

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



**RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
September 2014**

TABLE OF CONTENTS

I.	INTRODUCTION (Acknowledgements and Acronyms)	Pages 4-5
II.	BACKGROUND	Pages 6-11
	A. Rhode Island General Law 40-8-18.....	6
	B. Medicaid	7
	C. Medicaid in Rhode Island	8-9
	D. The Role of Special Education	10-11
	a. IDEA Part B	
	b. IEP	
III.	LEAs ENROLLING AS AN EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROVIDER (EPSDT)	
	Pages 12-19	
	A. Local Governing Authority Approval.....	12
	B. EOHHS/LEA Interagency Provider Agreement.....	12
	C. Certification of Funds Requirement.....	12
	D. HP ENTERPRISE SERVICES' Provider Enrollment Process	12-16
	1. Provider Enrollment Packet	12
	2. LEA Linkage Process	14
	3. Trading Partner Agreement (TPA) and Instructions... ..	14-16
	E. Eligibility Verification	16
	a. EOHHS Web Portal	16
	F. Medicaid Matching System	17-18
	G. Reference Materials	18
IV.	DIRECT SERVICES CLAIMING	Pages 20-31
	A. Free Care Principle	20
	B. Third Party Liability	20
	C. Claims Preparation Activities	20
	1. Pre-Claiming Activities.....	20
	2. Use of Billing Companies.....	21
	3. Record Keeping Requirements	22
	4. Provider Log Guidelines	22-23
	5. Claiming Activities	23-24
	6. Span Date Policy	24-25
	D. Quality Assurance.....	25-27
	E. Claims Reconciliation Activities.....	27-28

V. SERVICES: DEFINITIONS AND RECORD KEEPING GUIDELINES	Pages 29-64
• Medicaid Reimbursable Services.....	29
• Physical Therapy.....	30-32
• Occupational Therapy.....	33-35
• Speech and Language Therapy.....	36-39
• Orientation and Mobility Services.....	40-41
• Psychological Evaluations.....	42-44
• Counseling.....	45-46
• Expanded Behavioral Health.....	46-47
• Nursing.....	48
• Day Program.....	49-50
• Residential Program.....	51-52
• Transportation.....	53
• Case Management.....	54-56
• Personal Care.....	57-58
• Assistive Technology.....	59-60
○ Service	
○ Device	
• Child Outreach.....	61
○ Screening	
○ Re-screening	

VI. ROLES AND RESPONSIBILITIES FOR SCHOOL ADMINISTRATORS	Page 62
---	---------

VII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT	Pages 63-67
• Background.....	63
• FERPA.....	64-65
• HIPAA Definitions.....	66-67

VIII. REFERENCES AND KEY TECHNICAL ASSISTANCE CONTACTS	Pages 68-69
---	-------------

IX. ADDENDA

Addendum A:	Rhode Island General Law 40-8-18
Addendum B:	Department of Human Services Local Offices
Addendum C:	Social Security Administration Contact Information
Addendum D:	Medicaid Self-Audit Matrix
Addendum E:	On-Site Review Tool and Glossary of Terms
Addendum F:	Medicaid Action Plan
Addendum G:	Glossary Terms
Addendum H:	Sample Case Management Plan and Definitions
Addendum I:	Case Management Log
Addendum J:	LEA Provider Linkage Form
Addendum K:	Sample Certification of Funds Letter
Addendum L:	Fully Documented Record For Medicaid Claiming Purposes, EOHHS Provider Log Elements and RIDE Census Log
Addendum M:	Claim Adjustment Form and Recoupment Forms
Addendum N:	Sample Transportation Log
Addendum O:	Primary Special Education Disability and Diagnosis Codes, Services, Units, Qualifications and Codes
Addendum P:	Sample Expanded Behavioral Health Treatment Plan
Addendum Q:	Health Insurance Portability and Accountability Act Frequently Asked Questions (FAQ)
Addendum R:	Parental Consent
Addendum S:	Rhode Island Medical Assistance NPI Fact Sheet

I. INTRODUCTION

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

<http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/LocalEducationAgency.aspx>

Highlights in the Guidebook include:

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

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

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

Common Acronyms

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

II. BACKGROUND

A. Rhode Island General Law 40-8-18

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

Key Provisions of RIGL 40-8-18 include:

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

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

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

B. Medicaid

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

¹ The federal and state governments jointly fund state Medicaid programs.

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

- (1) assuring the availability and accessibility of required health care resources;**
- (2) helping Medicaid recipients and their parents or guardians effectively use these resources.**²

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

For more information, refer to CMS' June 2014 EPSDT Guide:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

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

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

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

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

For more information about Medicaid, please refer to:

www.medicaid.gov or
www.eohhs.ri.gov
www.eohhs.ri.gov/Consumer/FamilieswithChildren.aspx

For more information about Medicare, please refer to:

www.medicare.gov

C: Medicaid in Rhode Island

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

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

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

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

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

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

- (1) **RIte Care:** Eligibility is based on family income and is available for families who do not have insurance coverage. Refer by calling the Information Line at (401) 462-5300 or by calling the local EOHHS offices (Addendum B) or download an application for RIte Care from the EOHHS web site at <http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/FamilieswithChildren.aspx>
- (2) **RIte Share:** Families whose income falls within certain federal guidelines and who have access to employer-sponsored insurance may be eligible for RIte Share. For more information, call the RIte Share Information line at (401)462-0311 or download an application at <http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/FamilieswithChildren.aspx>
- (3) **SSI:** Eligibility is based on the child's disability *and* the family's income for children aged birth to 18 years old. Eligibility for youth 18 years and older is based on youth's disability and youth's income and assets. To initiate an application or for more information call the Social Security Administration (SSA) at 1-800-772-1213, call a local SSA office (Addendum C) or refer to the Social Security web site at <http://www.socialsecurity.gov/applyfordisability/>
- (4) **Katie Beckett:** Eligibility for children birth through 18 is based on a child's income and resources, disability and level of care.

For help with the application process, contact the EOHHS Katie Beckett Unit Social Caseworker at (401) 462-0760.
For clinical questions; contact EOHHS Public Health Nurse Consultant at (401) 462-6364.
For General Information, contact the EOHHS Info Line at (401) 462-5300.
For more information; refer to the EOHHS website at:
<http://www.eohhs.ri.gov/Consumer/PeoplewithSpecialNeeds.aspx>
- (5) **Adoption Subsidy:** Children in Adoption Subsidy may qualify for RIte Care or RIte Share. The adoption subsidy program is administered through the Department of Children Youth and Families. For more information, please contact: (401) 528-3676. For more information; refer to the DCYF website at:
<http://www.dcyf.ri.gov/adoption.php>
- (6) **Health Source RI (the RI Health Care Exchange):** For families that are uninsured or may qualify for Medicaid, refer to RI's Health Care Exchange. The intake process through Health Source RI will screen applicants for Medicaid eligibility and will be able to advise individuals and families about the health insurance coverage available to them. www.healthsourceri.com/
1-855-840-HSRI (4774).

D: The Role of Special Education

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

- Special Education is defined as “specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education. Special education includes each of the following speech-language pathology services, or any other related service, if the service is considered special education rather than a related service under State standards; travel training; and vocational education.”⁷
- Related services are defined as “transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools and parent counseling and training. [Exception as noted §300.34 (b) regarding cochlear implants.]”⁸

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

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

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

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

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

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

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

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

Before accessing Medicaid reimbursement, the LEAs must obtain written, informed parental consent in adherence with the requirements of the RI Board of Education Regulations Governing the Education of Children with Disabilities §300.154 (d) (2) (iv) (A).

(<http://www.ride.ri.gov/StudentsFamilies/SpecialEducation/SpecialEducationRegulations.aspx>)
For a sample copy of the IDEA Parental Consent to Access Public Benefits or Insurance e.g. Medicaid, please visit: <http://www.ritap.org/medicaid/idea-parental-consent-access-public-benefits-or-insurance-eg-medicaid>.

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

A. Local Governing Authority Approval

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

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

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

C. Certification of Funds Requirement

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

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

March 31	September 30
June 30	December 31

D. HP ENTERPRISE SERVICES Provider Enrollment Process

1. Provider Enrollment Packet

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

HP ENTERPRISE SERVICES can be reached by calling:

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

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

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

The Medicaid Direct Services Guidebook for Local Education Agencies Available on the EOHHS web site at

<http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/LocalEducationAgency.aspx>

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

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

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

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

provided the service in the appropriate field on the claim.

2. LEA Linkage Process and Linkage Form

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

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

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

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

3. Electronic Data Interchange Trading Partner Agreement (TPA)

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

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

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

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

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

LEA Instructions for Completing a Trading Partner Agreement

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

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

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

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

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

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

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

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

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

E. Eligibility Verification

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

EOHHS Web Portal Eligibility Verification System

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

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

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

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

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

HP Customer Service Help Desk

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

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

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

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

F. Medicaid Matching System

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

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

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

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

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

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

Important data formatting requirements:

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

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

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

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

G. Reference Materials

Visit the EOHHS website for Billing and Program Information:

<http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation.aspx>

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

IV. DIRECT SERVICES CLAIMING

A. Free Care Principle

An important requirement within Medicaid is the issue of free care. Under the free care principle, Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. An important exception to the free care requirement is services provided through IDEA. Section 1903 (c) of the Social Security Act prohibits the Department of Health and Human Services from refusing to pay or otherwise limit payment for services provided to children with disabilities that are funded under the IDEA through an IEP or IFSP.¹³

LEAs are able to submit claims for reimbursement from Medical Assistance for Medicaid beneficiaries even though they do not charge for services provided through Special Education. Although services are exempt from the free care rule, LEAs still need to pursue any liable third party insurers.¹⁴

B. Third Party Liability (TPL)

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

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

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

C. Claims Preparation Activities

1. Pre-Claiming Activities

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

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

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

2. Use of Billing Companies

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

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

3. Record Keeping Requirements

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

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

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

4. Provider Log Guidelines

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

Provider Log Recommendations:

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

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

Minimum information required by EOHHS and CMS.

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

5. Claiming Activities

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

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

Addendum D Medicaid Self-Audit Matrix.)

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

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

6. Span Date Policy

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

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

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

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

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

D. Quality Assurance

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

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

Quality Assurance Template

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

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

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

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

Medicaid Self-Audit Matrix

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

Sample On-Site Technical Review Tool

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

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

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

Glossary of Terms

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

E. Claims Reconciliation Activities

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

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

Claims Reconciliation Guidance:

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

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

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

More detailed information about claims reconciliation can be referenced in the Rehabilitation Provider Manual. HP ENTERPRISE SERVICES also posts Provider Updates monthly, typically with the first RA of the month and updates can be accessed on the EOHHS web site at:

<http://www.eohhs.ri.gov/News/ProviderNewsUpdates.aspx> These updates include important information for providers that can include billing and reconciliation policy as well as provider training opportunities.

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

Special Education Medicaid Reimbursable Services

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

Physical Therapy.....	Pages 30-32
Occupational Therapy.....	Pages 33-35
Speech, Hearing and Language Therapy	Pages 36-39
Orientation and Mobility Services	Pages 40-41
Psychological Evaluations	Pages 42-44
Counseling	Pages 45-46
Other Services.....	Pages 47-62

Physical Therapy Service Definitions and Record Keeping Requirements

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

Physical Therapy Service Definitions:

Physical Therapy

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

Physical Therapy Evaluation

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

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

Individual Physical Therapy w/Licensed Physical Therapist

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

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

Individual Physical Therapy Program

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

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

Physical Therapy Program-Group

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

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

Physical Therapy Record Keeping Requirements:

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

Evaluation

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

- Student attendance records
- Staff licensure

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

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

Occupational Therapy Service Definitions and Record Keeping Requirements

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

Occupational Therapy Service Definitions:

Occupational Therapy

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

Occupational Therapy Evaluation

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

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

Individual Occupational Therapy w/Licensed Occupational Therapist

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

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

Individual Occupational Therapy Program

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

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

Occupational Therapy Program-Group

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

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

Occupational Therapy Record Keeping Requirements:

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

Evaluations

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

- Student attendance records
- Staff licensure

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

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

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

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

Speech Hearing and Language (SHL) Therapy Service Definitions:

Speech Hearing and Language Services

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

Audiology

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

Speech Hearing and Language Evaluation

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

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

- It is an individual service

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

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

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

Individual Hearing Therapy with a Licensed Audiologist

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

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

Individual Speech, Hearing and Language Program

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

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

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

Speech Hearing and Language Therapy Program/Group

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

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

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

Evaluations

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

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

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

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

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

Orientation and Mobility (O & M) Service Definition:

- (1) Services provided to blind or visually impaired children by qualified personnel to enable those students to attain systemic orientation to and safe movement within their environments in school, home, and community; and
- (2) Includes teaching children the following, as applicable:
 - a) Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., using sound at traffic light to cross street);
 - b) To use the long cane or a service animal to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision;
 - c) To understand and use remaining vision and distance low vision aids; and
 - d) Other concepts, techniques, and tools.

