MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

REVISED EMAIL ADDRESS- 6/23/08

Bulletin Number: MSA 08-23

Distribution: School Based Services Providers and Billing Agents

Issued: May 22, 2008

Subject: Elimination of School Based Services Administrative Outreach and Transportation Programs

New Provider Manual Chapters for School Based Services and for School Based Services Random Moment Time Study

Effective: July 1, 2008

Programs Affected: Medicaid School Based Services

This bulletin is to notify providers of the federally mandated change to the School Based Services (SBS) program effective for dates of service on or after July 1, 2008.

Elimination of SBS Administrative Outreach and Transportation Programs

On December 28, 2007, the Centers for Medicare and Medicaid Services (CMS) issued Federal Regulation CMS-2287-F (Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School). The original effective date of this regulation was February 28, 2008. On December 29, 2007, a moratorium was signed by the President granting a six-month delay and making the new effective date June 30, 2008.

Beginning for dates of service on or after July 1, 2008, services provided under the Michigan School Based Services Administrative Outreach and Transportation programs will no longer be eligible for Medicaid reimbursement. Claiming activity for dates of service prior to July 1, 2008 will be reimbursed using the methodologies and timely filing limits previously established and approved for each program by CMS.

Public Consulting Group will continue to process and submit claims to MDCH on behalf of the Administrative Outreach Program for quarters prior to July 1, 2008. Providers will, therefore, continue to be responsible for contract costs incurred for program-related activities for the above-mentioned time periods for the Administrative Outreach Program.

New Provider Manual Chapters for School Based Services and for School Based Services Random Moment Time Study

Effective July 1, 2008, the Michigan Fee For Service (FFS) School Based Services program will be reimbursed based on a cost-based, provider-specific and annually reconciled methodology. The Michigan Department of Community Health, in conjunction with a workgroup comprised of members from Michigan Department of Education, the Centers for Medicare and Medicaid Services, and Intermediate School Districts, has worked to develop this federally mandated methodology.

The attached two new chapters describe the policy and procedures for the coverage, reimbursement and time study for this new methodology. These new chapters will replace the existing two chapters in the Michigan Medicaid Provider Manual in their entirety.

For dates of service on or after July 1, 2008, FFS School Based Services program providers will be reimbursed an ISD-specific interim monthly payment based on estimated costs. On an annual basis, providers will be reconciled to actual costs based on the allocated Medicaid-allowable costs submitted on their annual cost reports. Once the reconciliation is completed, cost settlements will be processed for any over or under payments. CMS has also mandated that FFS providers continue to submit the procedure specific claims through the claims processing system as an audit check in addition to the cost reports.

Beginning July 1, 2008, ISDs and local school districts will need to begin capturing Medicaid-allowable cost data for certain health services costs and staff to support this new reimbursement process.

The new methodology will also require some changes to the Random Moment Time Study methodology. There will be three staff pools that time studies will be performed on:

1. FFS staff (those staff that perform direct medical services),
2. Personal Care Services staff (those staff that perform Personal Care Services), and
3. Targeted Case Management staff (those staff who provide Targeted Case Management Services).

Listed below are some of the major changes addressed in the new policy chapters:

- Michigan School for the Deaf and Blind will no longer be an enrolled provider.
- Staff Case Management (procedure code T1017) is no longer a billable service under the School Based Services Program.
- Teacher Consultants are no longer eligible to bill for Developmental Testing (procedure codes 96110 or 96111).
- Orientation and Mobility services are only billable by an Orientation and Mobility Specialist with a current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or a certified and registered Michigan Occupational Therapist.
- Personal Care Services are added as a new billable service (procedure code T1020).
- Targeted Case Management services have been redefined to meet the new federal criteria.
- The Random Moment Time Study process has been modified to be used for fee for service staff, personal care staff and targeted case management staff.
- 3,000 moments per staff pool will be sampled beginning July 1, 2008 (the summer quarter remains at 800 moments).

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Linda Sowle
MDCH/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: ~~MSA-Policy@michigan.gov~~ MSAPolicy@michigan.gov

If responding by e-mail, please include “School Based Services - MSA 08-23” in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

CERTIFICATION OF PUBLIC EXPENDITURE (CPE)

GOVERNMENTAL PROVIDER USE ONLY: CERTIFICATION OF TOTAL COMPUTABLE PUBLIC EXPENDITURE

1 Governmental Provider Name and Address:

Provider Name
1234 Health Services Drive
Anytown, USA 99999

2 Reporting Period (Medicaid State Plan Rate Year):

From:

To:

Medicaid Provider Number:

3 a. Type of Report:

[ ] Partial Period Report

[ ] Quarterly Cost Report

[X] Full Year Cost Report

b. Total Computable Certified Public Expenditure by Component:

[X]
Medicaid
Medical Services

Total Computable Expenditure
(From Exhibit 11, Line 23)

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that:

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses, services and activities, and the attached worksheets for the period from _____ to _____ and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the governmental provider in accordance with applicable instructions.

2. The expenditures included in this statement are based on the actual cost of recorded expenditures and reflect the reporting provider's cost of serving Medicaid recipients and / or Medicaid-expansion SCHIP recipients during the reporting period under the approved State plan and / or the cost of conducting administrative activities under a CMS-approved administrative claiming plan.

3. I am the officer authorized by the referenced governmental provider to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.

4. The required amount of State and/or local funds were used to pay for total computable allowable expenditures included in this statement, and such State and/or local funds were in accordance with all applicable Federal requirements for the non-Federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching rquirements under other Federally funded programs).

