MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy updates the School Services Program chapter of the MDHHS Medicaid Provider Manual to incorporate the C4S expansion.

Reason for policy (problem being addressed):

To incorporate the C4S expansion.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

No.

Does policy have operational implications on other departments?

Yes - Michigan Department of Education.

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2402-SSP	**Date:** February 16, 2024

Comments Due: March 22, 2024
Proposed Effective Date: July 1, 2024
Direct Comments To: Kevin Bauer
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E-Mail Address: Bauerk2@michigan.gov
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Policy Subject: Update to the School Services Program Chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual

Affected Programs: School Services Program (SSP)

Distribution: SSP Providers

Summary: This policy updates the School Services Program chapter of the MDHHS Medicaid Provider Manual to incorporate the C4S expansion.

Purpose: To incorporate the C4S expansion.

Cost Implications: Budget Neutral

Potential Hearings & Appeal Issues: None

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**
Tribal Notification: Yes ☐ **No** ☒ **- Date:**	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: School Services Program Providers

Issued: June 1, 2024 (Proposed)

Subject: Update to the School Services Program Chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual

Effective: July 1, 2024 (Proposed)

Programs Affected: School Services Program (SSP)

The purpose of this policy is to update the School Services Program (SSP) chapter of the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual**.** The update includes combining the School-Based Services, School- Based Services Administrative Outreach Program, and School -Based Services Random Moment Time Study chapters into a single chapter, while incorporating the Caring for Students (C4S) expansion into the Medicaid Provider Manual. The update for C4S expansion includes:

- Addition of provider types not previously reimbursable by the SSP program
- Expansion of eligible students to include those not receiving Special Education services
- Directions for computing C4S Medicaid Reimbursement
- Other technical changes

SCHOOL SERVICES PROGRAM

This chapter is comprised of three parts:

The **SCHOOL SERVICES PROGRAM** portion of the chapter outlines the general requirements and direct service direct for the program.

The **SCHOOL SERVICES PROGRAM ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT** portion of the chapter outlines the program's administrative outreach requirements.

The **SCHOOL SERVICES PROGRAM RANDOM MOMENT TIME STUDY** portion of the chapter focuses on the RMTS requirements for the program.

SCHOOL SERVICES PROGRAM

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SECTION 1 - GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts, Detroit Public Schools Community District (DPSCD), and Michigan School for the Deaf (MSD).

This chapter describes the coverage and reimbursement policy for direct medical services, targeted case management (TCM), and personal care services (PCS). Coverage applies to individuals up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP), Section 504 Plan, other individualized health care plan, or as otherwise medically necessary. The Centers for Medicare & Medicaid Services (CMS) has determined that services provided in the "school" setting include services provided by qualified school staff in the "home" setting when necessary. For the purpose of this document, IEPs, IFSPs, Section 504 plans, individualized plans of care, and all other plans of care will be referred to as "plan of care (POC)" for simplicity.

These services assist students, with or without a disability, in benefiting from educational and related services. Medicaid reimbursement, through the Michigan Department of Health and Human Services (MDHHS), addresses the medical service needs of beneficiaries receiving educational and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover "related services" which are specified in Federal Medicaid statute as medically necessary and "included in the student's IEP/IFSP established pursuant to Part B of the IDEA or furnished to a disabled infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act." On December 15, 2014, CMS issued State Medicaid Director Letter (SMDL) 14-006 *Medicaid Payment for Services without Charge (Free Care)*. Based on that guidance, schools can seek reimbursement for all covered services provided to all students enrolled in Medicaid, regardless of whether the services are provided at no cost to other students and allows for Medicaid reimbursement for services delivered outside of an IEP or IFSP.

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to all students. These services are described in an individualized plan of care and provided free of charge to eligible students. Medicaid reimbursement is allowed for these services.

Medicaid services provided through SSP are not covered for students involuntarily residing in a detention setting with a Benefit Plan ID of INCAR-ESO, INCAR-MA, INCAR-MA-E, or MA-HMP-INC.

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

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. Medicaid

services provided by the ISDs are to be provided as outlined in the POC and are not expected to replace or substitute for services already provided by other agencies. If services are being provided by another program, ISDs are expected to coordinate the services to prevent service overlap and to assure continuity of care to the Medicaid beneficiary. Enrollment as a SSP provider is not expected to result in any change in the education agency's set of existing services or service utilization. MDHHS periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.

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

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability.
Assistive Technology Service	The term "assistive technology service" means any service that directly assists a student with a disability in the selection, acquisition or use of an ATD.
Caring for Students (C4S)	Program component enabling reimbursement of Medicaid costs associated with providing services to students outside of an IEP/IFSP.
Certified Public Expenditure	A certified public expenditure is an expenditure of a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match.
Direct Medical Services Program	Direct medical services, specialized transportation, TCM, and PCS provided in the school setting and reimbursed by Medicaid.
Direct Service Claiming (DSC)	Program component enabling reimbursement of Medicaid costs associated with providing services to students within an IEP/IFSP. This component was previously known as School-Based Services (SBS).

Durable Medical Equipment, Prosthetics, Orthotics & Supplies(DMEPOS)	▪ Durable Medical Equipment items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when: ➢ It is medically and functionally necessary to meet the needs of the beneficiary. ➢ It may prevent frequent hospitalization or institutionalization. ➢ It is life sustaining. ▪ Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that: ➢ Treat a medical condition. ➢ Prevent unnecessary hospitalization or institutionalization. ➢ Support DME used by the beneficiary. ▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Enable a beneficiary to ambulate or transfer. ▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Prevent or reduce contractures. ➢ Facilitate healing or prevent further injury.
Enrolled Medicaid Provider	The 56 Michigan Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf that have enrolled and revalidated with the MDHHS Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment subsystem.
HA Modifier (C4S)	The HA modifier is used with the appropriate procedure codes to identify services delivered outside of an IEP/IFSP.
HT Modifier (Multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA assessment. Each qualified staff bills using the appropriate procedure code followed by the HT modifier (multi-disciplinary team).
IDEA (Individuals with Disabilities Education Act)	The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.