Orientation and Mobility Evaluations

An evaluation for Orientation and Mobility services includes:

- (1) The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;
- (2) Medical history as it relates to the current course of therapy;
- (3) The beneficiary's current functional status (functional baseline);
- (4) The standardized and other evaluation tools used to establish the baseline and to document progress;
- (5) Assessment of the student's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment);
- (6) Assessment of the student's cognitive skill level (e.g., ability to follow directions,

including auditory and visual, comprehension); and

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

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

Evaluations

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

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

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

Psychological Evaluations: Definitions and Record Keeping Requirements

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

Definition of Evaluation Services:

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

Psychiatric Evaluation by a Board Certified Psychiatrist

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

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

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

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

Psychological Evaluation by a Licensed Clinical Psychologist

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

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

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

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

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

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

Evaluation by a Social Worker or a Licensed Mental Health Counselor

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

- The evaluation is used to determine initial eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services or to provide additional data for the IEP Team
- The child is Medicaid eligible
- The evaluation needs to last the minimum time required by EOHHS
- A LICSW, Licensed Certified Social Worker, - Certified School Social Worker, or a Licensed Mental Health Counselor¹ provides a clinical assessment or Mental Health evaluation
- It is an individual service

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

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

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

Counseling Definitions and Record Keeping Requirements

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

Definition of Counseling Services:

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

Counseling services can be provided by the following providers:

A Board Certified Psychiatrist, Licensed Clinical Psychologist, a Licensed Social Worker, a LICSW, Certified School Social Worker or a Licensed Mental Health Counselor² as identified through the IEP process for individual, individual w/Parent present or small group sessions. Providers include employees and contracted staff.

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

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

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

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

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

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

Expanded Behavioral Health Counseling Services and Record Keeping Requirements

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

Definition of Expanded Behavioral Health Services:

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

A Board Certified Psychiatrist, Licensed Clinical Psychologist, a Licensed Social Worker, LICSW, Certified School Social Worker, or a Licensed Mental Health Counselor³ may provide individual, individual w/Parent present or small group counseling as identified through a Treatment Plan. Providers include employees and contracted staff.

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

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

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

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

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

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

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

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

Nursing Services Definitions and Record Keeping Requirements

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

Nursing Services Definitions:

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

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

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

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

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

Day Program Treatment Definition and Record Keeping Requirements

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

Day Program Treatment Definition:

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

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

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

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

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days or 230 days, this amount equals the daily rate
- The daily rate then needs to be broken down into “daily treatment costs” and “daily educational costs”
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following services:
 - Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services, evaluations
- This daily treatment rate is the unit rate used for reimbursement of this service and must be calculated in accordance with OMB Circular A-87 Cost Principles for State, Local, and Indian Tribal Government Agencies

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

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

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

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

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

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

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

Residential Treatment Definition and Record Keeping Requirements

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

Residential Treatment Definition:

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

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

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

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

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days, 230 days or 365 days; this amount equals the daily rate
- The daily rate then needs to be broken down into “daily treatment costs”, “daily educational costs” and “daily room and board costs”
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following services:
 - Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services, evaluations
- This daily treatment rate is the unit rate used for reimbursement of this service and must be calculated in accordance with OMB Circular A-87 Cost Principles for State, Local, and Indian Tribal Government Agencies

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

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

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

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

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

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

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

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

Transportation Definition and Record Keeping Requirements

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

Transportation Definition:

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

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

On any day conditions are met, Medicaid payment for transportation to and from school is available.

If a child receives a Medicaid-covered IDEA service at an off-site facility during the school day, the cost of transportation from the school to the facility and back to the school would be reimbursable.²⁴

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

Documentation includes:

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

Case Management Services Definition and Record Keeping Requirements

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

Case Management Definition:

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

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

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

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

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

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

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

- (I) Services are being furnished in accordance with the individual's care plan.
- (ii) Services in the care plan are adequate.
- (iii) There are changes in the needs or status of the eligible individual.

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

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

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

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

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

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

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

Management Plan with Definitions

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

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

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

Personal Care Definition and Record Keeping Requirements

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

Personal Care Definition:

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

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

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

IADLs: Instrumental activities of daily living include activities associated with independent living necessary to support the ADLs (e.g., use of the telephone, ability to do laundry, and shopping).

Cognitive Impairments: A student may be physically capable of performing ADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task.

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

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

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

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

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

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

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

A. Assistive Technology Service

Definition:

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

- The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children with disabilities
- Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing or replacing assistive technology devices
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs
- Training or technical assistance for a child with a disability or, if appropriate, that child's family
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers or other individuals who provide services to employers or who otherwise are substantially involved in the major life functions of that child²⁵

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

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

- Certification/licensure
- Provider service logs

B. Assistive Technology Device

Definition:

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

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

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

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

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

Child Outreach: Screening and Re-Screening

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

Service definition:

A. Screening:

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

B. Re-screening:

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

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

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

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

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

VI. ROLES AND RESPONSIBILITIES FOR SCHOOL ADMINISTRATORS

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

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

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

The Departments of Education and Health and Human Services have issued joint guidance on the application of FERPA and HIPAA for LEAs. To access:

www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf

Background:

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

HIPAA

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

Electronic Transactions and Code Sets

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

Privacy Requirements

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

Security Requirements

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

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

National Identifier requirements

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

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

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

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

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

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

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

“Education Records” FERPA 34 CFR sec. 99.3

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

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

“Personally identifiable information” includes, but is not limited to:

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

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

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

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

HIPAA DEFINITIONS

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

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

The covered entity must require satisfactory assurance-usually a contract-that a business associate will safeguard protected health information, limit the use and disclosure of protected health information.

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

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

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

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

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

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

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

- (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

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

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

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

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

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

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

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

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

VIII. REFERENCES, ENDNOTES AND KEY TECHNICAL ASSISTANCE CONTACTS

References:

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

Resources:

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

Key Technical Assistance Contacts:

- Rhode Island Executive Office of Health and Human Services (EOHHS):
Lynn Doherty, (401) 462-0315, Lynn.doherty@ohhs.ri.gov
- Rhode Island Executive Office of Health and Human Services (EOHHS):
• Jason Lyon, (401) 462-7405, Jason.lyon@ohhs.ri.gov
- Rhode Island Technical Assistance Project (RITAP):
Denise Achin, (401) 222-8997, denise.achin@ride.ri.gov
- HP ENTERPRISE SERVICES
Karen Murphy, (401) 463-2304, karen.murphy3@hp.com

Endnotes

¹ *Medicaid and School Health: A Technical Assistance Guide*, U.S. Department of Health and Human Services Health Care Financing Administration, 1997

² <http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrnrn>

³ Ibid.

⁴ <http://questions.cms.hhs.gov>

⁵ Ibid

⁶ Individuals with Disabilities Education Act 2004 §300.101, §300.103 (b)

⁷ Ibid., §300.39

⁸ Ibid., §300.34 (a)

⁹ Regulations of the Rhode Island Board of Education Governing the Education of Children with Disabilities, §300.321

¹⁰ *Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies, November 1991*, U.S. Department of Health and Human Services Health Care Financing Administration, p. 1

¹¹ Opcit. *Rhode Island Regulations* §300.320 (a) (3) (i) (ii)

¹² Opcit. *Medicaid and School Health 1997*, p.1

¹³ Opcit. *Medicaid and School Health 1997*, Free Care

¹⁴ Ibid., Third Party Liability

¹⁵ Ibid

¹⁶ Ibid., Exceptions to Medicaid as Payer of Last Resort

¹⁷ Rhode Island Secretary of State's Public School Records Retention Schedule, LG5.8.32

¹⁸ Opcit. IDEA 2004 §300.34 (c) (6)

²⁰ Ibid. IDEA 2004 §300.34 (c) (15)

²¹ Ibid. IDEA 2004 §300.34 (c) (1) (i) (ii) (iii) (iv)(v)(vi)

²¹ Ibid. IDEA 2004 §300.34 (10) (i) (ii)

²² Ibid §300.34 (10)

²³ Ibid §300.34 (13)

²⁴ Opcit. *Medicaid and School Health 1997*, Transportation

²⁵ Opcit. IDEA 2004 §300.6

²⁶ Ibid. §300.5

SECTION IX: ADDENDA

Addendum A: Rhode Island General Law 40-8-18

Addendum B: Department of Human Services Local Offices

Addendum C: Social Security Administration Contact Information

Addendum D: Medicaid Self-Audit Matrix

Addendum E: On-Site Review Tool and Glossary of Terms

Addendum F: Medicaid Action Plan

Addendum G: Glossary Terms

Addendum H: Sample Case Management Plan and Definitions

Addendum I: Case Management Log

Addendum J: LEA Provider Linkage Form

Addendum K: Sample Certification of Funds Letter

Addendum L: Fully Documented Record For Medicaid Claiming Purposes, EOHHS Provider Log Elements and RIDE Census Log

Addendum M: Claim Adjustment Form and Recoupment Forms

Addendum N: Sample Transportation Log

Addendum O: Primary Special Education Disability and Diagnosis Codes, Services, Units, Qualifications and Codes

Addendum P: Sample Expanded Behavioral Health Treatment Plan

Addendum Q: Health Insurance Portability and Accountability Act Frequently Asked Questions (FAQ)

Addendum R: Parental Consent

Addendum S: Rhode Island Medical Assistance NPI Fact Sheet

ADDENDUM A
RHODE ISLAND GENERAL LAW 40-8-18

§ 40-8-18 Local Education Agencies as EPSDT providers. – (a) It is the intent of this section to provide reimbursement for early and periodic screening, diagnosis and treatment (EPSDT) services through local education agencies for children who are eligible for medical assistance. A local education agency's participation as an EPSDT provider is voluntary. Further, it is the intent that collaboration among the Executive Offices of Health and Human Services (EOHHS), the department of elementary and secondary education and local education agencies (LEAs) will result in state and local funds being used to maximize federal funding for such EPSDT services.

(b) The services available to eligible children under Title XIX of the Social Security Act for early and periodic screening, diagnosis and treatment (EPSDT) may be provided by local education agencies.

(c) Voluntary participation as an EPSDT provider shall require the local education agency to provide the state match to obtain federal financial participation for EPSDT services and associated administrative costs by certifying to the Executive Offices of Health and Human Services that sufficient qualifying local funds (local certified match) have been expended for such services and administrative costs; provided, however, that a local education agency shall not be required to provide local certified match for those EPSDT services for which the Executive Offices of Health and Human Services, or another state agency, agrees to provide the state match to obtain federal financial participation for EPSDT services.

(2) The local certified match shall be established in the local education agency pursuant to federal Title XIX provisions. Failure of the local education agency to provide the local match shall result in the penalties described in subsection (f).

(3) The Executive Offices of Health and Human Services shall pay the local education agency from the federal matching funds for EPSDT services pursuant to fee schedules established by rules and regulations of the Executive Offices of Health and Human Services, and for associated administrative costs pursuant to administrative cost reimbursement methodologies to be approved by the federal government, upon certification of the local match by the local education agency in accordance with federal Title XIX provisions. Payments made to the local education agency pursuant to this section shall be used solely for educational purposes and shall not be made available to local communities for purposes other than education. The local fiscal effort to support education referred to in subsection (d) herein shall not be reduced in response to the availability of these federal financial participation funds to the local education agency. These federal financial participation funds must supplement, not supplant, local maintained fiscal effort to support education.

(4) For the purposes of this subsection, the term local education agency shall include any city, town, state or regional school district or the school for the deaf or the William M. Davies, Jr. career and technical high school, the Metropolitan Career and Technical Center, any public charter school established pursuant to chapter 77 of title 16 of the general laws, any educational collaborative established pursuant to chapter 3.1 of title 16 of the general laws, or the department for children, youth, and families (DCYF).

(d) Each community shall maintain local fiscal effort for education. For the purpose of this subsection, to "maintain local fiscal effort" means each community shall contribute local funds to its school committee in an amount not less than its local contribution for schools in the previous fiscal year.

(2) Further, state support for education shall not be reduced from the prior fiscal year in response to local community participation in the EPSDT program.

(e) The Executive Offices of Health and Human Services and the department of elementary and secondary education shall effect the interagency transfers necessary to comply with the provisions of this section. The department of elementary and secondary education and the Executive Offices of Health and Human Services are authorized to promulgate any and all regulations necessary to implement this section. All local school agencies becoming EPSDT providers shall be required to comply with all provisions of Title XIX, 42 U.S.C. § 1396 et seq., of the Social Security Act relative to responsibilities of a Medicaid provider.

(f) Failure of the local education agency to establish a local certified match under this law sufficient to support its claims for reimbursement of EPSDT services and associated administrative costs will result in the withholding of state funds due that community in accordance with § 16-7-31 in an amount equal to the federal financial participation funds denied by the federal government as a result thereof. The withheld funds will be transferred to the Executive Offices of Health and Human Services.

(g) The Executive Offices of Health and Human Services with the aid of the department of education shall determine which health care related services are eligible for federal Medicaid reimbursement for health related services provided by local education agencies to children eligible for early periodic screening diagnosis and treatment. The Executive Offices of Health and Human Services, with the assistance of the department of administration, shall also develop the following resources in furtherance of the goal of recouping the maximum amount of administrative costs associated with such services;

(1) A time study training manual, which outlines how to complete a time study by school personnel to enhance recovery of administrative costs;

(2) A claiming manual, which outlines the financial information and claim submission requirements that are needed to complete the claim.