5. The total computable expenditures identified herein are submitted in accordance with 42 CFR 433.51.

6. I understand that this certification of public expenditures serves as the basis for Federal matching funds; that such expenditures were allowable to the State Medicaid program in accordance with all procedures, instructions, and guidance issued by and to the single state agency during the reporting period; and that falsification or concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE (officer of the governmental provider)

DATE

TITLE

PHONE NUMBER

SCHOOL BASED SERVICES

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts and Detroit Public Schools.

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

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

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

Medicaid school based services are not covered for beneficiaries involuntarily residing in a detention setting with a level of care code 32.

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

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

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

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.
Assistive Technology Service	The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device.
Certified Public Expenditure	A certified public expenditure is an expenditure of a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match.
Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)	▪ DME items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when: ➢ It is medically and functionally necessary to meet the needs of the beneficiary. ➢ It may prevent frequent hospitalization or institutionalization. ➢ It is life sustaining. ▪ Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that: ➢ Treat a medical condition. ➢ Prevent unnecessary hospitalization or institutionalization. ➢ Support DME used by the beneficiary. ▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Enable a beneficiary to ambulate or transfer. ▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Prevent or reduce contractures. ➢ Facilitate healing or prevent further injury.
Enrolled Medicaid Provider	The 57 Michigan Intermediate School Districts and Detroit Public Schools that have enrolled and revalidated with the MDCH CHAMPS Provider Enrollment subsystem.

FFS (Fee For Service) Program	The direct medical, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid.
HT Modifier (Multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team).
IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of 4 and 26 in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for beneficiaries up to the age of 21.
IFSP (Individualized Family Services Plan)	A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.
IDEA (Individuals with Disabilities Education Act)	The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.
IDEA Assessment	An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the individual.
ISD (District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 57 intermediate school districts.
MACS	Medicaid Administrative Claiming System is a custom-developed software that utilizes scanning hardware and software and spreadsheet software to automate the school district claiming process. The MACS is comprised of three components: sampling, training, and costs/claim generation.
MDE (Michigan Department of Education)	A department within the State of Michigan.
School-Based Services	A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs and the Detroit Public Schools participate in the Fee-for-Service Direct Medical Program.

Random Moment Time Study	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]).
Treatment Plan	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection of this section.

1.1 Children's Special Health Care Services

The Medicaid program reimburses services for beneficiaries who are dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid up to the age of 21. SBS providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only), and must not submit claims for these beneficiaries.

1.2 Medical Necessity

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

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self care;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually.

A stamped signature is not acceptable.

1.3 Under the Direction of and Supervision

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

direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.

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

1.4 Covered Services

Medicaid covered services billed by ISDs include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services
- Assistive Technology Device Services
- Physical Therapy Services
- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatrist Services
- Personal Care Services
- Targeted Case Management (TCM) Services

1.5 Service Expectations

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

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

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

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

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

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

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

1.6 TREATMENT PLAN

Requirements	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the beneficiary. The beneficiary's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described below. Only qualified staff may initiate, develop or change the beneficiary's treatment plan. The treatment plan must be signed, titled and dated by the qualified staff prior to billing Medicaid for services and must be retained in the beneficiary's school clinical record. (Refer to the Covered Services Section of this chapter for definitions of qualified staff.)
Components	The treatment plan, which is an immediate result of the evaluation, must consist of the following components: ▪ Beneficiary's name; ▪ Description of the beneficiary's qualifying diagnosis and medical condition; ▪ Time-related goals that are measurable and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals; ▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP;

	▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis.
Review	The treatment plan must be reviewed and updated at least annually as part of the IEP/IFSP multi-disciplinary team assessment process, or more frequently if the beneficiary's condition changes or alternative treatments are recommended.

1.7 EVALUATIONS

Evaluations for medical services are covered when:

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

1.7.A. EVALUATIONS PERFORMED FOR DMEPOS MEDICAL SUPPLIERS

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

1.8 DOCUMENTATION

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

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

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

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

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

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

SECTION 2 – COVERED SERVICES

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

Definition	The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the beneficiary. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered.
Provider Qualifications	Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA Assessment. To be covered by Medicaid, the staff must have the following Michigan current credentials: ▪ A certified and registered occupational therapist (OTR) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (LPT) ▪ An American Speech-Language Hearing Association (ASHA) certified speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC) ▪ A licensed audiologist ▪ A fully licensed psychologist (Doctoral level) ▪ A limited-licensed psychologist (Doctoral level) (under the supervision of a licensed psychologist) ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A registered nurse (RN)
Procedure Codes	Qualified staff can bill for three distinct types of assessments/evaluations/tests as follows. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. ▪ The **HT modifier** is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code below followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of

	eligibility for special education or early-on services. The determination date must be included in the assessment/evaluation/test. ▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. ▪ No modifier is used when assessments/evaluations/tests are provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with **no modifier.** The date of service is the date the assessment/evaluation/test is completed. Procedure codes to be used to bill for the above activities are: ▪ **T1024** - Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiply or severely handicapped children, per encounter. (This code can only be used with the TM modifier. Used by the Designated Case Manager billing for the IEP/IFSP multi-disciplinary assessment (TM) or an assessment not related to the revision of the IEP/IFSP (no modifier). The Designated Case Manager cannot bill using the HT modifier.) ▪ **99367** - Medical team conference with interdisciplinary team of health professionals, patient and/or family not present, 30 minutes or more; participation by physician. (Used by the physician billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **92506** - Evaluation of speech, language, voice, communication, and/or auditory processing. (Used by the speech pathologist or audiologist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **H0031** - Mental Health Assessment, by non-physician. (Used by the psychologist, counselor or licensed social worker billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).)
	▪ **T1001** - Nursing assessment/evaluation (registered nurse [RN]). (Used by the RN billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **97001**- Physical Therapy Evaluation.