IDEA Assessment	An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the individual.
IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of 4 and 26 in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for beneficiaries up to the age of 21.
IFSP (Individualized Family Service Plan)	A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.
ISD (Intermediate School District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 56 intermediate school districts.
MDE (Michigan Department of Education)	A department within the State of Michigan.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the student's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the POC. Medical necessity may support educational outcomes and goals.
Plan of Care (POC)	A POC is a form that summarize a student's health conditions, specific care needs, and current treatments. The POC outlines what needs to be done to manage the student's care needs and organizes and prioritizes services. The student's IEP/IFSP form, 504 plan, individual treatment plan, behavioral health plan, or any other plan may suffice as the POC as long as the document contains the required components described under the Plan of Care subsection of this section.
Random Moment Time Study	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
School Services Program (SSP)	A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public Schools Community District, and Michigan School for the Deaf participate in the School Services Program.
Specialized Transportation	Transport to and from the student's pick-up and drop-off site where school-based services are provided for students receiving services through an IEP/IFSP. Reimbursement for Specialized Transportation is not available for students receiving services outside of an IEP/IFSP.

TL Modifier (Re-evaluation of Existing Data [REED])	The TL modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the student's eligibility for special education services.
TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP plan of care. Each qualified staff bills for this assessment using the appropriate procedure codes with the modifier.
52 Modifier	The 52 modifier is used with the appropriate procedure codes to describe circumstances in which services provided were reduced in comparison to the full description of the service.
59 Modifier	The 59 modifier is used with the appropriate procedure codes to identify when a service was distinct or independent from other services provided on the same day with the same CPT codes.
93 Modifier	The 93 modifier is used with the appropriate procedure codes to identify when service is provided via telemedicine using audio only.
95 Modifier	The 95 modifier is used with the appropriate procedure codes to identify when a service is provided via telemedicine using audio and video.

1.1 Children's Special Health Care Services

The Medicaid SSP program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SSP providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only) and must not submit claims for these beneficiaries.

1.2 Third Party Liability

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid for services provided outside of an IEP/IFSP. If a Medicaid-eligible student is presently covered by another resource and the school district does not bill the other resource, Medicaid cannot be billed for the services outside of an IEP/IFSP. ISDs are not required to bill other resources prior to billing Medicaid for services provided through an IEP/IFSP. (Refer to the Coordination of Benefits chapter for additional information.)

1.3 Medical Necessity

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

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self-care;
- Is included in the student's IEP/IFSP, Section 504, other plan of care, or be otherwise medically necessary; and

- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of their practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. Electronic and faxed signatures are acceptable; however, stamped signatures are not acceptable.

1.4 Under the Direction of and Under the Supervision of

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

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

1.5 Covered Services

Medicaid covered services billed by ISDs include:

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

1.6 Service Expectations

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

To be covered by Medicaid, behavioral and physical health services must address a beneficiary's medical need that affects their ability to learn in the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure, and reading).

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

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

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

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

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

1.7 Plan of Care (POC)

Requirements	If an evaluation indicates that Medicaid-covered services are required, qualified staff must develop and maintain a POC for the student. The student's IEP/IFSP, Section 504 plan, or individual plan of care form may suffice as the POC if the IEP/IFSP, Section 504 plan, or individualized plan of care contains the required components described below. Only qualified staff may initiate, develop, or change the beneficiary's POC. The POC must be signed, titled, and dated by the qualified staff prior to billing Medicaid for services and must be retained in the student's school clinical record. Services may be billed in the absence of a POC for up to 30 calendar days when determined to be medically necessary, based on the urgency of the student's needs. (Refer to the Covered Services Section of this chapter for definitions of qualified staff.)

Components	The POC, which is an immediate result of the evaluation, must consist of the following components: ▪ Beneficiary's name and date of birth; ▪ Description of the beneficiary's qualifying diagnosis or medical condition; ▪ Time-related goals that are measurable and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators of when the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals, as applicable; ▪ Plan for reaching the functional goals and outcomes in the POC; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); ▪ All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis; and ▪ Signature, title, and date of the qualified medical professional signing the POC.

Individuals Authorized to Review/Sign the POC	The POC must be signed by a qualified medical provider listed below: ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully licensed speech-language pathologist (SLP) ▪ A licensed audiologist ▪ A fully licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A certified school psychologist ▪ A board-certified behavior analyst (BCBA) ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A licensed physician assistant (PA) ▪ A licensed nurse practitioner (NP) ▪ A licensed clinical nurse specialist (CNS) ▪ A registered nurse (RN) ▪ A qualified school nurse
Review	The POC must be reviewed and updated at least annually or more frequently if the student's condition changes or alternative treatments are recommended.
Revision	If the POC is updated in a way that changes the student's diagnosis and medical condition, goals, plan for reaching the functional goals and outcome, or frequency or duration of services, the POC must be revised and a new signature from a medically qualified provider is required.

1.8 Prescriptions, Referrals, and Authorizations

Prescriptions, referrals, and authorizations must include:

- Student's name
- Date
- Type of services to be provided
- Provider's typed or printed name
- Provider's NPI number when appropriate

1.9 EVALUATIONS

Evaluations for medical services are covered under any of the following conditions:

- Performed as part of the IDEA assessment.
- Performed as part of the student's initial assessment.
- The student left and is re-entering the SSP Program.
- An initial development, review or revision of the student's POC will occur.
- A change or decrease in function occurs.