ADDENDUM B

DEPARTMENT OF HUMAN SERVICES Offices

www.dhs.ri.gov/ContactUs/DHSOffices/DHSOfficesbyLocation/tabid/798/Default.aspx

For information on How to Connect to TTY, click [TTY - Teletypewriter Users](#) 

Office	Address	Phone	Fax
DHS Long Term Care Office	Building #55, Howard Avenue Cranston, RI 02920	462-5182; 462-2400	
Newport Regional Family Center	272 Valley Road Middletown, RI 02842	851-2100 or 1-800-675-9397	851-2105
South County Regional Family Center (Stedman Center)	4808 Tower Hill Rd., Suite G1 Wakefield, RI 02879	782-4300 or 1-800-862-0222	782-4316
Office of Rehabilitation Services	40 Fountain Street Providence, RI 02903	421-7005 ; TTY 421-7016; Spanish 272-8090	
Pawtucket DHS	249 Roosevelt Ave. Pawtucket, RI 02860	721-6600 or 1-800-984-8989	721-6659
Providence Regional Family Center	206 Elmwood Avenue Providence, RI 02907	415-8200	
RI Veterans Home	480 Metacom Avenue Bristol, RI 02809	253-8000 ext. 695	
RI Veterans Memorial Cemetery	301 South County Trail Exeter, Rhode Island 02822	268-3088	
Warwick DHS	195 Buttonwoods Avenue Warwick, RI 02886	736-1400	736-1442 or 736-1443
Woonsocket DHS	450 Clinton Street Woonsocket, RI 02895	235-6200	235-6237

ADDENDUM C

SOCIAL SECURITY ADMINISTRATION (SSA)

The Social Security Administration is a federal program that oversees many benefits and programs for most Americans. One of these is the Supplemental Security Income (SSI) program entitles eligible recipients for medical assistance (Medicaid) benefits and a monthly cash benefit. There is income as well as disability criteria that an individual needs to meet in order to be determined eligible for these benefits.

The best place to initiate contact is to call the SSA. The best place to get information is to log onto the SSA web.

National Toll Free Number 1-800-772-1213

Social Security operates its toll-free telephone listed above from 7:00AM to 7:00PM, Monday through Friday. If you have touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. A service option includes identifying and receiving directions to your local SSA office by entering your zip code.

National Toll-free TTY number, 1-800-325-0778

People who are deaf or hard of hearing may call the national toll-free TTY number between 7:00AM and 7:00PM on Monday through Friday. It is recommended that you have your social security number handy when you call.

SSA Website:

Home Page Social Security Administration Web site: www.ssa.gov

This web site provides information for all programs overseen by the SSA, including SSI, as well as information about how to contact SSA, how to start an application, and how to appeal a decision made by SSA

Information about SSI for adults and children: www.ssa.gov/pgm/ssi.htm This web site includes the process and the information needed by individuals applying for SSI.

Local SSA Offices:

SSA has local offices, the location and contact information for the local offices serving people who live in Rhode Island are listed below.

Office	Location	Zip Code	Toll Free Number	TTY Number
Newport	130 Bellevue Ave	02840	866-253-5607	401-849-0057
Pawtucket	4 Pleasant Street	02860	866-931-7079	401-729-1896
Providence	380 Westminster Street	02903	877-402-0808	800-325-0778
Warwick	30 Quaker Lane	02886	866-964-2038	800-325-0778
Woonsocket	2168 Diamond Hill Road	02895	877-229-3543	401-765-1620

Procedure Codes/MOD	Services	Units Correct	*Diagnosis Code	*IEP	Parental Consent	*Procedure/Activity Note	*Progress Notes	*Provider/Service Logs	*Attendance	*Cert/Lic	*Evaluation	*IHP	*Treatment Plan	Case Management Plan	*Tuition Rate
Physical Therapy Services															
97001	Physical Therapy Evaluation	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97110 - GP	Ind. P.T. W/Licensed PT	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
97530 - HM, GP	Ind. P.T. Program	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
97150 - GP	P.T. Program - Group	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
Occupational Therapy Services															
97003	Occupational Therapy Evaluation	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97110- GO	Ind. O.T. W/Licensed O.T.	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
97530 - HM, GO	Ind. O.T. Program	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
97150 - GO	O.T. Program - Group	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
Speech, Hearing, Lang., Services															
92521	Evaluation of Speech Fluency	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92522	Evaluation of Speech Sound Production	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92523-52	Evaluation of language comprehension and expression	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92524	Behavioral and qualitative analysis of voice and resonance	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92507 -GN	Ind. S.H.L. w/Speech Lang. Pathologist	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
92507	Ind. S.H.L. Program	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
92508	S.H.L. Program/Group	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
Evaluation Services															
90802	Psychiatric Evaluation	Y	Y-except for initial	Y-except for initial	Y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A	N/A
H0031 -AH	Psychological Evaluation	Y	per Spec Ed Census	Y-except for initial	Y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A	N/A
H0031 -AJ	Social Worker Evaluation	Y	per Spec Ed Census	Y-except for initial	Y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A	N/A
Counseling Services															
H0004	Psychiatric Counseling	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
H0004 - AH	Psychological Counseling	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
H0004 - AJ	Social Worker/ Mental Health Counselor Counseling	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
96153	Counseling Services - Group	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A

Procedure Codes/MOD	Services	Units Correct	*Diagnosis Code	*IEP	Parental Consent	*Procedure Note	*Progress Notes	*Provider Logs	*Attendance	*Cert./Lic	*Evaluation	*IHP	*Treatment Plan	Case Management Plan	*Tuition Rate
Expanded Behavioral Health Counseling Services															
H0004 - HA	Psychiatric Counseling	Y	V705	N/A	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A	N/A
H0004 - AH HA	Psychological Counseling	Y	V705	N/A	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A	N/A
H0004 -AJ HA	Social Worker/ Mental Health Counselor Counseling	Y	V705	N/A	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A	N/A
96153 - HA	Counseling Services - Group	Y	V705	N/A	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A	N/A
Other Services															
T1002	Nursing Services-(RN)	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	Y	N/A	N/A	N/A
T1003	Nursing Services - (LPN)	Y	per Spec Ed Census	Y	Y	Y	Y	Y	Y	Y	N/A	Y	N/A	N/A	N/A
T2003	Transportation	Y	per Spec Ed Census	Y	Y	N/A	N/A	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
X0215	Case Mgt	Y	per Spec Ed Census	Y	Y	Y	N/A	Y	N/A	Y	N/A	N/A	N/A	Y	N/A
S5125	Personal Care	Y	per Spec Ed Census	Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	N/A	N/A	N/A
E1399	Assistive Technology Device	Y	per Spec Ed Census	Y	Y	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
97535	Assistive Technology Service	Y	per Spec Ed Census	Y	Y	Y - except for AT eval	N/A	N/A	Y	Y - if applicable	Y - if applicable	N/A	N/A	N/A	N/A
T2048	Residential Placement Less Education & R. & B.	Y	per Spec Ed Census	Y	Y	N/A	Y	N/A	Y	Y	N/A	N/A	N/A	N/A	Y
H2018	Day Program Services	Y	per Spec Ed Census	Y	Y	N/A	Y	N/A	Y	Y	N/A	N/A	N/A	N/A	Y
T1023	Child Outreach Screening	Y	V705	N/A	Y	N/A	N/A	N/A	N/A	N/A	completed screening	N/A	N/A	N/A	N/A
T1023 - TS	Child Outreach Re-screening	Y	V705	N/A	Y	N/A	N/A	N/A	N/A	N/A	completed screening	N/A	N/A	N/A	N/A

Addendum E: On-Site Technical Review Tool

LEA Reviews:

Date:

Staff Present:

Record #	Demographic Information			Procedure Codes/MOD	Units Billed	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Score ___ / ___	Notes	
	Student Name	MID	Service Date			Units Correct	Diag	IEP	Parental Consent	Procedure/ Activity Note	Progress Notes	Provider/ Service Logs	Attendance	Cert./Lic Present	Cert./Lic Checked	Evaluation	IHP	Treatment Plan	Case Management Plan	Tuition Rate			
1						Y/N	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	Y/N	Y/N	Y/N	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	P/F/NA		
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							
11																							
12																							
13																							
14																							
15																							
16																							
17																							
18																							
19																							
20																							
21																							

Addendum F: Medicaid Action Plan

Date:

1. **Medicaid Contact(s):**
2. **Responsible person for Self-Audit in District:**
3. **Person responsible for compiling the “Certification of Funds Letter”:**
4. **MEDICAID DIRECT SERVICE CLAIMS - FINDINGS REQUIRING ATTENTION**
5. **MEDICAID ADMINISTRATIVE CLAIMS - FINDINGS REQUIRING ATTENTION**

Regularly scheduled reviews performed to verify completeness and correctness of:	Performed by (name, title, contact information)	Frequency and Dates
Attendance records		
Diagnosis codes		
Activity notes		
Progress notes		
Provider/Service logs		
Provider Certification/Licensure		
Transportation logs		
Treatment plan		
EDS remittance advice		

SIGNATURES OF SPECIAL EDUCATION DIRECTOR AND BUSINESS MANAGER

I have completed the enclosed “District Questionnaire on Medicaid Documentation and Quality Assurance” and any other attachments to the best of my knowledge and belief.

District Special Education Director

Date

District Business Manager

Date

Addendum G

Glossary Terms

Units Correct	The number of service units submitted for payment (documented on service log) should be checked for accuracy against the number of service units actually payed (detailed on Remittance Advice)
Diagnosis Code	A medical diagnosis is necessary for billing the Medicaid program. The student's primary special education disability reported to RIDE in the census for Special Education should be used for all reimbursement. This is true even if the diagnosis on the claim form does not seem directly related to the service being provided so long as the service being provided is clearly defined in the child's Individualized Education Program.
IEP	All services must be provided in accordance with a valid Individual Education Program, IEPs must conform to all requirements of Individuals with Disabilities Education Act (IDEA) and RI state regulations governing special education.
Procedure/Activity Note	The provider should write a description of the service provided to the child on that date. Providers should use their professional judgment to create a brief note that adequately documents the nature/extent of the service provided. The documentation of each medical encounter with the student should include or provide reference to: the reason for the encounter, and as appropriate, relevant history, as it relates to the therapy/service being provided.
Progress Notes	The inclusion of a progress note is imperative to document the medical necessity of the service provided and billed to Medicaid. The state Medicaid agency is only permitted to pay for services that are medically necessary. If the progress note required by the Department of Education captures the medical necessity and progress of this child, it may be used for Medicaid service description purposes. If the progress note does not capture the medical necessity and progress of the student, it is essential that the provider compose a separate progress note documenting the child's medical progress and need for continual care.
Provider/Service Logs	Refer to Addendum H of the Guidebook. The provider/service log captures the basic components needed to create a claim for Medicaid reimbursement. There are other documentation requirements needed to ensure this is a viable claim, e.g. progress notes, procedure/activity notes, attendance, cert./lic. etc. (who, what, when, where, how long) *Evaluation services - 1 unit equals the completed evaluation, therefore, the provider log is not applicable.
Attendance	Attendance records must be maintained and indicate that a student is present on date of service, exceptions may include evaluations provided off-site.
Certif./Licensures	A valid copy of/or original certification/licensure of all providers (contracted/employees) must be accessible at all times. It is recommended that LEA's maintain an annual file with copies of staff certification/licensure of all contracted employees, who's services are submitted for Medicaid reimbursement.
Evaluation	Evaluation services include administering psychological and educational tests, interpreting assessment results; obtaining, integrating , and interpreting information about students behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies as they relate to the child's learning.
Individualized Health Care Plan (IHCP)	A comprehensive plan for care of children with special health care needs developed by the certified school nurse teacher in collaboration with the student, parents/guardians, school staff, community, and health care provider(s), as appropriate.
Certif./Licensures Check	All DOH licensures are subject to suspensions, restrictions or revocation. Districts should check all provider licensures against the DOH licensure verification website at http://www.health.state.ri.us/hsr/professions/license.php to ensure validity .
Treatment Plan	A Treatment Plan is required for all Expanded Behavioral Health service claims. Refer to Addendum K in the Guidebook for specific documentation requirements.
Case Management Plan	A Case Management Plan is required for Case Management claims. Refer to Addendum E in the Guidebook for specific documentation requirements.
Tuition Rates	The tuition rates for day and residential programs must be broken down into daily treatment, education, room, and costs, as appropriate.

Addendum H

Sample Case Management Plan and Definitions

Student Name _____
 DOB _____ Grade _____
 School _____
 CMP To _____ From _____

Case Manager _____

CM Initials	Resources/Supports Currently Available		
	Assessments and Data	Support Documentation	Team Report / Decision Makers
Resource Location			

Case Management: Assisting children in arranging and obtaining health and related services in their communities (RI School Based Medicaid Guidebook)

Step 1. Check off the services, supplementary aids and supports the IEP team determines necessary.

Step 2. Identify a Course of Action for the Case Manager to monitor, implement, and assess the medical, educational, or social goals and objectives of the student.

Step 3. Record services on Case Management Log.