	(Used by the physical therapist billing for either the IEP/IFSP multi-disciplinary assessment, an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **97003** - Occupational Therapy Evaluation. (Used by the occupational therapist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) ▪ **V2799** – Vision services, miscellaneous. (Used by the orientation and mobility specialist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).)

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

2.2.A. Occupational Therapy Services

Definition	**Occupational Therapy:** Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. Occupational therapy services must require the skills, knowledge and education of an OTR, COTA or Orientation and Mobility specialist to provide services.
Prescription	Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	OT services may be reimbursed when provided by: ▪ A certified and registered occupational therapist in Michigan (OTR); or ▪ A certified occupational therapy assistant (COTA) registered in Michigan and under the direction of a currently-Michigan-registered OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising OTR.
Evaluations for Occupational Therapies	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an OTR. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;

	▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Assessments for Durable Medical Equipment	If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment (a pediatric sub-specialist is required for CSHCS eligible children). The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	Occupational therapy services include: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; ▪ Wheelchair management/propulsion training; ▪ Independent living skills training; ▪ Coordinating and using other therapies, interventions, or services with the ATD; ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian; ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services;

	▪ Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD; or ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	The following procedure codes may be used to bill for occupational therapy services: ▪ **97003** – Occupational therapy evaluation. This code can be used by itself, or with the HT or TM modifiers. ▪ **97110** – Therapeutic procedure, one or more areas, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion, and flexibility. ▪ **97150** – Therapeutic procedure(s), group (2 or more individuals). ▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers. ▪ **97755** – Assistive technology assessment (e.g., to restore, augment or compensate for existing functional tasks and/or maximize environmental accessibility), direct one-on-one contact by providers, with written report, each 15 minutes. (If assessments are done for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.)

2.2.B. ORIENTATION AND MOBILITY SERVICES

Definition	**Orientation and Mobility Services:** Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low vision aids/devices, as appropriate.

Prescription	Orientation and mobility services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	Orientation and mobility services may be reimbursed when provided by: ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or ▪ A certified and registered occupational therapist in Michigan (OTR).
Evaluations	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an Orientation and Mobility Specialist (O&M) or a certified and registered Occupational Therapist (OTR). An evaluation for Orientation and Mobility services includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Services	**Orientation and mobility services include:** ▪ Providing assistance in the development of skills and knowledge that enable the child to travel independently to the highest degree possible, based on assessed needs and the IEP; ▪ Training the child to travel with proficiency, safety and confidence in familiar and unfamiliar environments; ▪ Preparing and using equipment and material, such as tactile maps, models, distance low vision aids/devices, and long canes, for the development of orientation and mobility skills; ▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision; ▪ Communication skills training (teaching Braille is not a covered benefit);

	▪ Systematic orientation training to allow safe movement within their environments in school, home and community; ▪ Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation; ▪ Visual training to understand and use the remaining vision for those with low vision; ▪ Training necessary to activate visual motor abilities; ▪ Training to use distance low vision aids/devices; and ▪ Independent living skills training.
Procedure Codes	The following procedure codes may be used to bill for orientation and mobility services: ▪ **97533** – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes. ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. ▪ **G9041** – Rehabilitation services for low vision by qualified occupational therapist, direct one-on-one contact, each 15 minutes. ▪ **G9042** – Rehabilitation services for low vision by certified orientation and mobility specialist, direct one-on-one contact, each 15 minutes. ▪ **V2799** – Vision services, miscellaneous

2.2.C. Assistive Technology Device Services Performed by an Occupational Therapist

Definition	**Assistive Technology Device Services Provided by an Occupational Therapist:** An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, customized or developed by staff as an orthodox device, that is used to increase, maintain, or improve the functional capabilities of a beneficiary. The device primarily addresses a medical condition by replacing a missing body part, preventing or correcting a physical deformity or malfunction, supporting a weak or deformed portion of the body (prosthetic function), or restoring communication skills to meet basic medical needs by providing a tool to the beneficiary (rehabilitative function).
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.

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

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

2.3 Physical Therapy Services (Includes Assistive Technology Device Services)

2.3.A. Physical Therapy Services

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

Assessments for Durable Medical Equipment	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment (a pediatric sub-specialist is required for CSHCS-eligible children). The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	Physical therapy services include: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
Procedure Codes	The following procedure codes may be used to bill for physical therapy services: ▪ **97001** – Physical therapy evaluation. This code can be used by itself or with the HT or TM modifiers. ▪ **97110** – Therapeutic procedure, one or more areas, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion, and flexibility. ▪ **97116** – Gait training (includes stair climbing), each 15 minutes. ▪ **97150** – Therapeutic procedure(s), group (2 or more individuals), each 15 minutes. ▪ **97530** – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. ▪ **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes. (If wheelchair management services are provided for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.

	▪ **97755** – Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes. (If assessments are done for equipment that is covered under the Medicaid Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by school based providers.) ▪ **97762** – checkout for orthotic/prosthetic use, established patient, each 15 minutes.

2.3.B. Assistive Technology Device Services Performed by a Physical Therapist

Definition	**Assistive Technology Device Services Performed by a Physical Therapist:** An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, customized or developed by staff as an orthodox device, that is used to increase, maintain, or improve the functional capabilities of a beneficiary. The device primarily addresses a medical condition by replacing a missing body part, preventing or correcting a physical deformity or malfunction, supporting a weak or deformed portion of the body (prosthetic function), or restoring communication skills to meet basic medical need by providing a tool to the beneficiary (rehabilitative function).
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	Assistive Technology services may be reimbursed when provided by a licensed physical therapist (LPT) in Michigan. (ATD services provided by an OT, SLP or audiologist are described in those respective sections of this chapter.)
Evaluations for Assistive Technology Devices	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a LPT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;

	▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for Durable Medical Equipment	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment (a pediatric sub-specialist is required for CSHCS eligible children). The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers.