1.9.A. EVALUATIONS PERFORMED FOR DMEPOS MEDICAL SUPPLIERS

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

SECTION 2 – COVERED SERVICES

2.1 ASSESSMENT AND POC DEVELOPMENT, REVIEW AND REVISION

Definition	The assessment process includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and are related to the evaluation and functioning of the beneficiary. These services are reimbursable even if they do not result in the implementation of a POC. If a POC is not implemented within one year of the date of service, then none of the services provided are covered.
Provider Qualifications	Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA assessment. To be covered by Medicaid, staff must have the following Michigan current credentials: ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully licensed speech-language pathologist (SLP) ▪ A licensed audiologist ▪ A fully licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A certified school psychologist ▪ A board-certified behavior analyst (BCBA) ▪ A board-certified assistant behavior analyst (BCaBA) under the supervision of a BCBA ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A licensed physician assistant (PA) ▪ A licensed nurse practitioner (NP) ▪ A licensed clinical nurse specialist (CNS) ▪ A registered nurse (RN) ▪ A licensed practical nurse (LPN) ▪ A qualified school nurse

Procedure Codes	Qualified staff can bill for three distinct types of assessments/evaluations/tests. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately claimable. For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) ▪ The **HA modifier** is used with the procedure code when billing for services provided outside of an IEP/IFSP. ▪ The **HT modifier** is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA assessment. Each qualified staff bills using the appropriate procedure code below followed by the HT modifier (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or Early On® services. The determination date must be included in the assessment/evaluation/test. ▪ The **TL modifier** is used with the appropriate procedure codes to identify when a REED was used in the determination of the student's eligibility for special education services. ▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP POC. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. ▪ No modifier is used when assessments/evaluations/tests are provided not related to the IDEA assessment or the POC development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code with no modifier. The date of service is the date the assessment/evaluation/test is completed.

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

2.2.A. Occupational Therapy Services

NOTE: Telemedicine Services are covered in the Telemedicine chapter of this manual.

Definition	**Occupational Therapy:** Occupational therapy (OT) must be habilitative or rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. OT services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or orientation and mobility specialist.
Prescription	Occupational therapy services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated no less than annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.

Provider Qualifications	OT services may be reimbursed when provided by: ▪ A licensed occupational therapist (OT); or ▪ A licensed occupational therapy assistant (OTA) under the direction of a licensed OT. **NOTE:** The OTA's services must follow the evaluation and POC developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising OT.
Evaluations for Occupational Therapy	Evaluations are formalized testing and reports for the development of the beneficiary's POC. They may be completed by a licensed OT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the beneficiary.
Assessments for Durable Medical Equipment	If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	OT services include: ▪ Group therapy provided in a group of two to eight students; ▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; ▪ Wheelchair management/propulsion training; ▪ Independent living skills training; ▪ Coordinating and using other therapies, interventions, or services with the ATD; ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian; ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services; ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD; or ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.B. ORIENTATION AND MOBILITY SERVICES

Definition	**Orientation and Mobility Services:** Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low vision aids/devices, as appropriate.
Prescription	Orientation and mobility services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.

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

	▪ Visual training to understand and use the remaining vision for those with low vision; ▪ Training necessary to activate visual motor abilities; ▪ Training to use distance low vision aids/devices; and ▪ Independent living skills training.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.C. ATD SERVICES

Definition	Assistive Technology Device (ATD) Services General Description: Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ A licensed OT; or ▪ A licensed OTA.
Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by a licensed OT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and

	▪ Evaluation of the needs related to ATD services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for DME	If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs etc., is not a covered benefit of the SSP program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medicaid medical supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school-based providers.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3 PHYSICAL THERAPY SERVICES (INCLUDES ATD SERVICES)

2.3.A. PHYSICAL THERAPY SERVICES

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Physical therapy (PT) may be habilitative or rehabilitative, active or restorative, and designed to correct or compensate for a medical problem. PT services must require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	PT services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Provider Qualifications	PT services may be reimbursed when provided by: ▪ A licensed physical therapist (PT); or ▪ A licensed physical therapy assistant (PTA) under the direction of a licensed PT (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising PT.
Evaluations for Physical Therapies	Evaluations are formalized testing and reports to determine a beneficiary's need for services and recommend a course of treatment. They may be completed by a PT. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (i.e., functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD-services, including a functional evaluation of the beneficiary.
Assessments for DME	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	PT services include, but are not limited to: ▪ Group therapy provided in a group of two to eight students; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.B. ATD SERVICES

Definition	**ATD Services General Description:** Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ a licensed physical therapist (PT); or ▪ a licensed physical therapy assistant (PTA).

Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the beneficiary's POC. They may be completed by a PT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for DME	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and writer their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SSP program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by SSP providers.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4 Speech, Language and Hearing Therapy (Includes ATD Services)

2.4.A. Speech, Language and Hearing Therapy

NOTE: Telemedicine Services are covered in the Telemedicine chapter of this manual.

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist or audiologist to provide the therapy.
Prescription	Speech, language, and hearing services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.

Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A fully licensed speech-language pathologist (SLP); ▪ A licensed audiologist in Michigan; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or ▪ A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
Evaluations for Speech Pathology Services	Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by a licensed SLP or audiologist. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the beneficiary. Evaluations may also include, but are not limited to: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.