SERVICES: Based on assessments and evaluation team report, **CHECK THE SERVICES, SUPPLEMENTARY AIDS, AND SUPPORTS** the IEP team determines necessary to meet any medical, educational, or social goals and objectives

Occupational Therapy
 Physical Therapy
 Speech/ Language
 Audiology
 Adaptive PE

Mental Health Counseling
 Specialized Instruction
 1:1 Nursing Services
 1:1 Personal Care Services
 Assistive Technology

Contract / Consultation with Providers
 Orientation / Mobility
 Transportation Needs
 Vision Services
 Vocational

Other:

COURSE OF ACTION:

Case Management Services (Action Steps):	Frequency:					
Scheduling and Attending Meetings (Specify meetings):	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other:		
Maintaining contact with providers in and out of district (Specify):	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other:		
Communicating with student and/or family	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other:		
Monitor delivery / progress / adequacy of services	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other:		
Other	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other:		

School District:

Student Name:

DOB (MM/DD/YY):

Date	Start Time	Total Time	Scheduling and Attending Meetings Notes (Include participants)	Outstanding Issues and Follow Up

Date	Start Time	Total Time	Maintaining Contact w/providers in and out of dist. (List participants)	Outstanding Issues and Follow Up

Date	Start Time	Total Time	Communicating with student or family	Outstanding Issues and Follow Up

Date	Start Time	Total Time	Monitor delivery / progress / adequacy of services	Outstanding Issues and Follow Up

Elements of Case Management Plan (CMP)

The CMP is a document that outlines the action steps a designated case manager works through to ensure the students receives the services identified in the care plan.

Student Name: This field includes the name of the student receiving case management services.

Case Manager: This field lists the name of the individual/staff member designated to provide case management services for the student. This person is responsible for assessing the needs of the student, implementing and monitoring and the overall maintenance of the CMP. Students are allowed only one designated case manager. If there is a change of case managers please note on the CMP.

DOB: Student Date of Birth

Grade: Student grade level as of the date the CMP was initiated

School: List the name of the primary school in which the case management services are being provided

CMP To/From Dates: Type/write the month, day and year for which the CMP will begin and end. The CMP time period should not be greater than one year. This date range corresponds to the IEP.

CM Initials: Case manager needs to initial this box which validates that the resources exist and then identify the locations of the resources, for example, the student file.

Resources/Supports Currently Available: Below is a description of the documentation used to help develop the CMP. They may need to be retrieved in case of a review or audit.

Assessment and Data: This includes any and all assessment and evaluations used to support the need for case management services.

Team Report and Decision Makers: This is a form that lists the evaluation team and other decision makers to determine the services needed for the student.

IEP and Case Management Care Plan (CMP): The IEP and CMP that correspond to each other.

Services: Check or circle the services, supplementary aids and supports the IEP determines necessary.

Course of Action: This is a list of action steps carried out by the case manager that drives the Case Management Plan.

Frequency CMP is updated: The frequency in which the CMP is updated is at least annually. Specifically identify how frequent the action steps listed will be addressed. The plan should be updated more frequently if the student's needs change.

Addendum I

Case Management Log

This document records the events and encounters that support the action steps.

School District/Student Name/ DOB: Complete all of the sections.

Date: This should detail the date on which the case management service occurred.

Start Time and Total Time: Record the start time of the case management service and the total time to complete the service.

Identify Related Action Steps: This should correlate to the action steps identified in the CMP.

Outcomes and Follow up (notes): Services delivered to students should be monitored in order to track emerging needs and make adjustments to the CMP as they become necessary. Below are components of appropriate notes.

Meeting Attendees: This should list the name/s of the meeting attendees participating. If the meeting was conducted with the family, state as such.

Provider/Contact: This should detail the name of the individual that was contacted during the follow-up.

Outstanding Issues: List outcomes of the meeting and/ or issues that require follow up.

Progress: Are services being provided according to the student's care plan? Make a note regarding the progress of the student.

Amendments to CMP: If an amendment to the student's action plan is required then documentation of why the change occurred should also be detailed. Course of Action section should also be updated to accurately reflect this change.

Case Manager Name and Signature / Date: Self explanatory.

ADDENDUM J: 049 Linkage Forms



THE RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES



Dear Provider,

Thank you for your interest in the Rhode Island Medical Assistance Program. Enclosed are the forms and information necessary to enroll as a performing provider within an established group. Please send those that are marked mandatory for enrollment processing:

- Local Education Agency (LEA) Provider Linkage Form
- Current copy of your practice's form of licensure
- Provider Agreement and Addendums I & II
- NPI e-mail confirmation

Completed enrollment forms should be mailed to:

HP ENTERPRISE SERVICES
Provider Enrollment Unit
PO Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call HP ENTERPRISE SERVICES at **1-401-784-8100** for instate and long distance callers or 1-800-964-6211 for instate toll callers and border communities.

IMPORTANT NOTE: Please DO NOT send any claims with your application. Wait until you have received your provider number and a billing manual. If you are an out-of-state provider, wait for your provider number, manual and Prior Authorization before sending in any claims.

An incomplete application will be returned.



049 Linkage Forms

LEA Enrollment Instructions

The following fields must be completed:

PROVIDER NAME: Enter your individual or facility name.

SERVICE LOCATION ADDRESS: Enter the complete physical address where service is being conducted.

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by CMS (Centers for Medicare/Medicaid). If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY (ies) – Enter the Taxonomies established by CMS

PROVIDER TYPE/SPECIALTY: Indicate the specific service you provide. e.g., MD –Psychiatrist; Therapist – Social Worker, Psychologist, etc. (Disregard if you provided your NPI & Taxonomy/ies)

PROVIDER PHONE NUMBER: Enter the area code and telephone number of the location where service is being conducted.

LICENSE NUMBER: If you are required to be licensed to provide services, enter your license or certification number. A copy of the current valid license or certification letter must be submitted with the application.

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by CMS (Centers for Medicare/Medicaid) for the School department you are joining.

TAXONOMY (ies): Enter the Taxonomies established by CMS for the School department you are joining.

SCHOOL DEPT. NAME: Enter the name of the school department.

SCHOOL DEPT GROUP MA PROVIDER NUMBER: Enter the provider number(s).

SCHOOL DEPT. TAX IDENTIFICATION NUMBER: Enter the Federal Employer Identification Number (FEIN).

SCHOOL DEPT PAY TO ADDRESS: Enter the address where you want checks and/or Remittance Advice(s) sent.

SCHOOL DEPT MAIL TO ADDRESS: Enter the address where all other program information should be sent.

EFFECTIVE DATE: Enter the date you will begin servicing the students.

FAX NUMBER – Enter the office fax number

EMAIL ADDRESS – Enter the office email address for the actual provider (doctor) to receive future correspondences via email

PROVIDER SIGNATURE AND DATE: Application must be signed by the Individual Applicant along with the date of signature. Stamped or photocopied signatures are not acceptable.

AUTHORIZED SIGNATURE OF SCHOOL DEPARTMENT REPRESENTATIVE, TITLE, AND DATE: A Representative from the School Department must sign and date the form to indicate that they wish to be affiliated with the provider listed on the application.

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
LOCAL EDUCATION AGENCY (LEA) PROVIDER LINKAGE FORM

Provider Name: _____

Service Location Address: _____

National Provider Identifier NPI: _____

Taxonomy (ies): _____

Provider Type/Specialty: (please circle) if other, please specify:
(Disregard if you provided your NPI & Taxonomy/ies)

OT **PT Speech Social Worker**

Psychiatrist RN **Psychologist**

Transportation **Personal Care Attendant**

Residential Placement **Other** _____
the

Provider Phone Number: _____

License #: _____

Provider Signature

Authorized signature of School Department Representative

For HP ENTERPRISE SERVICES Use Only

Census Tract: _____

Town Code: _____

Town Code: _____

National Provider Identifier (NPI): _____
(School Dept. NPI)

Provider Taxonomy (ies): _____
(School Dept. Taxonomy/ies)

School Dept Name: _____

School Dept Group MA Provider Number: _____

School Dept Tax Identification Number: _____

School Dept Pay to Address: _____

School Dept Mail to Address: _____

Effective Date: * _____

Indicate the effective date when the Provider began providing services to

School Department

email address _____

fax # _____

Date

Title

Date

County Code: _____

Location Code: _____

Location Code: _____

ADDENDUM K

SAMPLE CERTIFICATION OF FUNDS LETTER

School Districts Letterhead

Jason C. Lyon, LICSW
Assistant Administrator
Executive Office of Health and Human Services
Hazard Bldg #74
74 West Road
Cranston, RI 02920
Administrative Activity Claim

Mr. Lyon,

I certify that sufficient state funds and/or local education funds were available in the quarter ending _____, to meet state match requirements.

Direct Services Claim Expenses	_____	Gross Amount
	_____	Net Amount

Signature of LEA Authorized Official

Date

Printed Name

ADDENDUM L

Fully Documented Record for Medicaid Claiming Purposes

States are also required in Section 1902 of the Social Security Act to “provide for agreements with every person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving medical assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.” This requirement is also reiterated in the Code of Federal Regulations (CFR) Section 431.107, which describes “Required provider agreement.”

State Medicaid Law requires that records used to support Medicaid claims must be retained for 7 years. Secretary of State Record Retention Schedule requires that education records must be retained for least 10 years. The following records must be retained to fully document a Medicaid Claim:

- 1) IEP indicating the need for a Medicaid covered service
- 2) Copy of the appropriate provider licensure, certification, etc. as required by state and federal law, as described by service/provider type in the CFR and state regulations
- 3) Referral/prescription, as required by state and federal law (in some states an IEP signed by an appropriate medical professional may suffice), as described by service/provider type in the CFR and state regulations
- 4) Provider/Service Log:
 - a) Student’s Name
 - b) Provider’s Name and Signature
 - c) Date of Service
 - d) Type of Service Provided
 - e) Length of Encounter (must include Start Time)
 - f) Group or Individual Setting
 - g) Place of service
 - h) Description of Service – including activity/procedure note for each date of service and supplemented by quarterly progress note, or as often as otherwise indicated educationally/medically
- 5) Documentation that services are being appropriately provided, as applicable, “under the supervision/guidance of” and meeting all federal and state oversight requirements
- 6) Other appropriate documents kept by schools, such as: child attendance records, school operating calendars (including snow days and other unscheduled school closings), or employee attendance record, etc.
- 7) Other state specific or professional association requirements, as applicable.

EOHHS Provider Log Elements

School/School District

These lines should be used to capture both the name of the school and the school district.

Service Period, Year:

This line indicates the evaluation period during which these services are delivered. For example, if you are operating under a quarterly evaluation system you may want to record this as Quarter One, 2002/2003 school year. Alternatively, if these forms are to be submitted on a monthly basis (for billing purposes) you may want to record simply the month and year.

Student Name:

This line should include the child's complete, legal name.

Student ID:

This line should capture the student's Medicaid Identification Number

Date of Birth

This line should record the child's complete date of birth

Provider Name:

This line should capture the complete name of the medical professional (or paraprofessional) that is actually delivering services to the child. This individual is responsible for completing this form completely and accurately and his/her signature attests to the validity of the documentation.

Service Specialty:

This line should record the professional capacity of the medical provider. For example, one would record here "certified speech pathologist" or "speech pathology assistant." If the provider type is paraprofessional, it is imperative that the supervisory professional (under whose direction the paraprofessional is providing services) review and co-sign the service log and clearly state their professional affiliation.

Date:

This column should indicate the date a Medicaid service is provided to the child. This entry should be included every time a service is delivered.

Goals & Objectives Addressed/Procedure Activity Notes/Comments:

In this area, the provider should write a short description of the service provided to the child on that date. Providers should use their professional judgment to create a brief note that adequately documents the nature/extent of the service provided. At the discretion of district, where medically appropriate, descriptive codes may substitute a written note. **If districts are capturing this by the way of either a drop down list or a check off box, then the district needs to ensure they offer a comprehensive list by communicating with providers on the all services provided within the district. (Please see sample form)**

Progress Indicator:

The progress indicator denotes how well the particular given therapy/service is in helping the student achieve their stated goals and objectives. **If the goals and objectives detailed on the provider log are the same goals and objectives documented within the student's IEP, then the progress indicator can be substituted for Medicaid required progress notes.**

Small Group/Individual:

Reimbursement for school based services may be dependent on the setting in which the services were provided. In accordance with state specifications, please indicate if the service was delivered to the child on an individual basis, in a small group, in a large group or in another setting that would effect reimbursement.

Time or Number of Service Units (Cumulative):

This column captures the quantity of service provided to the child. Depending on the state's reimbursement system, this can be recorded as an amount of time (20 minutes) as a unit of time rounded according to state direction (in 15 minute increments, for example), or as a service unit (3 units, for example, may represent 45 minutes of service). This line can capture the cumulative time/units the provider spend delivering services over the course of the day.

Signatures:

By signing his/her name to this document, the service provider is attesting to the veracity of the record. The medical professional/paraprofessional is assuring that services were provided in accordance with all relevant state and federal law and within professional standards/guidelines. He/she is verifying that all entries are accurate records of Medicaid billable services provided to the appropriate Medicaid beneficiary. This form is a legally binding document, the submission of which will lead to an expenditure of state and federal dollars.