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

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

2.4.A. Speech, Language and Hearing Therapy

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. Speech, language and hearing therapy must require the skills, knowledge and education of a qualified speech-language pathologist or audiologist to provide the therapy.
Prescription	Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A speech-language pathologist (SLP) possessing a current ASHA Certificate of Clinical Competence (CCC); ▪ A licensed audiologist in Michigan; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately-credentialed SLP or licensed audiologist; teacher of students with speech and language impairments (TSLI), under the direction of an SLP or audiologist. All documentation must be reviewed and signed by the appropriately-credentialed supervising SLP or licensed audiologist.

Evaluations for Speech Pathology Services	Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by an SLP or audiologist. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. Evaluations may also include, but are not limited to,: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, and measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.
Speech Assessments for Durable Medical Equipment	If an ISD speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment (a pediatric sub-specialist is required for CSHCS-eligible children). The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	Speech, language and hearing services include: ▪ Group therapy provided in a group of two to eight beneficiaries. ▪ Articulation, language, and rhythm. ▪ Swallowing dysfunction and/or oral function for feeding. ▪ Voice therapy. ▪ Speech, language or hearing therapy. ▪ Speech reading/aural rehabilitation. ▪ Esophageal speech training therapy. ▪ Speech defect corrective therapy. ▪ Fitting and testing of hearing aids or other communication devices.
Procedure Codes	The following procedure codes may be used to bill for speech, language and hearing therapy services: ▪ **92506** – Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. This code can be used with no modifier, or with the HT or TM modifiers. ▪ **92507** – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehab); individual. ▪ **92508** – Therapeutic procedure(s), group (2 or more individuals). ▪ **97530** – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes.

2.4.B. Assistive Technology Device Services Performed by an Audiologist or Speech Language Pathologist

Definition	**Assistive Technology Device Services Performed by an Audiologist or SLP:** An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, customized or developed by staff as an orthodox device, that is used to increase, maintain, or improve the functional capabilities of a beneficiary. The device primarily addresses a medical condition by replacing a missing body part, preventing or correcting a physical deformity or malfunction, supporting a weak or deformed portion of the body (prosthetic function), or restoring communication skills to meet basic medical need by providing a tool to the beneficiary (rehabilitative function).
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.

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

Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	The following procedure code may be used to bill for ATD services: ▪ **97535** – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. (Use this code only when billing for speech-related ATD services.)

2.5 PSYCHOLOGICAL, COUNSELING AND SOCIAL WORK SERVICES

Definitions	Psychological, counseling and social work services include planning, managing and providing a program of face-to-face services for beneficiaries with diagnosed psychological conditions. Psychological, counseling and social work services must require the skills, knowledge and education of a psychologist, counselor or licensed social worker to provide treatment. Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy.

	▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a beneficiary who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. ▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.
Provider Qualifications	Psychological, counseling and social work services may be reimbursed when provided by: ▪ A licensed physician or psychiatrist in Michigan; ▪ A fully licensed psychologist (Doctoral level) in Michigan; ▪ A limited-licensed psychologist (Doctoral level) under the supervision of a licensed psychologist; ▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; ▪ A licensed professional counselor in Michigan; or ▪ A limited licensed counselor under the supervision of a licensed professional counselor.
Evaluations	Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed social worker must complete them.
Psychological Testing	Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A fully licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's condition. Medicaid does not cover the time that a beneficiary spends alone in testing. The beneficiary's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing.

	The psychological testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.
Procedure Codes	The following procedure codes may be used to bill for psychological testing: ▪ **96101** – Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. To evaluate intellectual abilities, psychopathology, psychodynamics, risk for mental illness and other factors influencing treatment and diagnosis. ▪ **96116** – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. ▪ **96118** – Neuropsychological testing (e.g., Halstead-Reitan Neurological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), per hour of the psychologist's time or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. The following procedure codes may be used to bill for psychological, counseling and social work services. Only one individual psychotherapy procedure code (20 to 30 minutes or 45 to 50 minutes) may be billed per day: ▪ **90804** – Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, 20 to 30 minutes, face-to-face with the patient. ▪ **90806** – Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient. ▪ **90810** – Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with patient. ▪ **90812** – Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with patient.

	▪ **90846** – Family psychotherapy (conjoint psychotherapy), without the patient present. ▪ **90847** – Family psychotherapy (conjoint psychotherapy), with patient present. ▪ **90853** – Group psychotherapy (other than a multiple-family group). ▪ **H0004** – Behavioral health counseling and therapy, per 15 minutes. ▪ **H0031** – Mental health assessment, by non-physician (e.g., psychologist, counselor, licensed social worker). This code can be used by itself or with the HT or TM modifiers.
Crisis Intervention	Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the beneficiary's IEP/IFSP treatment plan. Crisis intervention must be billed using the following procedure code: ▪ **S9484** – Crisis intervention mental health services, per hour.

2.6 DEVELOPMENTAL TESTING

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the beneficiary's history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid.
Documentation	The developmental testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ The dated signature, address and phone number of the person administering the tests.

Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: ▪ A fully-licensed psychologist (Doctoral level) in the State of Michigan; ▪ A limited-licensed psychologist (Doctoral level) under the supervision of a licensed psychologist; ▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; or ▪ A licensed physician or psychiatrist in Michigan.
Procedure Codes	The following codes may be used to bill for developmental testing: ▪ **96110** – Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. ▪ **96111** – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments), with interpretation and report.

2.7 NURSING SERVICES

Definition	Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse (RN) and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices. Services include: ▪ Catheterizations or Catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. LPN services can only be billed if performed under the supervision of an RN or physician.

