations and FERPA Regulations indicates that LEAs that adhere to FERPA are exempt form the HIPAA Privacy Regulations. To

understand this exemption requires a clear understanding of several definitions in FERPA.

"Education Records" FERPA 34 CFR sec. 99.3

(a) The term means those records that are:
    (1) Directly related to a student; and
    (2) Maintained by an educational agency or institution or by a party acting for the agency or institution.
(b) The term does not include:
    (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.

"Record" means any information recorded in any way, including but not limited to, handwriting, print, computer media, video or audiotape, film, microfilm, and microfiche.

"Personally identifiable information" includes, but is not limited to:

(a) The students name;
(b) The name of the student's parent or other family member;
(c) The address of the student or student's family;
(d) A personal identifier, such as the student's social security number or student number;
(e) A list of personal characteristics that would make the student's identity easily Traceable; or
(f) Other information that would make the student's identity easily traceable.

In summary, education records maintained by school districts billing Medicaid through a billing agent are subject to FERPA regulations and, therefore, are not subject to HIPAA Privacy Regulations. In light of this exemption, it is especially important that each LEA strictly and fully implement the FERPA regulations and the confidentiality requirements of IDEA and the RI Regulations.[4] Please note that Rhode Island's Education Records Bill of Rights (ERGR §16-71 et seq) contains many of the same confidentiality requirements as FERPA.

Any records transmitted electronically by LEAs that are not defined as education records and are not subject to FERPA because they do not become education records will be subject to the Privacy Regulations and the Security Regulations of HIPAA.

[4] Student special education records must be retained 5 years after the student leaves the program or 5 years after the student reaches the age of 18, whichever is longer. See Rhode Island Secretary of State's Public School Retention Schedule, LG5.1.14.

HIPAA DEFINITIONS

The following terms as defined in the Health Insurance Portability and Accountability Act may assist LEA staff in understanding HIPAA:

Business Associate: A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. The definition includes agents, contractors, or others hired to do work of or for a covered entity that requires use or disclosure of protected health information. A business associate can also be a covered entity in its own right. [Also, see Part II, 45 CFR 160.103.]
The covered entity must require satisfactory assurance-usually a contract-that a business associate will safeguard protected health information, limit the use and disclosure of protected health information.

Centers for Medicare and Medicaid Services (CMS): The Health and Human Services (HHS) agency responsible for Medicare and parts of Medicaid. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.

Code Set: Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also, see Part II, 45 CFR 162.103.

Covered Entity: Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Hybrid Entity: A covered entity that also does non-covered functions, whose covered functions are not its primary functions. [This would include LEAs.] Most of the requirements of the Privacy Rule apply to the health care components of the entity and not to the parts of the entity that do not engage in covered functions.

Health Care Provider: a provider of services, a provider of medical or health services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Health Care Clearinghouse: A public or private entity that does either of the following (Entities, including but not limited to, billing services, re-pricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Health Information: means any information whether oral or recorded in any form or medium, that:

(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: A Federal law that allows persons

to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. HIPAA is also known as the Kennedy-Kassebaum Bill, K2 or Public Law 104-191.

National Provider Identifier*:* HIPAA mandates the adoption of standard unique identifiers for health care providers, as well as the adoption of standard unique identifiers for health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the **National Plan and Provider Enumeration System (NPPES)** to assign these unique identifiers. If you are a **Health Care Provider**, the National Provider Identifier (NPI) is your standard unique identifier. If you are a covered **Health Plan**, the National Health Plan Identifier (NPlanID) is your standard unique identifier

Office of Civil Rights (OCR): This office is part of HHS. Its HIPAA responsibilities include oversight of the privacy requirements.

Protected health information (PHI): includes individually identifiable health information (with limited exceptions) in any form, including information transmitted orally, or in written or electronic form by covered entities or their business associates. Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC 1232g; (ii) Records described at 20 USC 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer.