Sample Provider Log

School District Name	School Name	Service Month/Year
Student Name (Last, First, MI)	Student ID	Date of Birth
Provider Name: <i>(printed)</i>		Service Specialty Occupation Therapist-OTR/L

Goals & Objectives:

To Improve/Increase

- A) Fine Motor Manipulation Skills
- B) Visual Perceptual Skills
- C) Self Care Skills
- D) Balance Skills
- E) Visual Motor Skills
- F) Sensory Integration
- G) Bilateral Integration

Procedures:

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> 1.) Hand Strengthening 2.) Letter Formation 3.) Grasp Pattern 4.) Place words on a line 5.) Space Words Properly 6.) Increase Keyboarding Skills 7.) Increase Bilateral Coordination 8.) Drink from Cup | <ul style="list-style-type: none"> 9.) Food Self w/Utensil 10.) Fasten/Unfasten Buttons 11.) Pull Up/Unfasten Buttons 12.) Balance 13.) Speed/Dexterity Activities 14.) Puzzles 15.) Draw Shap/Letter/Characters 16.) Cut on a line | |
|--|---|--|

PROFESSIONAL SERVICE LOG		PROGRESS INDICATOR			SERVICE					
DATE	GOALS & OBJECTIVES/PROCEDURE ACTIVITY NOTES ADDRESSED/COMMENTS**	Progressed	Maintained	Regressed	Time/Unit			Type		
					Start Time/End Time/Total Minutes	Total Minutes		Individual	Group	Evaluation

***Write a Goal/Objectives Code & Procedure/Activity Code & **Comment**

(Provider Signature)

Date

(Supervisor Signature if applicable)

Date

ADDENDUM M



RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAM

SINGLE ADJUSTMENT REQUEST FORM

1. CLAIM INTERNAL CONTROL NUMBER										Detail No.		HP ENTERPRISE SERVICES USE ONLY												
2. RECIPIENT NAME										3. RECIPIENT MEDICAL ASSISTANCE NUMBER														
4. PROVIDER NAME AND ADDRESS										5. FROM DOS					6. TO DOS									
										7. BILLED AMT.					8. PAID AMOUNT					9. R/A DATE				
10. PLEASE SPECIFY REASON FOR ADJUSTMENT																								
<p>IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED AND THE APPROPRIATE REMITTANCE ADVICE IS ATTACHED</p>																								
11. SIGNATURE										CONTACT NUMBER										DATE				
<p>****HP ENTERPRISE SERVICES USE ONLY****</p>																								
EXAMINER										DATE					ACTION TAKEN									
REMARKS:																								
<p>MAIL TO: HP ENTERPRISE SERVICES ADJUSTMENTS P.O. BOX 2010 WARWICK, RI 02887-2010</p>																								

ADDENDUM M

RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES



MEDICAL ASSISTANCE PROGRAM

MULTIPLE ADJUSTMENT REQUEST FORM

1. PROVIDER NAME: _____				
2. PROVIDER NUMBER: _____				
3. REASON FOR ADJUSTMENT (MUST BE SAME FOR ALL ATTACHED):				
HP ENTERPRISE SERVICES USE ONLY	4. CLAIM INTERNAL CONTROL NUMBER	5. MEDICAL ASSISTANCE RA DATE	6. RECIPIENT NAME FIRST/LAST	7. RECIPIENT MEDICAL ASSISTANCE NO.
0				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED AND THE APPROPRIATE REMITTANCE ADVICE IS ATTACHED.				
SIGNATURE			CONTACT NUMBER DATE	
HP ENTERPRISE SERVICES USE ONLY				
EXAMINER	DATE	ACTION TAKEN		
REMARKS:				
<div style="float: right; text-align: right;"> MAIL TO: HP ENTERPRISE SERVICES ADJUSTMENTS P.O. BOX 2010 WARWICK, RI 02887-2010 </div>				
MULTIPLE ADJUST FORM				

ADDENDUM M

Applicable Adjustment Reason Codes

Reason Code	Financial Reason Code Description	Reason Code	Financial Reason Code Description
020	Wrong dates of service	054**	Provider wrong TPL payment**
021	Wrong patient status	065	Drug unit dose adjustment
026	Adjusted wrong tooth number/surface	067	Change in recipient eligibility
029	Incorrect Medicare paid amount, co-ins/deductible	068	Recipient has Medicare coverage
050	Provider Wrong Proc/Drug code	069	Recipient has verified other insurance
051	Provider wrong procedure modifier	070	Provider Change in Ownership
052	Provider wrong units of service	087	Adjust Wrong Units and Billed Amount
053	Provider wrong submitted charge	160	Retro rate, liability change

**Adjustments for dates-of-service >365 days are not allowed when a new claim will be submitted for increased reimbursement without a primary payer EOB dated within 90 days.*

***Must attach primary payer explanation of benefits for Adjustment Reason Code 054*

Print, sign and mail to:

RI MEDICAID PROGRAM • HP ENTERPRISE SERVICES • P.O. BOX 2010 • WARWICK, RI 02887-2010

Requestor (Print Name):	Title:
Provider/Authorized Agent Signature:	HP Use Only
Date:	HP Examiner:
	Date:

Version Number 1.0 03/01/2013

Claims can be replaced electronically if submitted within one calendar year. This process makes corrections and resubmissions quick and easy. Please contact your provider representative for more information.

Addendum N

Sample Transportation Log

STUDENT NAME:

DOB:

	DATE	TO	FROM
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			

ATTENDANCE CHECKED:

YES	NO
-----	----

Signature

Date

Authorized Signature

Date

ADDENDUM O: Primary Special Education Disability and Diagnosis Codes

Primary Special Education Disability	Diagnosis Code
Speech or Language Disorder	V401
Learning Disabled	V400
Emotionally Disturbed	V403
Developmentally Delayed	V793
Mentally Retarded	V402
Orthopedically Impaired	V495
Autistic	V409
Traumatic Brain Injury	V488
Other Health Impaired	V419
Deaf/Blind	V418
Hearing Disabled/Deaf	V412
Hearing Disabled/Hard of Hearing	V413
Blind or Visually Impaired	V410
Multi-Handicapped	V498
Other	V705

Other – V705, should only be used for those claims where there is no primary special education disability, e.g. Child Outreach Screening, Child Outreach Rescreening, Expanded Behavioral Health Counseling and initial evaluations.

Claiming Hints

- Use whole units: do not use fractions
- Minimum length of time for hour evaluations (PT, OT, SLP) is 60 minutes
- Complete each unit and fee entered with a number-do not use dittos
- Use complete from and to date of service in 6-digit MMDDYY format
- Diagnosis Code used for Medicaid billing should be primary disability code reported to RIDE in the Census for Special Education

Note regarding HIPPA Administrative Simplification: Electronic Transactions and Code Sets

The identification of National Code Sets, comprising National standards for formats and data content are part of the Administrative Simplification requirement of the Health Insurance Portability and Accountability Act. Using the same health care transactions, code sets, and identifiers as other providers across the country was intended to give the health care industry a common language to make it easier to transmit information electronically. The Executive Offices of Health and Human Services and its fiscal agent, HP ENTERPRISE SERVICES, completed a crosswalk of all “state-only” codes to an established national code list. Included in this activity were the state-only codes used for services reimbursed by Local Education Agencies. All state-only codes, with the exception of X0215, were converted to a code from the National Code Set. The following table lists the Medicaid applicable procedure codes, national definitions and corresponding local usages, as well as units, rates and provider qualifications.

SERVICES, UNITS, QUALIFICATIONS AND CODES

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Physical Therapy Services						
97001	Physical Therapy Evaluation	Physical Therapy Evaluation	1 unit equals 1 hour Max units equals 3 units per day	\$85.00 per hour	Physical Therapist licensed by the Department of Health	Page 33-35
97110 GP	Therapeutic Procedure, One or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Ind. P.T. W/Licensed PT	1 unit equals 15 minutes Max units equals 12 units per day	\$15.74 per 15 minutes	Physical Therapist licensed by the Department of Health	Pages 33-35
97530 HM GP	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Ind. P.T. Program	1 unit equals 15 minutes Max units equals 6 units per day	\$12.00 per 15 minutes	Physical Therapy Assistant (PTA) licensed by the Department of Health working under the supervision of a Licensed Physical Therapist	Pages 33-35
97150 GP	Therapeutic procedure(s), Group (2 or more individuals), 15 minutes	P.T. Program - Group	1 unit equals 15 minutes Max units equals 8 units per day	\$9.50 per 15 minutes per Medicaid eligible child(ren)	Physical Therapist licensed by the Department of Health Or Physical Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Physical Therapist	Pages 33-35
Occupational Therapy Services						
97003	Occupational Therapy Evaluation	Occupational Therapy Evaluation	1 unit equals 1 hour Max units equals 3 units per day	\$85.00 per hour	Occupational Therapist licensed by the Department of Health	Page 36-38
97110 GO	Therapeutic Procedure, One or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Ind. O.T. W/Licensed O.T.	1 unit equals 15 minutes Max units equals 8 units per day	\$14.50 per 15 minutes	Occupational Therapist licensed by the Department of Health	Pages 36– 38

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
97530 HM GO	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Ind. O.T Program	1 unit equals 15 minutes Max units equals 8 units per day	\$12.00 per 15 minutes	Certified Occupational Therapy Assistant (COTA) licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist	Pages 36– 38
97150 GO	Therapeutic procedure(s), Group (2 or more individuals), 15 minutes	O.T. Program - Group	1 unit equals 15 minutes Max units equals 8 units per day	\$9.50 per 15 minutes per Medicaid eligible child(ren)	Occupational Therapist licensed by the Department of Health Or Certified Occupational Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist	Pages 36– 38
Speech, Hearing, Lang., Services						
92506	Identification of children with speech or language impairments; diagnosis and appraisal of specific speech or language impairments	Speech, Hearing, Lang., Evaluation	1 unit equals 1 hour Max units equals 3 units per day	\$85.00 per hour	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE or an Audiologist licensed by DOH	Pages 39-42
92507 GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Ind. S.H.L W/Licensed S.H.L	1 unit equals 15 minutes Max units equals 8 units per day	\$15.86 per 15 minutes	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE or an Audiologist licensed by the Department of Health	Pages 39-42
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Ind. S.H.L. Program	1 unit equals 15 minutes Max units equals 8 units per day	\$12.00 per 15 minutes	A paraprofessional working under the supervision of a A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE	Pages 39-42

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Orientation and Mobility Services						
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.	Sensory Integration Therapy	1 unit equals 15 minutes Max units equals 16 units per day	\$26.55 per 15 minutes	Current O & M Specialist Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	
T1024	Orientation and Mobility Evaluation	Orientation and Mobility Evaluation	1 unit equals 15 minutes Max units equals 16 units per day	\$26.55 per 15 minutes	Current O & M Specialist Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	
T1024 TS	Orientation and Mobility Re-Evaluation	Orientation and Mobility Re-Evaluation	1 unit equals 15 minutes Max units equals 16 units per day	\$26.55 per 15 minutes	Current O & M Specialist Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	
Evaluation Services						
Psychological						
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication	Psychiatric Evaluation	1 Unit equals the completed evaluation, including the report writing Max unit equals 1 unit per day	\$135.00 per completed evaluation	Board Certified Psychiatrist	Page 43-45
H0031 AH	Mental health assessment, by non-physician	Psychological Evaluation	1 Unit equals the completed evaluation, including the report writing Max unit equals 1 unit per day	\$126.68 per completed evaluation	Clinical Psychologist Licensed by the Department of Health	Pages 43-45
H0031 AJ	Mental health assessment, by non-physician	Social Worker /Licensed Mental	1 Unit equals the completed	\$135.49 per completed	LICSW, LCSW , a Certified School Social Worker or a	Pages 43-45

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
		Health Counselor Evaluation	evaluation, including the report writing Max unit equals 1 unit per day	evaluation	Licensed Mental Health Counselor	
Counseling Services						
Psychological Counseling						
H0004	Behavioral health counseling and therapy (with or w/o parent present),, per 15 minutes	Psychiatric Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$22.50 per 15 minutes	Board Certified Psychiatrist	Page 46
H0004 AH	Behavioral health counseling and therapy (with or w/o parent present),, per 15 minutes	Psychological Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$20.00 per 15 minutes	Clinical Psychologist Licensed by the Department of Health	Page 46
H0004 AJ	Behavioral health counseling and therapy (with or w/o parent present),, per 15 minutes	Social Worker/Mental Health Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$16.93 per 15 minutes	LICSW, LCSW by the DOH, a Certified School Social Worker, or a Licensed Mental Health Counselor	Page 46
96153	Health and behavior intervention, each 15 minutes, face to face; group (2 or more patients)	Counseling Services - Group	1 unit equals 15 minutes Max units equals 8 units per day	\$10.00 per 15 minute per Medicaid eligible child(ren)	Small group session conducted by any of the above	Page 46
Expanded Behavioral Health						
H0004 HA	Behavioral health counseling and therapy (with or w/o parent present),, per 15 minutes	Psychiatric Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$22.50 per 15 minutes	Board Certified Psychiatrist	Page 47-48
H0004 AH HA	Behavioral health counseling and therapy (with or w/o parent present),, per 15 minutes	Psychological Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$20.00 per 15 minutes	Clinical Psychologist Licensed by the Department of Health	Page 47-48