Prescription	Direct service interventions require a physician's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the beneficiary's attending physician. The nurse is responsible for notifying the attending physician of any change in the beneficiary's condition which may result in a change or modification to the care plan.
Provider Qualifications	Nursing services may be reimbursed when provided by: ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ A Licensed Practical Nurse (LPN) in Michigan.
Evaluations	A RN must complete the evaluations/assessments and prepare a nursing care plan. An evaluation/assessment may be performed when a change in the beneficiary's medical condition occurs. LPNs cannot bill for evaluations/assessments.
Procedure Codes	To bill for nursing services, use procedure codes: ▪ **T1001** – Nursing assessment/evaluation. To be billed by the RN only. This code can be used by itself or with the HT or TM modifiers. ▪ **T1002** – RN services, up to 15 minutes ▪ **T1003** – LPN/LVN services, up to 15 minutes

2.8 PHYSICIAN AND PSYCHIATRIST SERVICES

Definition	Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a beneficiary's medical or other health-related condition. Physician/psychiatrist services include: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled school district. Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled school district.
Provider Qualifications	A licensed physician or psychiatrist (MD or DO) in Michigan.

Procedure Codes	The procedure codes listed below may be used to bill for physician or psychiatrist services. Procedure codes 99367 and G9008 will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable. ▪ **99367** – Medical team conference with interdisciplinary team of health professionals, patient and/or family not present, 30 minutes or more; participation by physician. This code can be used by itself, or with the HT or TM modifiers. ▪ **G9008** – Coordinated care fee, physician coordinated care oversight services. (This code is to be used for billing the physician record review.)

2.9 PERSONAL CARE SERVICES

Definition	Personal Care Services are a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/her self. Personal Care Services may be provided when: ▪ The service is medically necessary. ▪ The service categories are documented in the IEP/IFSP. The treatment plan should contain the details of the service, frequency and duration and can either be part of the IEP/IFSP or an attached document. ▪ The service is ordered by a Physician in accordance with an individual plan of services at least annually. Personal Care Services are not covered if they are: ▪ Provided by a family member. A family member is described by the Centers for Medicare & Medicaid Services (CMS) to be "legally responsible relatives"; thus, spouses of beneficiaries and parents of minor beneficiaries (including stepparents who are legally responsible for minor children). ▪ Not documented in the IEP/IFSP. ▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation. ▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. Personal Care Services may include, but are not limited to, assisting with the following: ▪ Eating/feeding; ▪ Respiratory assistance; ▪ Toileting; ▪ Grooming;

	▪ Dressing; ▪ Transferring; ▪ Ambulation; ▪ Personal hygiene; ▪ Mobility/Positioning; ▪ Meal preparation; ▪ Skin care; ▪ Bathing; ▪ Maintaining continence; ▪ Assistance with self administered medications; ▪ Redirection and intervention for behavior; and ▪ Health related functions through hands-on assistance, supervision and cueing.
Personal Care Paraprofessional Provider Qualifications	The personal care paraprofessional personnel are employed in the Special Education Program and shall be qualified under the requirements established by their respective ISD plan. Providers must be trained in the skills needed to perform covered services, and must be under the direction of a qualified professional as designated in the IEP/IFSP. Paraprofessional personnel include: ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ Trainable Aides
Prescription	Personal care services require an authorization by a physician, in accordance with an individual plan of services, and are rendered by a qualified person.
Documentation	Personal care services must be medically necessary and the need for the service documented in the student's IEP/IFSP. Each child's school clinical record must contain a completed, signed and dated monthly activity checklist.
Procedure Codes	The following procedure code may be used to bill for personal care services. ▪ **T1020** – Personal care services, per diem; not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD; part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).

2.10 TARGETED CASE MANAGEMENT SERVICES

Definition	Targeted case management (TCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational or other services. Targeted case management services include the following assistance: ▪ A comprehensive assessment and periodic reassessment of an individual to determine the need for medical, social, educational or other services. These assessment activities include: ➢ Taking client history; ➢ Identifying the individual's needs and completing related documentation, ▪ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual. ▪ Development (and periodic revision) of a specific care plan that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the individual; ➢ Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and ➢ Identifies a course of action to respond to the assessed needs of the eligible individual. ▪ Referral and related activities: ➢ To help an eligible individual obtain needed services, including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual; ➢ Monitoring and follow-up activities; ➢ Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met: ♦ Services are being furnished in accordance with the individual's care plan; ♦ Services in the care plan are adequate.

	▪ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements. TCM services may be reimbursed when provided by a Designated Case Manager. Providers must maintain case records that document, for all individuals receiving case management, the following: the name of the individual, the dates of the case management services, the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the care plan have been achieved, whether the individual has declined services in the care plan, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the plan.
Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the plan of care/treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria: ▪ A licensed RN in Michigan; ▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of an individual with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: ▪ Services for infants and toddlers who are eligible under the IDEA law as appropriate; ▪ Part C of the IDEA law and the associated regulations; ▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provisions of direct care services to individuals with special needs; and ▪ Provisions of culturally competent services within the community being served.
Designated Case Manager Services	Targeted Case Management services include: ▪ Assuring that standard re-examination and follow-up of the beneficiary are conducted on a periodic basis to ensure that the beneficiary receives needed diagnosis and treatment; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services; ▪ Assuring that case records are maintained and indicate all contacts with, or on behalf of, a beneficiary in the same manner as other covered services;

	▪ Coordinating school based services and treatment with parents and the child; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team treatment plan; ▪ Activities that support linking and coordinating needed health services for the beneficiary; ▪ Provide summary of provider, parent and student consultation; and ▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.
Procedure Code	▪ **T1017** – Targeted case management, each 15 minutes.

SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

3.1 QUALITY ASSURANCE

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

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

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

3.2 SERVICE COORDINATION AND COLLABORATION

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

3.3 ISD RESPONSIBILITIES

Each ISD must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the RMTS sample frame (designated employees), adherence to the MDCH-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also

fully cooperate with any review requested by the Department of Health and Human Services (DHHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

3.3.A. SANCTIONS

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

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

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to use the MACS software.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDCH, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.

SECTION 4 – PROVIDER ENROLLMENT

4.1 ENROLLMENT

The 57 Michigan Intermediate School Districts (ISDs) and the Detroit Public Schools (DPS) are the only providers eligible to bill Medicaid for School Based Services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

4.2 CERTIFICATION OF QUALIFIED STAFF

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

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

4.3 MEDICAID ELIGIBILITY RATE

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

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

SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

5.1 FINANCIAL DATA

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

5.2 UNALLOWABLE COSTS

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

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

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

Funds received by an ISD/DPS for school based direct medical services under the fee-for-service component are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

SECTION 6 – SCHOOL BASED SERVICES REIMBURSEMENT

6.1 METHOD OF REIMBURSEMENT DIRECT MEDICAL SERVICES (FFS), PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

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

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

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

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

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

- The SBS fee-for-service (FFS) procedure code specific billing process;
- The random moment time study (RMTS) component;
- The interim payment process, and;
- The cost reconciliation and cost settlement process.

6.1.A. FEE FOR SERVICE PROCEDURE CODE SPECIFIC BILLING

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

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

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

6.1.B. Random Moment Time Study

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

The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement and entered onto the first sheet of the MACS Workbook. Once complete, the workbooks are forwarded to the Michigan Department of Community Health (MDCH) where they are uploaded into the cost settlement program.

Costs are reported for FFS direct medical on the Medicaid Expenditure Report and collected via financial worksheets for Personal Care Services and Targeted Case Management.

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

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

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

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

Summer Quarter Process

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

The summer quarter will be divided into two parts producing two partial claims. The sum of both claims will be submitted to Medicaid for reimbursement for the quarter. The first part of the quarter will extend from July 1 to the date the 9-month staff return to work. The second part of the quarter will be from the date the 9-month staff return to work through September 30.

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

6.1.C. Interim Payment Process

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

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

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

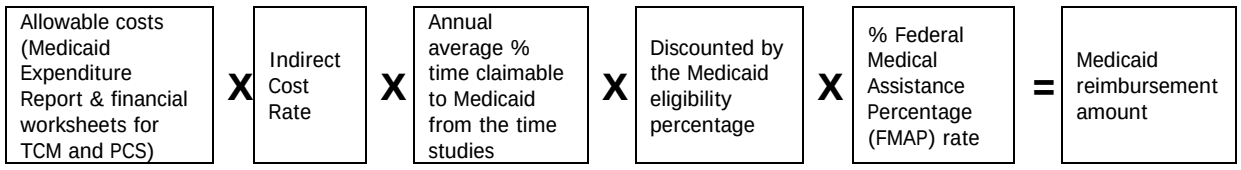
Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the Medicaid Expenditure Report. Any written inquiries should be addressed to MDCH Hospital and Health Plan Reimbursement Division.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

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

6.1.D. Cost Reconciliation and Settlement

Allowable cost will be based on the following components:

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



The Medicaid Expenditure Report (modeled after the MDE SE-4096 cost report) is utilized to collect allowable costs for the medical professional staff. Costs for the staff providing targeted case management services and personal care services that are not included in the direct medical costs are obtained from the participating ISD/DPS financial accounting

system via financial worksheets sent out by the State Contractor. The filed cost data is used to calculate an interim settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

Within 18 months after the school fiscal year end, the ISD/DPS will review, certify, and finalize the Medicaid Expenditure Report. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDCH before a final settlement will be processed. The final settlement process will begin within 18 – 20 months after the close of the school fiscal year. Settlements may take several months for completion. (Refer to the Forms Appendix for a copy of the CMS-10231.)

LEAs may submit revisions to the Medicaid Expenditure Report until the final settlements are processed. Instructions for completing revisions are attached to the Medicaid Expenditure Report.

SECTION 7 – INDIRECT COST RATE (ICR)

7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget Circular A-87 "Indirect Cost Allocation Principles." The methodology used to determine the indirect cost rate specific to each district is approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

SECTION 8 – COST CERTIFICATION

8.1 COST CERTIFICATION

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

SECTION 9 – COST ALLOCATION FACTORS

9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATE

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

9.2 DISCOUNTED HEALTH-RELATED MEDICAID ELIGIBILITY RATE (MER)

The discounted health-related Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the special education student population that is Medicaid eligible in each ISD/DPS with a health-related support service code indicated on their December 1 Student Count Report. A health-related support service code is attached to any one or more of the following services: Speech and Language, Social Work, Psychological, Occupational Therapy, Physical Therapy, Audiology, and Orientation and Mobility.

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

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

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

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

SECTION 10 – DOCUMENTATION

10.1 FEE FOR SERVICE DOCUMENTATION

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

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

Districts must cooperate fully with any review requested by the MDCH, the CMS, and special monitoring staff and maintain all necessary records for a minimum of seven (7) years.

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

10.2 RMTS DOCUMENTATION

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

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

Districts must cooperate fully with any review requested by the MDCH and the CMS and maintain all necessary records for a minimum of seven (7) years.

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

SCHOOL BASED SERVICES RANDOM MOMENT TIME STUDY

TABLE OF CONTENTS

SECTION 1 – GENERAL TIME STUDY INFORMATION

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

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

1.1 FEE FOR SERVICE DIRECT MEDICAL SERVICES

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

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

1.2 STAFF POOLS AND CONFIDENCE LEVELS

The RMTS is carried out utilizing custom-developed software, the Medicaid Administrative Claiming Software (MACS), which is integrated with scanning hardware/software and spreadsheet capabilities to create a system that automates the school district time study process. The MACS is comprised of three components: sampling, training, and cost/claim generation.