Speech Assessments for DME	If an ISD speech-language pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier chapter of this manual. For example, the clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	Speech, language and hearing services include, but are not limited to: ▪ Group therapy provided in a group of two to eight students ▪ Articulation, language, and rhythm ▪ Swallowing dysfunction and/or oral function for feeding ▪ Voice therapy ▪ Speech, language or hearing therapy ▪ Speech reading/aural rehabilitation ▪ Esophageal speech training therapy ▪ Speech defect corrective therapy ▪ Fitting and testing of hearing aids or other communication devices
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4.B. ATD SERVICES

Definition	**ATD Services General Description:** Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician's assistant, nurse practitioner, or clinical nurse specialist and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ A licensed audiologist; or ▪ A fully licensed speech-language pathologist (SLP).

Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the beneficiary's POC. They may be completed by an audiologist or SLP. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for DME	If an ISD audiologist or speech-language pathologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SSP program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services.

	▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.5 PSYCHOLOGICAL, COUNSELING AND SOCIAL WORK SERVICES

NOTE: Telemedicine Services are covered in the Telemedicine chapter of this manual.

Definitions	Psychological, counseling, and social work services include planning, managing and providing a program of face-to-face services for beneficiaries with diagnosed psychological conditions. Psychological, counseling, and social work services must require the skills, knowledge and education of a psychologist, counselor, or licensed social worker to provide treatment. Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy. ▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a beneficiary who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. ▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.

Provider Qualifications	Psychological, counseling and social work services may be reimbursed when provided by: ▪ A licensed physician or psychiatrist; ▪ A fully licensed psychologist; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A certified school psychologist ▪ A board-certified behavior analyst (BCBA) ▪ A board-certified assistant behavior analyst (BCaBA) under the supervision of a BCBA ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker; or ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker.
Evaluations	Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed master's social worker must complete them.
Psychological Testing	Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A fully licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's condition. Medicaid does not cover the time that a beneficiary spends alone in testing. The beneficiary's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing. The psychological testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.

Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)
Crisis Intervention	Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the beneficiary's POC.

2.6 DEVELOPMENTAL TESTING

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language, and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the beneficiary's history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid.
Documentation	The developmental testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Tests administered; ▪ A completed quarterly claim breakdown, produced by the claims development software; ▪ Treatment recommendations; and ▪ The dated signature, address and phone number of the person administering the tests.
Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: ▪ A fully-licensed psychologist; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A licensed master's social worker; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; or ▪ A licensed physician or psychiatrist.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.7 NURSING SERVICES

NOTE: Telemedicine Services are covered in the Telemedicine chapter of this manual.

Definition	Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), School Nurse, Registered Nurse (RN), and Licensed Practical Nurse (LPN), provided during a face-to-face encounter and provided on a one-to-one basis. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices. Services include, but are not limited to: ▪ Catheterizations or catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. LPN services can only be billed if performed under the supervision of an RN or physician.
Prescription	Direct service interventions require a physician's, physician's assistant's, nurse practitioner's, or clinical nurse specialist's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the beneficiary's attending physician. The nurse is responsible for notifying the attending physician of any change in the beneficiary's condition which may result in a change or modification to the POC. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Provider Qualifications	Nursing services may be reimbursed when provided by: ▪ A licensed Nurse Practitioner (NP); ▪ A licensed Clinical Nurse Specialist (CNS); ▪ A certified School Nurse; ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ A Licensed Practical Nurse (LPN) in Michigan.
Evaluations	A NP, CNS, RN, or School Nurse must complete the evaluations/assessments and prepare a nursing POC. An evaluation/assessment may be performed when a change in the beneficiary's medical condition occurs. LPNs cannot bill for evaluations/assessments.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.8 PHYSICIAN AND PSYCHIATRIST SERVICES

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a beneficiary's medical or other health-related condition. Physician/psychiatrist services include: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SSP may be billed and reimbursed through the enrolled ISD. Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled ISD.
Provider Qualifications	A licensed physician or psychiatrist (MD or DO) in Michigan.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) Procedure codes that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable.

2.9 PERSONAL CARE SERVICES

Definition	Personal Care Services (PCS) are a range of human assistance services 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 or cueing so that the student performs the task by themself. PCS may be provided when: ▪ The service is medically necessary. PCS are not covered if they are: ▪ Provided by a family member. A family member is described by CMS to be "legally responsible relatives"; thus, spouses of beneficiaries and parents or guardians of minor beneficiaries (including stepparents who are legally responsible for minor children). ▪ Not documented in the POC. ▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation. ▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. PCS may include, but are not limited to, assisting with the following: ▪ Eating/feeding ▪ Respiratory assistance ▪ Toileting ▪ Grooming ▪ Dressing ▪ Transferring ▪ Ambulation ▪ Personal hygiene ▪ Mobility/Positioning ▪ Meal preparation ▪ Skin care ▪ Bathing ▪ Maintaining continence ▪ Assistance with self-administered medications ▪ Redirection and intervention for behavior ▪ Health related functions through hands-on assistance, supervision, and cueing