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
H0004 AJ HA	Behavioral health counseling and therapy (with or w/o parent present), per 15 minutes	Social Work/ Mental Health Counseling	1 unit equals 15 minutes Max units equals 6 units per day	\$16.93 per 15 minutes	LICSW, LCSW by the DOH, a Certified School Social Worker or Licensed Mental Health Counselor	Page 47-48
96153 HA	Health and behavior intervention, each 15 minutes, face to face; group (2 or more patients)	Counseling Services - Group	1 unit equals 15 minutes Max units equals 8 units per day	\$10.00 per 15 minutes per Medicaid eligible child(ren)	Small group session conducted by a Board Certified Psychiatrist, a Clinical Psychologist Licensed by DOH, a LICSW, LCSW by DOH, a Certified School Social Worker or a Licensed Mental Health Counselor	Page 47-48
Other Services						
T1003	LPN individual non-routine nursing service per 15 minutes	Nursing Services	1 unit equals 15 minutes Max units equals 40 units per day	\$8.13 per 15 minutes	A Licensed Practical Nurse	Page 49
T1002	RN individual non-routine nursing service per 15 minutes	Nursing Services	1 unit equals 15 minutes Max units equals 40 units per day	\$15.44 per 15 minutes	A Certified School Nurse Teacher or a Registered Nurse	Page 49
T2003	Non-emergency transportation	Transportation	Transportation Max units equals 4 units per day	1 unit (1 way) equals \$5.00	Transportation provided in accordance with federal and state law and as defined in Section V	Pages 55
X0215	Case Management	Case Mgt	1 unit equals 15 minutes Max units equals 6 units per day	\$17.50 per 15 minutes **	Designated case manager within school who provides activities described in Section V of the Guidebook	Pages 56-59
S5125	Attendant care services per 15 minutes	Personal Care	1 unit equals 15 minutes Max units equals 40 units per day	\$5.69 per 15 minutes	Appropriately credentialed paraprofessional working under the supervision of the classroom teacher or other school staff	Pages 60-61
E1399	Durable medical equipment,	Assistive Technology	1 unit is equal to the	Variable rate:	Appropriately credentialed staff	Page 62

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
	miscellaneous	Device	purchase of one device Max units equals 3	rate is the cost of the item	order the device	
97535	Self care/home management training direct one on one contact by provider, each 15 minutes	Assistive Technology Service	1 unit is equals 15 minutes Max units equals 20 units per day	\$15.07 per 15 minutes	Appropriately credentialed staff provide the service	Page 63
Other Services						
T2048	Behavioral health; long-term care residential, with room and board, per diem	Residential Placement Less Education & R. & B.	1 unit equals 1 day in attendance in the program Max units equals 1 unit per day	Variable rate determined by the treatment costs of the individual program and the costs for room and board only in JCAHO accredited facilities utilizing rate methodology defined in Addendum O	Approved residential treatment programs	Pages 52-54
H2018	Psychosocial rehabilitation services, per diem	Day Program Treatment	1 unit equals 1 day in attendance in the program Max units equals 1 unit per day	Variable rate determined by the treatment costs of the individual program utilizing rate methodology defined in Addendum O	Providers can be another Local Education Agency (LEA) or a program approved by the RIDE	Pages 50-51
T1023	Screening to determine the appropriateness of	Child Outreach Screening	1 unit equals the completed screening	\$60.00 per completed	Appropriately licensed staff perform the screening	Page 64

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
	consideration of an individual for participation in a specified program, project or treatment protocol, per encounter		Max units equals 1 unit per day	screening		
T1023 TS	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Child Outreach Re-screening	1 unit equals the completed re-screening Max units equals 1 unit per day	\$30.00 per completed re-screening	Appropriately licensed staff perform the re-screening	Page 64

ADDENDUM P

Sample Expanded Behavioral Health Plan

Child's Name:

Service Provider:

Date of Birth:

**Presenting Problem/
Diagnosis:**

Plan of Treatment:

Intervention:

Goals and Objectives:

Progress Notes:

Provider Signature

Date

ADDENDUM Q

HIPAA

FREQUENTLY ASKED QUESTIONS

Prepared by

Denise Achin, M.Ed

Medicaid Specialist
R.I. Technical Assistance Project
Rhode Island College
Judith A. Saccardo, Ed.D. Director

Prepared for

R.I. Department of Education
Ken Swanson
Director, Office of Special Needs

References:

www.cms.hhs.gov/hipaa/

<http://www.dhs.state.ri.us/dhs/dhipaa.htm>

“Standards for Privacy of Individually Identifiable Health Information”, OCR HIPAA Privacy, December 3, 2002, Revised April 3, 2003

Disclaimer

The material contained in this document is intended for general information and guidance regarding the implications of the Health Insurance Portability and Accountability Act on local education agencies in Rhode Island. This document does not necessarily reflect the legal opinions of the U.S. Department of Education or its Office for Civil Rights, the U.S. Department of Health and Human Services or its Office for Civil Rights, the R.I. Department of Education, or Rhode Island College. This document is for general informational purposes only and is not intended to provide legal advice.

BACKGROUND

Q: What is HIPAA?

A: HIPAA is the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Q: What is the intent of the HIPAA law?

A: This law was passed to protect individual's rights to health insurance coverage (Portability) and to promote standardization and efficiency in the health care industry (Accountability).

Q: What is the "Portability" component of the HIPAA law?

A: The portability component of HIPAA includes important new-but limited-protections for Americans and their families. HIPAA may lower your chance of losing existing coverage, enhance your ability to switch health plans and/or help you buy coverage on your own if you lose your employer's plan and have no other coverage available. This may result in health coverage continuity for pre-existing conditions when there is a change in health insurance coverage do to a change in jobs or in new employer-sponsored coverage.

HIPAA:

- May increase your ability to get health coverage for yourself and your dependents if you start a new job;
- May lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
- May help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
- May help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Q: What is "Administrative Simplification" within the HIPAA law?

A: HIPAA mandated that Congress, or by default the Department of Health and Human Services (HHS), establish and implement the four parts of the Administrative Simplification component of HIPAA. These are: the Privacy Rule; Security Rule; Standard transactions and code sets; and National Identifier System.

Privacy Rule

Q: What are the privacy standards?

A: The HIPAA privacy standards are regulations approved by Congress to protect the privacy of protected health information (PHI) in oral, written or electronic format by covered entities. These standards set parameters for the use and disclosure of PHI. They went into effect for most providers April 14, 2003 and for small providers (those with annual receipts less than \$5 million) compliance must be met by April 14, 2004.

Q: Why is the HIPAA Privacy Rule needed?

A: In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. Prior to HIPAA Privacy regulations, hospitals, doctors' offices, insurers or third party payers relied on a patchwork of Federal and State laws. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws that provide stronger privacy protections will continue to apply over and above the new Federal privacy standards.

Q: What does the HIPAA Privacy Rule create?

A: The HIPAA Privacy Rule, for the first time, creates national standards to protect individuals' medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- It strikes a balance when public responsibility supports disclosure of some forms of data, for example, to protect public health.

Q: What does it mean for patients?

A: It means patients being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.

- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.
- It empowers individuals to control certain uses and disclosures of their health information.

Security Rule

Q: What are the security standards?

A: The HIPAA Security Standards stipulate that health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule outlines the minimum administrative, physical and technical safeguards to protect electronic protected health information in their care to prevent unauthorized access to protected health care information. The security standards work in concert with the final privacy standards adopted by HHS in 2002. The privacy standards have been in effect for most covered entities since April 14, 2003 and small providers have an additional year to meet compliance (April 14, 2004). The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Most providers need to be compliant with the security standards by April 21, 2005 and small providers have an additional year to meet compliance (April 21, 2006).

Q: Do LEAs need to be compliant with the Security standards?

A: A review and analysis of these standards and their application to the LEAs needs to be completed. RIDE will send out notification as soon as this analysis has been done. In the meantime, it is recommended that LEAs: implement computer passwords for users who maintain protected health information, including Medicaid claims; instruct employees to turn off their computers when they leave their work stations; position computer screens away from the view of passersby; maintain electronic data in a secure manner to prevent unauthorized access from computer hackers...

Transactions and Code Sets

Q: What are the national transactions and code sets?

A: National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every covered/hybrid entity that does business electronically to use the same health care transactions, code sets, and identifiers. Transactions and code sets standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically.

By October 16, 2003, all providers will need to utilize standard procedure and diagnosis codes when submitting claims. An extension through December 31, 2003 has been given for the conversion of state-only codes. Between October 16, 2003 and December 31, 2003, LEAs will need to utilize new HIPAA compliant software using the current MMIS (Medicaid Management Information System) codes. Effective January 1, 2004, LEAs will need to utilize the HIPAA compliant software with newly assigned HIPAA procedure codes. It is recommended that LEAs become up to date with their Medicaid claiming to decrease conversion difficulties with the new timelines.

Q: Why does HIPAA require national transactions and code sets?

A: The transactions and code sets component of HIPAA are intended to promote standardization in the Health Care industry across the country, with providers utilizing the same codes in order to simplify billing and to cut down on administrative costs.

Q: What is the implementation date for transactions and code sets?

A: All covered/hybrid entities must utilize HIPAA compliant software and national code sets by October 16, 2003. LEAs will continue to use their existing MMIS procedure codes through December 31, 2003 and will utilize new "HIPAA" procedure codes starting January 1, 2004.

Q: Where can Rhode Island providers acquire HIPAA compliant software?

A: Free Provider Electronic Solutions (PES) software is available from (HP ENTERPRISE SERVICES) or providers may purchase or have software developed by private entities.

This software is available once a covered entity submits an Electronic Data Interchange Trading Partner Agreement with HP ENTERPRISE SERVICES and the Executive Offices of Health and Human Services.

Q: What are the recommended hardware requirements to use the PES?

A: The following are the recommended hardware requirements to use PES:

- Windows 2000, Windows NT or Windows XP
- 128 MB RAM
- 1024 X 768 monitor resolution
- 9600 baud rate modem or faster is preferred
- CD ROM drive
- Printer is preferred

Trading Partner Agreement (TPA)

Q: What is a Trading Partner (Electronic Data Interchange-EDI) Agreement?

A: A Trading Partner (Electronic Data Interchange-EDI) Agreement is an agreement between a provider or a billing company and HP ENTERPRISE SERVICES and the EOHHS in order to exchange electronic data. A copy of this form and instructions to complete can be accessed through the EOHHS web site at <http://dhs.embolden.com/ForProvidersVendors/MedicalAssistanceProviders/FormsApplications/tabid/164/Default.aspx>

Q: Who needs to complete a TPA?

A: Anyone who performs an electronic transaction with HP ENTERPRISE SERVICES or EOHHS needs to complete a TPA with the EOHHS and HP ENTERPRISE SERVICES. This includes:

- Any provider who verifies patient eligibility through the RI Medicaid Portal
- Any provider or billing agent who will check claim status through the RI Medicaid Portal
- Any Clearing House that bills electronically i.e., Web MD

- Any Billing Agent who will exchange data electronically
- Any provider and /or billing agents checking remittance advice payments
- *Remittance advice/files and Pended Claims reports will be available to only one trading partner.* (LEAs utilizing a billing company need to decide if they will have access or if their billing agent will have access to the Remittance files and pended claims reports).

If you have any questions about completing the TPA, call the HP ENTERPRISE SERVICES Electronic Data Interchange help desk at 401-784-8100 for instate, 1-800-964-6211 for long distance callers or contact Denise Achin at 1-401-222-8997 or Denise.Achin@ride.ri.gov

Q: Should an LEA complete a TPA?

A: If an LEA wants to do any of the electronic transactions listed above, then it would need to complete a TPA. If an LEA does not do any of the transactions electronically listed above, it does not have to complete a TPA. If an LEA contracts with a billing service to submit its claims, then the billing service would have to complete a TPA that is signed by the LEA. You do not need to complete a TPA if you submit claims on paper only, and do not wish to access the MMIS Web portal for any other electronic querying, e.g. eligibility, claim status, prior authorization status, or want access to a provider-specific Message Center. However, it is highly recommended that you complete a TPA for future access to these new MMIS Web portal functionalities.

National Identifier

Q: What is the National Identifier?

A: HIPAA will require that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN or TIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The remaining identifiers are expected to be determined in 2003 with compliance not due until 2005.

Covered Entities

Q: Who must comply with HIPAA regulations?

A: "Covered Entities" must comply with the HIPAA regulations. Under HIPAA, a covered entity is a health care provider, a health care clearinghouse or a health plan that transmits any health information in electronic form in connection with a HIPAA electronic transaction. To determine if you are a covered entity, go to the HIPAA website at www.cms.hhs.gov/hipaa. To access the "Covered Entity Tool", click "Administrative Simplification, scroll down to "General Information" and click "Covered Entity Decision Tools".

Q: Are Local Education Agencies (LEAs) in Rhode Island covered entities?

A: Yes, LEAs that submit claims for Medicaid reimbursement are considered hybrid [covered] entities under HIPAA law.

Q: What is a Hybrid Entity?

A: The term "hybrid entity" is used to describe an organization that has a component that is a health plan, health care clearinghouse, or a covered health care provider, and whose business activities include both covered and non-covered functions. This includes Local Education Agencies, whose covered functions are not its primary functions. While LEAs perform covered functions such as submitting claims for Medicaid reimbursement, the primary function of an LEA and most of its activities revolves around the education of students.

Q: Do LEAs need to comply with the HIPAA privacy standards?