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

- FFS/Direct Medical Staff – This staff pool consists of individuals who perform FFS/Direct Medical activities.
- Personal Care Services Staff – This staff pool consists of individuals who perform direct care Personal Care Services.

- Targeted Case Management staff: This staff pool consists of individuals who perform Targeted Case Management (TCM) Services.

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

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

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

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

SECTION 2 – CENTRALIZED CODING

The State Contractor will assign a designated coder for the time study moments. MDCH will oversee the Contractor and ISDs/DPS participating to assure their compliance with all aspects of program policy and federal regulations.

SECTION 3 – TIME STUDY METHODOLOGY

3.1 TIME STUDY OVERVIEW

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

All districts must identify three separate staff pools: (1) FFS/Direct Medical staff pool, (2) Personal Care Services staff pool, and (3) Targeted Case Management staff pool. The respective staff pools identify staff that spend a portion of their time performing one of the listed duties and assure that the staff will be available to participate in a quarterly time study.

3.2 RANDOM MOMENT TIME STUDY OVERVIEW

The RMTS method measures the work effort of the entire group of approved staff involved in the ISD/DPS FFS direct medical, personal care services and targeted case management staff pools by sampling and analyzing the work efforts of a randomly-selected cross-section of the group. RMTS methods employ a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the same three-month period comprising each quarter of the federal calendar, except there is an abbreviated sample period used in the summer quarter.

Medicaid will use the Medicaid Administrative Claiming System (MACS) software to conduct the statewide time studies each quarter.

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

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

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to three questions (What are you doing? Who are you with? Why are you doing it?). These questions relate to their activities at the time of their randomly selected moment.

- In the second step, the time study forms are collected from the participants, and the designated coder, from the State Contractor, will assign the appropriate activity code for that moment based on the answers to the three time study questions.

At this point, the time study form is completed and can be scanned into the MACS by the State Contractor.

The State Contractor will conduct the statewide time study each quarter for all ISDs/DPS and produce a report detailing the results. This involves importing clinician information from the ISDs/DPS to compile the statewide pool of all eligible time study participants. There will be three separate staff pools sampled for the RMTS each quarter: 1) the FFS/Direct Medical services staff pool will have 800 moments randomly selected for the Summer quarter and 3,000 moments randomly selected for all other quarters, 2) the Personal Care Services staff pool will have 800 moments randomly selected for the Summer quarter and 3,000 moments randomly selected for all other quarters, and 3) the Targeted Case Management staff pool will have 800 moments randomly selected for the Summer quarter and 3,000 moments randomly selected for all other quarters. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs/DPS prior to the beginning of the reporting period. The Contractor will directly distribute and collect the time study forms for the ISDs/DPS.

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

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

3.3 TIME STUDY PARTICIPANTS

The following is the description of the eligible participants for the three staff pools.

3.3.A. FFS/DIRECT MEDICAL STAFF POOL

FFS/Direct Medical Staff Pool:

- American Speech-Language-Hearing Association (ASHA) certified Speech Language Pathologist *****
- Audiologist
- Counselor
- Licensed Practical Nurse
- Occupational Therapist
- Occupational Therapist Assistant
- Orientation and Mobility Specialist
- Physical Therapist
- Physical Therapist Assistant
- Physician and Psychiatrist
- Psychologist
- Registered Nurse
- Social Worker

***** Includes a Teacher of Students with Language Impairments under the direction of an ASHA certified SLP or audiologist

3.3.B. Personal Care Services Staff Pool

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

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

3.3.C. Targeted Case Management Services Staff Pool

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

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

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

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

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

SECTION 4 – DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the seven (7) code categories and indicates whether they are claimable for reimbursement under the FFS Direct Medical program, allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities would be those that are purely educational in nature.

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

- "A" = Allowable means the expense is allowable for Medicaid reimbursement;
  - Direct medical IEP/IFSP services have a federal match rate that varies from year to year;
- "U" = Unallowable means the expense is not allowable for Medicaid reimbursement;
- "R" = Reallocated means reimbursement across multiple activities that is allocated to isolate the amount applicable to the Medicaid allowable category;
- "IEP MER" = The direct medical IEP Medicaid Eligibility Rate (IEP MER) is determined by calculating the percentage of special education students with health related services in their IEP/IFSP that are Medicaid eligible.

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

Activity Code	Federal Matching Rate	FFS	IEP MER
13 IEP/IFSP Direct Medical Services	Annual FMAP Rate	A	IEP MER
13 (A) IEP/IFSP Personal Care Services	Annual FMAP Rate	A	IEP MER
13 (B) IEP/IFSP Targeted Case Management Services	Annual FMAP Rate	A	IEP MER
13 (C) Other and Non IEP/IFSP Direct Medical Services		U	U
16 General Administration		R	R
17 School-Related and Educational Activities		U	U
18 Not Scheduled to Work and Not Paid		U	U

4.1 Activity Coding

4.1.A. Code 13 – IEP/IFSP Direct Medical Services

A – Fee-For-Service

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

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

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

4.1.B. Code 13 (A) – IEP/IFSP Personal Care Services

A – Fee-For-Service

This code is used for providing a range of human assistance services to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/her self. The need for services must be documented in the

child's IEP/IFSP. Services are not covered when provided by a family member or if they are educational in nature.

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

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

4.1.C. Code 13 (B) – IEP/IFSP Targeted Case Management Services

A – Fee-For-Service

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

Case management services must be in units of 15 minutes or less.