Personal Care Paraprofessional Provider Qualifications	The personal care paraprofessional personnel are employed by the ISD and shall be qualified under the requirements established by their respective POC. Providers must be trained in the skills needed to perform covered services, and must be under the direction of a qualified professional as designated in the POC. Paraprofessional personnel include: ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ Trainable Aides ▪ Behavioral Health Aides
Prescription	In accordance with 42 CFR 440.167, authorization for PCS may be done by a physician or "other licensed practitioner" operating within the scope of their practice. The State definition of "other licensed practitioner" consists of Registered Nurse (RN), Licensed Occupational Therapist (OT), Licensed Physical Therapist (PT), Master of Social Work (MSW), or fully licensed Speech Language Pathologist (SLP). It is expected that PCS will be authorized by the appropriate practitioner and updated annually. A stamped signature is not acceptable; however, electronic and faxed signatures are acceptable.
Documentation	PCS must be medically necessary and the need for the service must be documented in the student's POC. Each student's school clinical record must contain a completed, signed and dated monthly activity log. Any days where the student is absent must be documented on the monthly activity log. The monthly activity log may be in an electronic format; however, all services provided to the student must be listed. Service categories (i.e., toileting, feeding, transferring, etc.), times, and frequencies must be documented either in the POC, in an attached document, or in the student's treatment authorization.
Procedure Codes	For a complete listing of procedure codes, refer to the CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.10 TARGETED CASE MANAGEMENT (TCM) SERVICES

Definition	Targeted case management (TCM) services are services furnished to assist students in gaining access to needed medical, social, educational, or other services. TCM services include the following assistance: ▪ A comprehensive assessment and periodic reassessment of an student to determine the need for medical, social, educational, or other services. These assessment activities include: ➢ Taking student history; ➢ Identifying the student's needs and completing related documentation; and

	➢ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the student. ▪ Development (and periodic revision) of a POC that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the student; ➢ Includes activities such as ensuring the active participation of the eligible student, and working with the student (or the student's authorized health care decision maker) and others to develop those goals; and ➢ Identifies a course of action to respond to the assessed needs of the eligible student. ▪ Referral and related activities: ➢ To help an eligible student obtain needed services, including activities that help link a student with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the student; ➢ Monitoring and follow-up activities; ➢ Activities and contacts that are necessary to ensure the POC is implemented and adequately addresses the student's needs, and which may be with the student, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met: ♦ Services are being furnished in accordance with the student's POC; ♦ Services in the POC are adequate. If there are changes in the needs or status of the student, necessary adjustments are made to the POC and service arrangements. TCM services may be reimbursed when provided by a Designated Case Manager. Providers must maintain case records that document, for all students receiving case management services, the following: the name of the student, the dates of the case management services, name of the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the POC have been achieved, whether the student has declined services in the POC, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the POC.

Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the POC. The Designated Case Manager must be an individual who meets one of the following criteria: ▪ A licensed RN in Michigan; ▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of an student with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: ▪ Services for infants and toddlers who are eligible under IDEA as appropriate; ▪ Part C of IDEA and the associated regulations; ▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provision of direct care services to students with special needs; and ▪ Provision of culturally competent services within the community being served.
Designated Case Manager Services	TCM services include: ▪ Ensuring that standard re-examination and follow-up of the beneficiary are conducted on a periodic basis to ensure that the beneficiary receives needed diagnosis and treatment; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services; ▪ Assuring that case records are maintained and indicate all contacts with, or on behalf of, a beneficiary in the same manner as other covered services; ▪ Coordinating SSP services and treatment with parents/guardians and the student; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team POC; ▪ Activities that support linking and coordinating needed health services for the beneficiary; ▪ Providing a summary of provider, parents/guardians and student health and behavioral consultation; and

	▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.
Procedure Code	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.11 SPECIALIZED TRANSPORTATION

Definition	Specialized transportation services include transport to and from the beneficiary's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service. The need for special education transportation must be specified in the student's IEP/IFSP plan of care. Medicaid may reimburse for special education transportation when a beneficiary receives a Medicaid-covered service on the same day as the day transportation is provided. Medicaid does not reimburse for transportation provided in a regular or general education school bus. There is no additional payment for an attendant. Specialized transportation is limited to students receiving services through an IEP/IFSP.
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Taxi and Private Vehicle Transportation	For a taxi or private vehicle transportation expense to be reimbursed, the following documentation must be on file at the local education agency (LEA) or intermediate school district (ISD): ▪ Specialized transportation must be included in the IEP/IFSP POC. ▪ A Medicaid covered medical service must be provided on the same day as the transportation. ▪ Dates and times of each trip must be listed on the LEA's or ISD's trip log. ▪ Documentation from the student's physician or a school provider treating the student, stating the reason taxi or family transportation is required must be retained in the student's file. ▪ For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file. ▪ For ongoing transportation needs, documentation is only required once per student per school year. ▪ For one-time or occasional use transportation, documentation is required for each trip or trip period per student. ▪ The total number of trips claimed for taxi and family transportation must be included in the Special Education trip count on the Medicaid Allowable Expenditure Report (MAER). Claims must be filed through CHAMPS within one year from the date of service according to Medicaid timely filing requirements. Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a student in a prone or supine position (e.g., Ambucab).

SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

3.1 QUALITY ASSURANCE

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

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

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

3.2 SERVICE COORDINATION AND COLLABORATION

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

3.3 ISD RESPONSIBILITIES

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

Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

3.3.A. SANCTIONS

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

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

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDHHS, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through CHAMPS.

SECTION 4 – PROVIDER ENROLLMENT

4.1 ENROLLMENT

The 56 Michigan Intermediate School Districts (ISDs), Detroit Public Schools Community District, and Michigan School for the Deaf are the only providers eligible to bill Medicaid for SSP services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

4.2 CERTIFICATION OF QUALIFIED STAFF

MDE must provide MDHHS with documentation that enrolled ISDs meet the regulatory requirements set forth for all staff providing services in the school setting.

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

4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual direct medical and behavioral health services activities that occur in a school on any given day. Since these services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what services are being provided. For this reason, it is necessary to calculate two separate Medicaid eligibility rates.