A. Congress specifically exempted records that are covered by the Family Educational Rights and Privacy Act (FERPA) from having to be covered also by the HIPAA privacy rule. Even though LEAs are considered hybrid entities under HIPAA, they do not need to comply with the HIPAA privacy regulations for those records covered by FERPA.

Q: What are a Covered entity's requirements to implement the Privacy Rule?

A: To implement the Privacy Rule, covered entities are required to: designate a privacy official and contact person; develop policies and procedures (including for receiving complaints); provide privacy training to its workforce; implement administrative, technical, and physical safeguards; develop a system of sanctions for employees; meet documentation requirements; mitigate any harmful effect of a use or disclosure of protected health information that is known to the covered entity; refrain from intimidating or retaliatory acts; and not require individuals to waive their rights to file a complaint with the Secretary or their other rights under this Rule.

Family Education Rights and Privacy Act (FERPA)

Q: What is the Family Education Rights and Privacy Act (FERPA)?

A: FERPA is a federal law that applies to an educational agency or institution to which funds have been made available under any program administered by the Secretary of Education (this includes all LEAs).

FERPA sets out the requirements for the protection of privacy of parents and students with respect to educational records maintained by the LEA.

Based on an analysis of applicable HIPAA Privacy Regulations, it has been determined that education records which are subject to FERPA are exempt from HIPAA Privacy Regulations.

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

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

A careful analysis of applicable HIPAA Privacy Regulations and FERPA Regulations indicates that LEAs that adhere to FERPA are exempt from the HIPAA Privacy Regulations. To understand this exemption requires a clear understanding of several definitions in FERPA.

Q: What are Educational Records as defined by FERPA 34 CFR sec. 99.3?

A: The term Educational Records defined by FERPA include:

- (a) Those records that are:
 - (1) Directly related to a student; and
 - (2) Maintained by an educational agency or institution or by a party acting for the agency or institution.
- (b) The term does not include:

- (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.

Q: What is the definition of “Record” in FERPA?

A: The definition of “Record” in FERPA means any information recorded in any way, including but not limited to, handwriting, print, computer media, video or audiotape, film, microfilm, and microfiche.

Q: What is the definition of “Personally identifiable information” in FERPA?

A: Personally identifiable information within FERPA includes, but is not limited to:

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

Q: How should LEAs maintain records that support Medicaid claiming?

A: Educational records maintained by school districts billing Medicaid through a billing agent are subject to FERPA regulations and, therefore, are not subject to HIPAA Privacy Regulations. In light of this exemption, it is especially important that each LEA strictly and fully implement the FERPA regulations and the confidentiality requirements of, IDEA and the RI Special Education regulations.

LEAs that electronically transmit records that are not subject to FERPA because they do not become educational records will be subject to the Privacy Regulations and Security Regulations of HIPAA.

NOTE: It is important to note that the FERPA regulations are currently in effect and all LEAs must be compliant with these requirements. For technical assistance, please contact the Rhode Island Department of Elementary and Secondary Education legal office at 222-2057 or the Rhode Island Technical Assistance Project at Rhode Island College at 456-4600.

Q: Do School Based Health Centers (SBHCs) in Rhode Island need to be HIPAA compliant?

A: Yes, HIPAA regulations apply to all SBHCs in Rhode Island because SBHCs are administered by covered entities and the records maintained in SBHCs are not considered FERPA records. All SBHCs in Rhode Island are operated independently and are not subject to FERPA because services are provided on a voluntary basis and SBHCs are not providing education or support services.

PROTECTED HEALTH INFORMATION (PHI)

Q: What is protected health information?

A: Protected Health Information includes individually identifiable health information (with limited exceptions) in any form, including information transmitted in oral, written or electronic form by covered entities or their business associates. PHI excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act (FERPA), as amended, 20 USC

PHI is the coupling of an individual's health information with individual identifiers. Individual identifiers include:

Name

E-mail address

Address/zip code	Health Plan Subscriber Number
Social Security Number	(Recipient ID number)
Driver's License Number	Vehicle Identification Number (VIN)
Credit Card Number	Device Identifier Numbers (e.g. wheelchair)
Dates (birth, treatment)	Web Universal Resource Locator (URL)
Names of relatives	Internet Protocol Address
Name of employer	Finger or voiceprints
Telephone number	Photographic images
Fax number	any other unique identifier or code

Q: What do the Privacy regulations protect health information from?

A: The regulations put parameters on the release of protected health information by covered/hybrid entities.

Q: Under what circumstances can a covered/hybrid entity disclose protected health information?

A: Covered/hybrid entities may disclose protected health information about the individual to the individual upon request as well as to other entities when authorized to do so by the individual. Covered/hybrid entities may disclose PHI under circumstances known as treatment, payment and other health care operations (TPO), without the authorization of the individual, and for executive (Presidential) and national emergency considerations.

Q: What is "treatment"?

A: Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Q: What is "payment"?

A: Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is considered "health care operations"?

A: These are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business. These are listed at 45 CFR 164.501 and include:

- Conducting quality assessment and improvement activities
- Training, accreditation, certification, licensing, or credentialing activities
- Conducting or arranging for medical review, legal, and auditing services
- Business management and general administrative activities
 - Activities related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules
 - Customer service
 - Resolution of internal grievances
 - Creating de-identified information

Q: What information *is not covered* under the Privacy Rule protections?

A: The following information *is not covered* under the HIPAA Privacy Regulations:

- (1) De-identified information
- (2) Employment records

(3) FERPA records

Q: Under what circumstances can protected health information be shared *without* authorization?

A: Authorization for the release of PHI *is not* required under the following:

- (1) To the individual (or personal representative)
- (2) For treatment, payment, and health care operations (TPO)
 - Health Plans can contact their enrollees
 - Providers can talk to their patients
 - Providers can talk to other providers of medical services about shared patients
 - To carry out essential health care functions
- (3) Limited data set
 - For research, public health, health care operations purposes
 - Direct identifiers must be removed
 - Allows zip codes and dates
- (4) Opportunity to agree or object
 - Facility directories (name, location, general condition, clergy-religious affiliation)
 - To persons involved in care or payment for care and notification purposes
 - Friends or family members can pick up prescriptions
 - Hospitals can notify family members of patient's condition
 - Covered entities can notify disaster relief agencies

Individual Rights and Disclosure of PHI

Q: What are individual's rights under HIPAA privacy regulations?

A: Individuals have the right to:

- A written notice of privacy practices (NPP) from covered entities
- Inspect and obtain a copy of their PHI
- Amend their records
- Request restriction on uses and disclosures
- Accommodation of reasonable communication requests
- Complain to the covered entity and to HHS

Q: Are hospitals able to inform the clergy about parishioners in the hospital?

A. Yes, the HIPAA Privacy Rule allows this communication to occur, as long as the patient has been informed of this use and disclosure, and does not object. The hospital or other covered health care provider may maintain the following information about an individual in a directory and share this information with the clergy:

- Individual's name
- Location in the facility
- Health condition expressed in general terms
- Religious affiliation

B. Directory information, except for religious affiliation, may be disclosed only to other persons who ask for the individual by name.

Q: Under what conditions may a health care provider use, disclose, or request an entire medical record?

A. The Privacy Rule does not prohibit the use, disclosure, or request of an entire medical record; and a covered entity may use, disclose, or request an entire medical record without a case-by-case justification, if the covered entity has documented in its policies and procedures that the entire medical record is the amount reasonably necessary for certain identified purposes. No justification is needed

in those instances where the minimum necessary standard does not apply, such as disclosures to or requests by a health care provider for treatment purposes or disclosures to the individual who is the subject of the protected health information.

Q: When are authorizations required?

A: Authorizations are required for uses and disclosures not otherwise permitted or required by the Rule. Generally, an entity cannot condition treatment, payment, eligibility, or enrollment on an authorization. However, if eligibility for Federal or State healthcare coverage (Medicare/Medicaid) requires documentation of disability or financial condition and this information is not granted, then coverage *can* be denied because eligibility for program determination cannot be made. Authorization must contain core elements & required statements, including an expiration date or event and a statement that authorization is revocable.

Q: What rule applies to the amount of information requested?

A: There is a “Minimum Necessary” standard in HIPAA that requires covered entities make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum amount necessary to accomplish intended purpose.

Q: Are there exceptions to the Minimum Necessary Standard?

A: Yes, the exceptions to the Minimum Necessary standard include: disclosures to or requests by providers for treatment; disclosures to the individual; uses/disclosures with an authorization; uses/disclosures required for HIPAA standard transaction; disclosures to HHS/OCR for enforcement; and uses/disclosures required by law.

KEY DEFINITIONS

Q: What is a Business Associate?

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

The covered entity must require satisfactory assurance-usually a contract-that a business associate will safeguard protected health information and limit the use and disclosure of protected health information.

Contracts between an LEA and a billing company should include a confidentiality clause addressing the information being shared with the contractor and the use of this information by the contractor.

Q: What are the Centers for Medicare and Medicaid Services (CMS)?

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

Q: What is Code Set:

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

Q: What is a Covered Entity?

A: Under HIPAA, a covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. To determine if you are a covered entity, go to the HIPAA website at www.cms.hhs.gov/hipaa. To access the "Covered Entity Tool", click "Administrative Simplification, scroll down to "General Information" and click "Covered Entity Decision Tools".

Q: What is a Hybrid Entity?

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

Q: What is a Health Care Provider?

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

Q: What is a Health Care Clearinghouse?

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

Q: What is considered "health care operations"?

A: These are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business. These are listed at 45 CFR 164.501 and include:

- Conducting quality assessment and improvement activities
- Training, accreditation, certification, licensing, or credentialing activities
- Conducting or arranging for medical review, legal, and auditing services
- Business management and general administrative activities
 - Activities related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules
 - Customer service
 - Resolution of internal grievances
 - Creating de-identified information

Q: What is Health Information?

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

- (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Q: What is the Health Insurance Portability and Accountability Act (HIPAA) of 1996?

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

Q: What is the Office of Civil Rights (OCR)?

A: OCR is an office that is part of Federal Department of Health and Human Services. Its HIPAA responsibilities include oversight of the privacy requirements.

Q: What is “payment”?

A: Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is protected health information (PHI)?

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

Q: What is a Small Health Plan or Small Providers?

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

Q: What is Privacy?

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

Q: What is Security?

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

Q: What are the HIPAA Security Standards?

A: The HIPAA Security Standards stipulate that health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule requires covered entities to implement administrative, physical and technical safeguards to protect electronic protected health information in their care. The security standards work in concert with the final privacy standards adopted by HHS in 2002 and the privacy standards are scheduled to take effect for most covered entities April 14, 2003, small health plans have an additional year to comply. The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Covered entities (except small health plans) must comply with the security standards by April 21, 2005, small health plans have an additional year to comply.

Q: What is a Trading Partner Electronic Data Interchange-EDI Agreement?

A: A Trading Partner EDI Agreement is an agreement between a covered/hybrid entity, including billing companies, and HP ENTERPRISE SERVICES and the EOHHS in order to exchange electronic data. Copies of this form can be accessed through the EOHHS web site at <http://dhs.embolden.com/Portals/0/Uploads/Documents/Public/tpa.pdf>

Q: What is “treatment”?

A: Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Addendum R: Parental Consent

This addendum includes:

- (1) Sample Parental Consent forms in English and Spanish for LEAs in Rhode Island
- (2) A memo regarding FAPE (Fair Appropriate Public Education) from the Executive Offices of Health and Human Services and the Rhode Island Department of Education

ADDENDUM R

Effective October 9, 2013 Rhode Island Model Form: Parental Consent to Access Public Benefits

PARENT/GUARDIAN CONSENT TO ACCESS MEDICAID FUNDS

Student's Name	Birth Date (DOB)	Grade	Today's Date
Parent/Guardian Name	Parent/Guardian Address		

Background:

The [_____] provides special education and related services as a free and appropriate public education (FAPE), **at no cost to the parents**, in the least restrictive environment (LRE). The [_____] can seek reimbursement through Medicaid for some special education services for students who are eligible for Medicaid benefits. Section 300.154 of the Rhode Island Board of Education's Regulations Governing the Education of Children with Disabilities Education requires that the [_____] receive your **written informed consent** in order to seek Medicaid reimbursement for certain special education services.

Before you give or deny consent, please read the following:

Please check all of the following (this is informed consent):

- I understand that giving my consent to the district to access Medicaid reimbursement for services provided to my child **will not impact** my ability to access these services for my child outside the school setting.
- I understand this consent **does not include consent for assistive technology devices**. The district needs a **separate consent form** when accessing reimbursement for any assistive technology device.
- I understand that services in my child's IEP must be provided at **no cost** to me, whether or not I give consent to bill Medicaid. [If I refuse consent or if I revoke (withdraw) this consent, the school district is still responsible to provide special education and any related services identified for my child through the special education eligibility processes and these services will be provided at **no cost** to me. This includes no costs for co-pays, deductibles, loss of eligibility or impact on lifetime benefits.]
- I understand that my consent is **voluntary** and I may revoke (withdraw) my consent **in writing** at anytime after it is given. If I revoke (withdraw) my consent, the school department will no longer bill Medicaid from the date the written revocation (withdrawal) of consent is received by the district.
- I understand that the district follows both the Health Insurance Portability and Accountability Act (HIPAA -- the federal health privacy act) and the Family Educational Rights and Privacy Act (FERPA -- the federal education privacy act) requirements to protect my confidential information and that Medicaid funds received by the district directly support education in our district.