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

- Assure that standard re-examination/follow-up of the student is periodically conducted to ensure the student receives needed diagnosis and treatment
- Assist families in identifying/choosing appropriate care providers and services
- Maintain case records and indicate all contact for student in the same manner as other covered services
- Coordinate performance evaluations/assessments and other service needs for the student
- Prevention of duplicate services
- Facilitation/participation in development, review and evaluation of the multi-disciplinary assessment
- Supporting activities that link or coordinate needed health services for the student
- Meeting with teachers and other professional staff to discuss testing, planning, treatment, coordinating effective interventions, and student progress
- Coordinate school based services and treatment with parents and student
- Monitoring and recommending a plan of action
- Providing modifications to the multi-disciplinary, patient-centered treatment plan
- Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting
- Provide summary of provider, parent and student consultation

4.1.D. Code 13 (C) – Other and Non IEP/IFSP Direct Medical Services

U – Fee-For-Service

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

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

4.1.E. Code 16 – General Administration

R – Fee-For-Service

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

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

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

4.1.F. Code 17 – School-Related and Educational Activities

U – Fee-For-Service

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

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

- Providing classroom instruction (including lesson planning).
- Testing and correcting papers.

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

4.1.G. Code 18 – Not Scheduled to Work and Not Paid

U – Fee-For-Service

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

Examples of this may include:

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

SECTION 5 – CONFIDENTIALITY

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

SECTION 6 – TIME STUDY TRAINING

6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies. For example, all time study participants must clearly understand how to complete the time study form.

The State Contractor along with the Michigan Department of Community Health (MDCH) are responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the State Contractor will provide statewide and other services that will be provided to the individual ISDs/DPS.

6.1.A. LOCAL ISD COORDINATOR TRAINING

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

6.1.B. TIME STUDY PARTICIPANT TRAINING

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

SECTION 7 – SUMMARY OF TIME STUDY STEPS

7.1 SUMMARY OF TIME STUDY STEPS

The State Contractor duties are to:

- Import eligible school district staff information.
- Randomly select staff/moments to be sampled.
- Generate printed RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD/DPS Coordinators as a local control list.
- Generate mailing labels addressed to randomly selected staff.
- Scan completed and coded time study forms.
- Transfer raw data from scanned forms to MACS.
- Calculate activity percentages for each of the seven (7) activity codes.
- Produce a quarterly report summarizing the results of the time study and forward it to the ISDs/representative within one month of the end of each quarter.
- Produce periodic and special RMTS reports that provide data and information sorted by LEA, ISD/DPS that are provided to the CMS, MDCH, MDE, ISDs/DPS and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs/DPS.
- Distribute time study forms and collect completed time study forms.
- Designate centralized coders to code the activity forms received from the ISDs/DPS.
- Initiate and complete the ISD/DPS claim workbooks with the RMTS results. Obtain the financial data from each LEA and compile data to complete the workbook sheets.

SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

8.1 SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

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

The summer quarter is divided into two parts producing two partial claims. The sum of both claims is submitted to Medicaid for reimbursement for the quarter. The first part of the quarter is from July 1 to the date the 9-month staff return to work. The second part of the quarter is from the date the 9-month staff return to work through September 30.

The RMTS of 800 moments is performed in the summer quarter but takes place only after the employees start back to work and is only applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS is performed during a shorter time period.

8.1.A. PART I - JULY 1 TO THE DATE 9-MONTH STAFF RETURN TO WORK

For the first part of the summer quarter, the staff pool list for the ISD is the same RMTS staff pool list used for the preceding April-June quarter.

8.1.B. PART II - DATE 9-MONTH STAFF RETURN TO WORK THROUGH SEPTEMBER 30

The financial data reporting for Part II of the summer quarter are based on the actual costs incurred during this timeframe for the staff on the August-September staff pool list.

SECTION 9 – AUDIT AND QUALITY ASSURANCE

9.1 AUDIT

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

MDCH audit staff review of selected ISD/DPS cost reports includes the following activities:

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

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

9.1.B. SAS 70 AUDIT REQUIREMENT

The State Contractor is required to have a Type II Statements on Auditing Standards (SAS) 70 audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) has been properly applied.

A SAS 70 audit is an independent audit performed for the purpose of evaluating and issuing an opinion on a service organization's operational processes and controls. The auditor of the service organization is required to issue a report on controls placed in operation and tests of operating effectiveness, which is commonly referred to as a "Type II report", in accordance with the American Institute of Certified Public Accountants (AICPA) Statements on Auditing Standards (SAS) No. 70 - Reports on the Processing of

Transactions by Service Organizations, as amended by SAS No. 88 - Service Organizations and Reporting Consistency.

The State Contractor must undergo a SAS 70 audit annually. If significant systems changes or changes in methodology have occurred, a SAS 70 audit must be completed in the year of the change. Once the SAS 70 audit has been performed under the new program, the school district's auditor should extend their audit procedures to a review of the billing company's process in the years that a SAS 70 audit is not completed if the program is selected for testing as a major program under the requirements of OMB Circular A-133.

The SAS 70 audit must cover, at a minimum, the most recent six months. The SAS 70 audit must be submitted within 90 days after the end of the examination period.

Three (3) copies of the audit should be forwarded to the MDCH Program Policy Section.

9.2 Quality Assurance

Oversight, monitoring and quality assurance activities include:

9.2.A. MDCH Program Policy – Oversight of Administration and Operations

MDCH policy staff responsibilities are:

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

9.2.B. MDCH Program Investigation Section – Post Payment Review and Compliance

Program Investigation staff responsibilities are:

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

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

9.2.C. MDCH Special Programs Section – Cost Settlement Review

Cost Settlement staff responsibilities are:

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

9.2.D. Contractor Oversight and Quality Assurance

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

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

9.2.E. ISD / DPS OVERSIGHT

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