4.3.A. C4S MEDICAID ELIGIBILITY RATE (MER)

The C4S Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the public student population that are Medicaid eligible in each ISD in comparison to the total student population in the ISD. The eligibility rate is determined once each year utilizing the Student Count Report. The calculation for the C4S eligibility rate is as follows:

$$\frac{\text{Medicaid Eligible Students}}{\text{Total Student Population}}$$

4.3.B. DSC MER

The DSC MER percentage is determined by the percentage of the special education student population with a health-related support service in their IEP/IFSP that are Medicaid eligible in each ISD in comparison to the total special education student population with a health-related support service in the ISD. The Medicaid eligibility rate is determined once each year utilizing the Student Count Report. The calculation for the DSC eligibility rate is as follows:

$$\frac{\text{Medicaid eligible Special Education Students with a health-related support service in their IEP}}{\text{Total Special Education Students with a health-related support service in their IEP}}$$

SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

5.1 FINANCIAL DATA

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

5.2 UNALLOWABLE COSTS

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

Claims for approved Medicaid SSP functions may not include expenditures of:

- Federal funds received by the ISD/Local Education Agency (LEA) directly
- Federal funds that have been passed through a State or local agency
- Non-federal funds that have been committed as local match for other federal or State funds or programs

Funds received by an ISD for SSP direct medical services are not federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

SECTION 6 – SCHOOL SERVICES PROGRAM REIMBURSEMENT

6.1 METHOD OF REIMBURSEMENT FOR DIRECT MEDICAL SERVICES, PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

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

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

Claims are submitted and processed through CHAMPS; however, the procedure code fee screens are set to pay zero. SSP providers receive their cash flow from the interim monthly payment process described below.

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

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

- The SSP direct medical services procedure code specific billing process;
- The RMTS component;
- The interim payment process; and,
- The cost reconciliation and cost settlement process.

6.1.A. DIRECT MEDICAL SERVICES PROCEDURE CODE SPECIFIC BILLING

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

Claim documentation must be sufficient to identify the student clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be adequate to demonstrate that the service was provided and that the service followed the Student's POC.

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

6.1.B. Random Moment Time Study (RMTS)

For the RMTS, all ISDs are required to utilize the services of the State Contractor who will conduct the statewide time studies.

The quarterly RMTS sampling results are produced by the State Contractor who converts the results to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.

Costs are reported for direct medical services and specialized transportation services on the LEA Cost Report and collected via financial worksheets for PCS and TCM.

The MDHHS Hospital and Clinic Reimbursement Division combines all cost information and the RMTS results, the indirect cost rate, and the MER to calculate the total allowable costs. The MDHHS Hospital and Clinic Reimbursement Division performs the reconciliation and cost settlement process.

The ISD and/or State Contractor must comply with all conditions set forth by MDHHS as SSP policy.

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

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

Summer Quarter Process

A weighted average of the three time study results for the staff pool periods listed below is applied to the LEA Cost Report total costs. The MAER costs include the annual costs associated with the direct medical services, personal care services and TCM services.

The direct medical services time study application is comprised of the following elements:

Cost Pool	The costs from the annual LEA Cost Report (direct medical services, TCM, and PCS).
RMTS	A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

6.1.C. Interim Payment Process

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

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

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

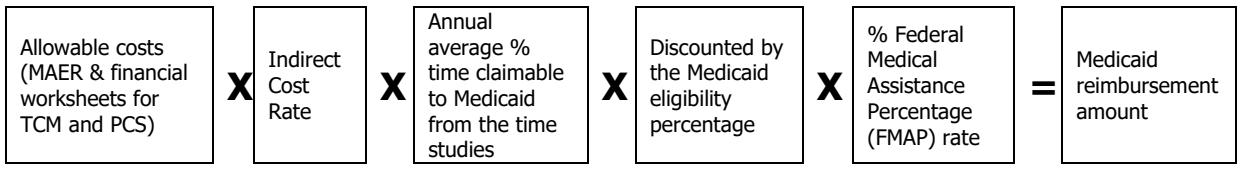
ISDs may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the LEA Cost Report. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to ISDs, how the interim payment revenue is distributed to the respective LEAs and how the initial and final settlements are handled is at the discretion of the ISD.

6.1.D. Cost Reconciliation and Settlement

Allowable cost will be based on the following components:

- Costs from the MAER
- TCM and PCS Financial Worksheets
- MDE Indirect Cost Rate
- RMTS Percentage
- Health Related IEP Medicaid Eligibility Rate (IEP MER)
- Federal Medical Assistance Percentage (FMAP)



The LEA Cost Report is utilized to collect allowable costs for the medical professional staff. Costs for the staff providing TCM services and PCS that are not included in the direct medical costs are obtained from the participating ISD's financial accounting system via financial information entered by the ISD.

To report direct service-related costs, ISDs will utilize the LEA Cost Report. The LEA Cost Report is available in CHAMPS within the Facility Settlement (FS) subsystem. Documentation and instructions are available by accessing the information button and worksheets within the FS subsystem. Worksheets may be extracted through an Excel extract at any time. After submission of the LEA Cost Report, the ISD shall review and approve the submission. Once approved, the ISD may calculate the ISD Cost Report which, using the LEA Cost Reports, will compile and calculate the data used to reimburse for SSP costs. Access and authorization are administered through CHAMPS and also maintained through MiLogin user access. MILogin registration instructions are also

available on the SSP Provider Specific webpage. (Refer to the Directory Appendix for website information.)

The filed cost data is used to calculate an initial settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion.

ISDs may submit revisions until the final settlements are processed.

6.2 Method of Reimbursement for Specialized Transportation

6.2.A. Reimbursement

Specialized transportation costs reported on the MDE Transportation Expenditure Report (form SE-4094) are only the costs associated with the special education buses, taxis or private vehicles used for the specific purpose of transporting only special education children. This report does not include any federal dollars.