Small Health Plan/Small Providers: Under HIPAA, this is a health plan with annual receipts of $5 million or less. Small providers have been given one-year extensions to implement HIPAA components, e.g. code sets, privacy regulations, security regulations.

Privacy: Privacy is defined as controlling who is authorized to access information (the right of individuals to keep information about themselves being disclosed).

Security: Security is defined as the ability to control access and protect information from accidental or intentional disclosure to unauthorized persons and from altercation, destruction or loss.

VIII. REFERENCES, ENDNOTES AND KEY TECHNICAL ASSISTANCE CONTACTS

References:

- HP ENTERPRISE SERVICES: *Rehabilitation Provider Manual*
- *EOHHS Website at:* http://www.eohhs.ri.gov/Home.aspx
- *Medicaid and School Health: A Technical Assistance Guide*, U.S. Department of Health and Human Services Health Care Financing Administration, 1997, Available on the Federal Medicaid Website at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/School_Based_User_Guide.pdf
- *Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An examination of Federal Policies*, U.S Department of Health and Human Services 1991
- *IEP Manual*
- *IEP: Process, Product and Purpose: Second Edition 2002*
- *Individuals with Disabilities Education Act,* as amended December 2004

Resources:

www.medicaid.gov
http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html
http://www.hhs.gov/ocr/privacy/
www.medicare.gov
http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf (CMS Administrative Claiming Guide, May 2003)
http://www.eohhs.ri.gov/Home.aspx
www.ride.ri.gov
www.ritap.org/medicaid
www.ssa.gov
www.medicaidforeducation.org

Key Technical Assistance Contacts:

- Rhode Island Executive Office of Health and Human Services (EOHHS):
  Lynn Doherty, (401) 462-0315, Lynn.doherty@ohhs.ri.gov

- Rhode Island Executive Office of Health and Human Services (EOHHS):
- Jason Lyon, (401) 462-7405, Jason.lyon@ohhs.ri.gov

- Rhode Island Technical Assistance Project (RITAP):
  Denise Achin, (401) 222-8997, denise.achin@ride.ri.gov

- HP ENTERPRISE SERVICES
  Karen Murphy, (401) 463-2304, karen.murphy3@hp.com

Endnotes

[1] *Medicaid and School Health: A Technical Assistance Guide,* U.S. Department of Health and Human Services Health Care Financing Administration, 1997
[2] http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn
[3] Ibid.
[4] http://questions.cms.hhs.gov
[5] Ibid
[6] Individuals with Disabilities Education Act 2004 §300.101, §300.103 (b)
[7] Ibid, §300.39
[8] Ibid, §300.34 (a)
[9] Regulations of the Rhode Island Board of Education Governing the Education of Children with Disabilities, §300.321
[10] *Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies, November 1991*, U.S. Department of Health and Human Services Health Care Financing Administration, p. 1
[11] Opcit, *Rhode Island Regulations* §300.320 (a) (3) (i) (ii)
[12] Opcit, Medicaid and School Health 1997, p.1
[13] Opcit, *Medicaid and School Health 1997* ,Free Care
[14] Ibid, Third Party Liability
[15] Ibid
[16] Ibid, Exceptions to Medicaid as Payer of Last Resort
[17] Rhode Island Secretary of State's Public School Records Retention Schedule, LG5.8.32
[18] Opcit. IDEA 2004 §300.34 (c) (6)
[20] Ibid. IDEA 2004 §300.34 (c) (15)
[21] Ibid. IDEA 2004 §300.34 (c) (1) (i) (ii) (iii) (iv)(v)(vi)
[21] Ibid. IDEA 2004 §300.34 (10) (i) (ii)
[22] Ibid §300.34 (10)
[23] Ibid §300.34 (13)
[24] Opcit. *Medicaid and School Health 1997*, Transportation
[25] Opcit. IDEA 2004 §300.6
[26] Ibid. §300.5