Permission given or denied (please check one):

- I give permission to the district to share information about my child with the state Medicaid Agency, its fiscal agent, and the district's Medicaid billing agent. The information shared may include my child's name, date of birth, address, primary special education disability, Medical Assistance Identification number (MID), and the type and amount of health services provided. Services may include personal care, assistive technology services, day program treatment, residential program treatment, child outreach screening, transportation, and services and/or evaluations provided by physical therapists, occupational therapists, speech, hearing and language therapists, licensed psychologists, social workers and nurses.
- I do not give permission to the district to share information about my child in order to seek Medicaid reimbursement for services provided to my child.

Parent/Guardian Signature

Date

ADDENDUM R

Formulario modelo en Rhode Island, válido desde el 9 de octubre de 2013: Consentimiento Paterno para Acceso a Beneficios Públicos

CONSENTIMIENTO DE PADRE O MADRE/TUTOR PARA ACCEDER A FONDOS DE MEDICAID

Nombre del estudiante	Fecha de nacimiento	Grado	Fecha de hoy
Nombre del padre o madre/tutor	Dirección del padre o madre/tutor		

Antecedentes:

La autoridad educativa local _____ provee educación especial y servicios relacionados en la forma de educación pública gratuita y apropiada (FAPE por sus siglas en inglés), **sin costo alguno para los padres**, en los entornos menos restrictivos (LRE por sus siglas en inglés). La autoridad educativa local _____ puede solicitar reembolso a Medicaid en pago de ciertos servicios de educación especial a estudiantes elegibles para beneficios de Medicaid. Según la sección 300.154 del reglamento de la Junta de Educación de Rhode Island que rige la educación de niños con discapacidad, _____ debe obtener **consentimiento informado por escrito** de usted para poder solicitar reembolso a Medicaid en pago de ciertos servicios de educación especial. Le rogamos leer lo siguiente antes de otorgar o negar su consentimiento:

Por favor, marque todos los enunciados a continuación (esto es un consentimiento informado):

- Entiendo** que mi consentimiento para que el distrito tenga acceso a reembolso de Medicaid en pago de servicios proporcionados a mi niño, **no afectará** mi capacidad de acceder a esos servicios para mi niño fuera del entorno escolar.
- Entiendo** que este consentimiento **no incluye consentimiento para aparatos de tecnología asistencial**. El distrito necesita un **formulario de consentimiento distinto** para obtener reembolso de aparatos de tecnología asistencial.
- Entiendo** que los servicios en el Plan de Educación Individualizado (IEP por sus siglas en inglés) de mi niño deben proveerse **sin costo alguno** para mí, ya sea que otorgue mi consentimiento o no para cobrarle a Medicaid. (Si me rehúso a dar el consentimiento, o si revoco o anulo este consentimiento, el distrito escolar aún tendrá la responsabilidad de proporcionar educación especial y cualquier servicio relacionado, identificado para mi niño mediante los procesos de elegibilidad para educación especial, y proporcionarlos **sin costo alguno** para mí, lo que también se aplica a copagos, deducibles, pérdida de elegibilidad e impacto en beneficios de por vida.)
- Entiendo que mi consentimiento es voluntario** y que después de dar mi consentimiento puedo revocarlo o anularlo **por escrito** en cualquier momento. Si revoco o anulo mi consentimiento, el departamento escolar dejará de cobrarle a Medicaid a partir de la fecha en que el distrito reciba mi revocación o anulación del consentimiento por escrito.
- Entiendo** que el distrito se rige por la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (HIPAA por sus siglas en inglés, que es la ley federal de privacidad de la salud) y la Ley de Derechos de Educación y Privacidad de las Familias (FERPA por sus siglas en inglés, que es la ley federal de privacidad de la educación) para proteger mi información confidencial, y que los fondos de Medicaid recibidos por el distrito ayudan a financiar directamente la educación en nuestro distrito.

Otorgamiento o negación de permiso (por favor marque una de las siguientes opciones):

- Doy permiso** al distrito de compartir información de mi niño con la agencia estatal de Medicaid, su agente de finanzas, y el agente de cobros a Medicaid del distrito. La información compartida puede incluir el nombre, fecha de nacimiento, dirección y número de identificación de Asistencia Médica de mi niño, e información sobre la discapacidad principal de mi niño por la que recibe educación especial. Además puede incluir el tipo y cantidad de servicios de salud recibidos. Los servicios pueden incluir cuidado personal, servicios de tecnología asistencial, programa de tratamiento diurno, programa de tratamiento residencial, exámenes de detección para niños, transporte, y servicios y/o evaluaciones de parte de fisioterapeutas, terapeutas ocupacionales, terapeutas del habla, audición y lenguaje, psicólogos autorizados, trabajadores sociales y enfermeros.
- No doy permiso** al distrito de compartir información de mi niño para solicitar reembolso a Medicaid en pago de servicios proporcionados a mi niño.

Firma de padre o madre/tutor

Fecha

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS



Executive Office of Health and Human Services
74 West Road
Hazard Bldg. #74

Memorandum

To: All Rhode Island LEA Providers
From: Rhode Island Executive Offices of Health and Human Services
Rhode Island Department of Elementary and Secondary Education
Date: April 14, 2010
Subject: Impact on Families accessing services when Medicaid Reimbursement is received by Local Education Agencies (LEAs)

As of 1992, under RI General Law 40-8-18 (revised in 2000) school districts and public charter schools are eligible to enroll as Medicaid providers of school-based services. With the consent of the parent, LEAs can seek Medicaid reimbursement for certain school-based services as dictated by the student's Individualized Education Plan (IEP). Recently, it has come to the attention of the Executive Offices of Health and Human Services (EOHHS) and the Department of Education (RIDE) that families have expressed concerns in regards to signing their district's *Consent to Bill Medicaid* forms due to the belief that it will cause other services provided to their child or family to be denied by the Medical Assistance Program. With the exception of a claim for an assistive technology device, this is not true.

It is admissible for a child to receive speech therapy (or any other Medicaid reimbursable school based service) in school and speech therapy by a community provider on the same day, with both entities seeking reimbursement from Medicaid within the parameters and guidelines set forth for the deliverance of that service. Although it is possible for Medicaid to deny the claim submitted by the community provider, an LEA submitting a claim for the same service on the same day for the same type of service would not be a reason for denial.

All Medicaid providers, including LEAs, *must* adhere to all rules and regulations pursuant to participating in the Medical Assistance Program. These include, but are not limited to:

1. Providers should only seek reimbursement for services rendered by qualified professionals.
2. Providers should not seek reimbursement for services rendered by another entity.
3. Providers should not seek reimbursement for services they charged to another entity.

For more information please contact Denise Achin at 401-222-8997 or denise.achin@ride.ri.gov or Lynn Doherty at 401-462-0315 lynn.doherty@ofhhs.ri.gov.

Addendum S

Rhode Island Medical Assistance NPI Fact Sheet

What is an NPI?

HIPAA mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. The Secretary adopted the NPI. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.

The number can be either a Type 1 or a Type 2. Type 1 NPIs are for individuals. Type 2 NPIs are for businesses or group practices. The Type 1 NPI will be assigned to the provider and will not change regardless of where he or she practices. The Type 2 NPI will not change if a business changes ownership.

It is accommodated in all standard transactions, and contains no embedded information about the health care provider that it identifies. Effective May 23, 2007, the NPI will be the only healthcare provider identifier that will be accepted/used for identification purposes for standard transactions by covered entities.

What is Taxonomy?

The Health Care Provider Taxonomy code set is an external non medical data code set designed for use in an electronic environment, specifically within the ANSI ASC X12N health care transactions. This includes the transactions mandated under HIPAA.

The Health Care Provider Taxonomy code is a unique, alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.

The National Uniform Claim Committee (NUCC) is presently maintaining the code set. It is used in transactions specified in HIPAA and the National Provider Identifier (NPI) application for enumeration. Effective 2001, the NUCC took over the administration of the code set. Ongoing duties, including processing taxonomy code requests and maintenance of the code set, fall under the NUCC Code Subcommittee. Primary distribution of the code set remains the responsibility of Washington Publishing Company (WPC), through its web site.

- A Taxonomy Code is an additional, unique, 10 position number to be listed on the NPI application
- It provides additional information about the provider. The Taxonomy Code is structured into three distinct "Levels"—Level 1, Provider Type—Level II, Classification—Level III, Area of Specialization

To apply for your NPI:

You can apply for an NPI by any of the following methods:

- Call the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 to request an application
- Electronically file for an NPI from the NPPES Web site at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Purpose of NPI and Taxonomy

Establishes the standard for the unique health identifier for health care providers to simplify the administration of the health care system. What the rule does:

Establishes the Standard: The National Provider Identifier (NPI) is the unique health identifier for health care providers. The NPI is a 10-digit numeric identifier with a check digit.

Establishes the National Provider System: The National Provider System (NPS) will be the system used to assign unique numbers to health care providers.

Defines Implementation Specifications for Covered Entities: Health Care Providers must obtain an NPI and use it on standard transactions; Health Plans and Health Care Clearinghouses must use the NPI to identify health care providers on standard transactions where the health care provider's identifier is required.

Defines Compliance Dates for Implementation of the NPI: Health Care Providers, Health Plans (except small health plans), and Health Care Clearinghouses must comply with the NPI implementation specifications no later than May 23, 2007. Small Health Plans must comply with the NPI implementation specifications no later than May 23, 2008.

Do I need to get an NPI?

All health care providers that meet the definition of a covered entity (healthcare providers that conduct certain transactions in electronic form, health plans, or healthcare clearinghouses), as defined in 45 CFR 160.103, are eligible for NPIs. Health care providers who transmit any health information in electronic form in connection with a transaction are required to obtain and use NPIs. Health care providers who are not considered covered entities may also apply and be assigned an NPI. However, entities that do not provide health care (e.g., transportation services) are not eligible to be assigned NPIs because they do not meet the definition of “health care provider” and are not subject to HIPAA regulations.

If you provide services that fall within the realm of “Health Care” as defined by 45 CFR 160.103, you are required to obtain an NPI. This includes care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. Examples include but are not limited to physicians, nurses, hospitals, physical and occupational therapists and pharmacies/pharmacists.

Why do I need to get an NPI?

All healthcare providers who are Health Insurance Portability Accountability Act (HIPAA) covered entities will need to get an NPI to file claims with RIMAP. This includes filing claims using the Web site and/or the Provider Electronic Solutions software after May 23, 2007.

When should I get my NPI?

RIMAP recommends obtaining, and notifying HP ENTERPRISE SERVICES of this number, all associated taxonomies, and the current RI Medicaid Provider ID (Legacy #), as soon as possible. Failure to obtain your NPI by May 23, 2007, could result in nonpayment of claims.

How do I notify RIMAP of my NPI?

Providers should notify RIMAP of their NPI, Taxonomy, and current RI Medicaid Provider ID (Legacy #) by sending the official CMS approval by either fax, 467-9581 Attn: Provider Enrollment

When may I start using my NPI on submissions of claims to RIMAP?

RIMAP will begin accepting NPI's on May 23, 2007.

For further questions regarding NPI, please contact RIMAP at (401) 784-8877 to leave a voice message. Please include your name, contact phone number, and a brief message. All calls will be responded to within 48 hours/2 business days.

Are there any changes with the paper claim forms?

The State of Rhode Island's Medical Assistance program recommends using both the NPI and taxonomy on all paper claim forms for those providers required to obtain an NPI. This directive will encompass all provider numbers including billing, rendering, performing, and referring. When an NPI is used on a paper claim form then a taxonomy is required.

The CMS-1500 claim form was updated to accommodate the mandated National Provider Identifiers (NPIs). The previous CMS-1500 (12-90) form did not have the fields for reporting of NPIs. Further information on the CMS-1500 form is available through the NUCC web site: <http://www.nucc.org>

The National Uniform Billing Committee (NUBC) is responsible for updating the UB-92; it has been replaced by the UB-04 paper. You may obtain copies of the CMS-1450 form, which is also known as the UB-04, from the Standard Register Company, Forms Division. HIPAA requires submission of National Provider Identifiers (NPIs) on claims effective May 23, 2007. To accommodate this transition, HP ENTERPRISE SERVICES will continue to accept the old paper claim forms until September 1, 2007. Please consult with your software/billing vendor to ensure that all the necessary charges are made to your system to accommodate billing paper claims on the updated forms.

What changes should I expect to see related to NPI?**Recipient Eligibility Verification System (REVS)**

When checking eligibility providers will be able to use either the NPI or the current RI Medical Assistance Provider Id.

If checking payment information on REVS with an NPI, the provider will receive a total dollar amount for the current financial cycle for all Medical Assistance Provider Id's associated with that NPI. If checking payment information on REVS with a Medical Assistance Provider Id, the provider will only receive the total dollar amount for that Medical Assistance Provider Id entered into REVS.

Paper Remittance Advices (RA)

The Paper Remittance Advice will remain unchanged with the exception of printing the NPI number under the RI Medical Assistance Id in the upper left corner of the RA.

835 – Electronic Remittance Advice

The 835 will return claims adjudication information for all RI Medical Assistance Id's associated with the NPI.