Medicaid-allowable specialized transportation costs include the following costs from the SE-4094:

- Salaries [Sec. 52 & Sec. 53a]
  - Bus Drivers
  - Aides
  - Employee Benefits (Bus Drivers and Aides only)
- Purchased Services – Staff (Bus Drivers and Aides only)
- Purchased Services – Vehicle Related Costs [Sec. 52 & Sec. 53a]
  - Pupil Transportation by Carrier
  - Pupil Transportation by Carrier (b/y)
  - Family Vehicle K Cost
  - Contracted Taxis
  - Pupil Transportation Fleet Insurance
  - Contracted/Leased Buses
- Supplies [Sec. 52 & Sec. 53a]
  - Gasoline/Fuel
  - Oil/Grease
  - Tires/Batteries
  - Other Expense/Adjustments, only the costs associated with adjustments to allowable costs

- Bus Amortization

For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's IEP/IFSP.

6.2.B. Specialized Transportation Reconciliation and Settlement

On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from CHAMPS to arrive at the Medicaid allowable cost.

An "allowable" one-way trip is one that is provided to Medicaid eligible student and fulfills all of the following requirements:

- Documentation of ridership is on file;
- The need for the specialized transportation service is identified in the student's IEP/IFSP; and
- A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid covered service must also be documented in the IEP/IFSP.

The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for specialized transportation is combined with the cost settlement amounts for Direct Medical Services, TCM, and PCS; any over/under adjustments are processed as one transaction.

SECTION 7 – INDIRECT COST RATE (ICR)

7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each school district is approved by the Federal cognizant agency. The indirect cost rates are updated annually by MDE.

SECTION 8 – COST CERTIFICATION

8.1 COST CERTIFICATION

Once all cost reports and financial worksheets have been received by MDHHS, the summary report of the LEA Cost Report will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for annually certifying that the total amount of expenditures for covered services has been expended and that none of the expenditures were used as match for other programs or services. This is accomplished in CHAMPS when submitting cost in the LEA Cost Report.

SECTION 9 – COST ALLOCATION FACTORS

9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) RATE

Federal regulations allow for payments to states on the basis of a FMAP for part of their expenditures for services under an approved State Plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act. Under the formula:

- If a state's per capita income is equal to the national average per capita income, the federal share is 55%.
- If a state's per capita income exceeds the national average, the federal share is lower, with a statutory minimum of 50%.
- If a state's per capita income is lower than the national average, the federal share is increased, with a statutory maximum of 83%.

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

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

SECTION 10 – DOCUMENTATION

10.1 DIRECT MEDICAL SERVICES DOCUMENTATION

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

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

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

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

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

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

10.2 RMTS DOCUMENTATION

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

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

ISDs/LEAs must cooperate fully with any reviews requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years.

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

SECTION 11 – AUDIT AND RECOVERY PROCEDURES

11.1 DIRECT SERVICE/TRANSPORTATION PROGRAM AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS AUDIT DIVISION

MDHHS audit review of selected ISDs cost reports for the SSP Program may include the following activities:

- Verification that the LEA Cost Report accurately reports the allowable costs incurred for the appropriate period.
- Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the LEA Cost Report staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on LEA Cost Reports and that LEA Cost Report costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD should be prepared to direct the auditor to any document used to support and identify the reported MAER costs.

11.2 STUDENT CLAIMS AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS AUDIT DIVISION

MDHHS audit review of selected ISDs for approved SSP student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual.
- Verification that occupational, physical, and speech, language and hearing therapy address a student's medical need that affects their ability to learn in the classroom environment.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.

- Verification that the providers requiring supervision, both "under the direction of" and "under the supervision of," have the necessary support documentation on file.
- Verification that the student receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation.
- Confirmation that support documentation for PCS includes a completed, signed and dated monthly activity checklist.
- Verification that group therapy or treatment was provided in groups of two to eight.
- A standard review of the POC areas, such as the inclusion of a description of the student's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the student's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals.
- Any other area deemed necessary.

The ISD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

11.3 Audit Activities to be Performed by MDHHS Audit Division Staff

MDHHS audit review of selected ISD cost reports for the Administrative Outreach Program (AOP) may include the following activities:

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

The ISD should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

11.4 Audit Findings and Resolution

Audit findings and resolution will include the following:

- Identified overstatement of expenditures on the LEA Cost Report will require the revision of the LEA Cost Report and a revised final settlement for all specifically identified overstatements.
- For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.

SCHOOL SERVICES PROGRAM ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT

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SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDHHS will select one Contractor to implement and administer the random moment time study (RMTS). The Contractor will also provide the intermediate school districts (ISDs)/Detroit Public Schools Community District (DPSCD) the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPSCD that choose to participate in this portion of the State contract and pay for these services.

1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All ISDs/DPSCD will be required to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies and develop and submit claims on their behalf each quarter.

The State's Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPSCD to conduct the statewide time studies each quarter, utilizing the claims development software, as well as complete all other key functions required for valid claim development.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPSCD (after federal match).

1.2 OVERVIEW OF CLAIMS DEVELOPMENT PROCESS

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor utilizing the claims development software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement.
- The cost/claim generation component of the claims development software uses ISD/DPSCD costs and other claim factors to calculate and produce the claim.
- The claim is submitted to MDHHS.
- The ISD/DPSCD and/or Contractor must comply with all conditions set forth by MDHHS as School Services Program (SSP) policy.

SECTION 2 - CLAIM CALCULATIONS

2.1 SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a corrective plan if the State-selected contractor or the ISD/DPSCD are not in compliance with the new SSP Administrative Outreach Program published policy. If this is not successful, a contract payment freeze will be implemented, and sanctions put in place until the matter is resolved. Those independent ISDs/DPCDS not participating in the State's claims development contract will be held accountable for their vendor's actions.

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

- Failure to complete minimum threshold of sampled moments each quarter.
- Repeated errors in filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to cooperate with, or submit requested information, reports, or data to, the State's Claims Development Contractor, CMS, MDHHS, MDE, and other staff involved during site visits, reviews or audits.

2.2 FACTORS FOR CLAIMS DEVELOPMENT

MDHHS will submit quarterly claims on behalf of all participating school districts to CMS. Each claim will be based on the following factors: The allowable financial expenditures, percentage of time claimable to Medicaid Administrative Outreach Program administration, the Federal Financial Participation (FFP) rate, the Medicaid indirect cost rate, and the Medicaid eligibility rate for that individual ISD.

2.2.A. ALLOWABLE FINANCIAL EXPENDITURES

This consists of the actual costs incurred for the quarter being claimed, such as salaries, benefits, and contracted staff costs. Each participating ISD/DPSCD must certify that the claim they submit to MDHHS contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

2.2.B. FEDERAL FINANCIAL PARTICIPATION RATE

Federal regulations allow for a reimbursement rate of 50 percent for most Medicaid administrative activities. (Note that Medicaid-related translation has a 75 percent FFP.)

2.2.C. MEDICAID ELIGIBILITY RATE

The Medicaid Eligibility Rates (MER) are determined by the percentage of the population in each ISD/DPS who are actual Medicaid beneficiaries. The MER will be determined once each year and applied to certain activities in the claim calculation formula. To calculate the MER, the claiming entity will obtain the Fall pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will

include the pupil's name and date of birth. MDHHS will provide a method for using the list to verify the number of Medicaid-eligible pupils. This number will be used in a calculation with the total pupil count to determine the percentage of Medicaid-eligible pupils in the ISD/DPS.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims

Allowable Financial Expenditures (salaries, overhead, etc.)	X	% time claimable for Medicaid outreach activities from time studies	X	Discounted by the Medicaid eligibility percentage	X	% Federal Financial Participation (FFP) rate	=	The amount of the claim submitted for Medicaid reimbursement

Summer Quarter Formulas

Cost pools (salaries, overhead, etc.)	X	Average % of time claimable for Medicaid outreach activities from the previous three quarters	X	Discounted by the Medicaid eligibility percentage	X	% Federal Financial Participation (FFP) rate	=	The amount of the claim submitted for Medicaid reimbursement

- Salary and related costs of all staff eligible for the time study are included in the cost pool, along with other allowable overhead.

2.3 Financial Data

The financial data reported (salaries, benefits, contracted staff costs, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to be reported using cash-basis accounting. Include only actual expenditures incurred during the claiming period.

2.4 RMTS Documentation and Recordkeeping/Audit File Requirements

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

- Financial data used to establish cost pools and factors.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that payment from MDHHS was received.

Districts must cooperate fully with any review requested by MDHHS and CMS and maintain all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

2.5 Non-Pupil Specific/Pre-Medicaid Eligibility Determination

Additional Administrative Outreach activities and expenditures not related to a specific pupil are approved by Medicaid for claiming. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual pupils, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid Administrative Outreach claim based on the results of the time study conducted during the claiming period.

2.6 Pupil-Specific Administrative Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual pupils after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted MER.

2.7 Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Title 2 CFR Part 225, must be followed. Examples include conference fees, registration fees, mileage, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

2.8 Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/DPSCD and LEA Medicaid indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA Medicaid indirect cost rate is calculated using the OMB Title 2 CFR Part 225. The methodology used to determine the indirect cost rate specific to each district, as approved by the Federal cognizant agency. Indirect cost rates are updated annually by MDE.

2.9 Claim Certification

The accuracy of submitted claims must be certified by the chief financial officer, the superintendent of the district, or the ISD/DPSCD designee. Such certification is accomplished when the quarterly claim meets the requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be

maintained by the ISD/DPSCD for audit or future reference purposes according to the terms identified in the interagency agreement between the district and MDHHS.

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.

2.10 Claim Amendments

In the event that an error in the claim process has been identified, it is the responsibility of the district to notify the State's Claims Development Contractor. The contractor will open an amendment to the quarterly claim for which the error was identified. The district will correct the error by amending the previously filed financial data. After the data is submitted, the contractor will calculate a new claim for the period. The ISD/DPSCD will review and certify the claim using the same process as the original submission. The adjustment will be filed with the next claim submission to MDHHS and the adjustment will be processed with the current quarterly submission and the current payment will reflect the current payment and any adjusted payments.

2.11 Fiscal Provisions

ISDs/DPSCD must use an appropriate revenue code to identify Medicaid Administrative Outreach Program funds within their accounting records.

2.12 Submission of Claims

All claims are to be submitted in accordance with the reporting requirements established by MDHHS. It is imperative that districts work closely with the State Claims Development Contractor to provide pertinent financial, enrollment, and personnel data and meet their deadlines and any other technical specifications.

2.13 Periodicity of Reporting

ISDs/DPSCD must submit claims for expenditures related to approved Medicaid administrative outreach activities to MDHHS on a quarterly basis. The claim is due to MDHHS on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDHHS

	REPORTING PERIOD		CLAIM DUE TO MDHHS	CLAIM SUBMITTED TO CMS BY MDHHS
	BEGIN DATE	ENDING DATE		
Summer	July 1	September 30	January 28	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 29	September 30
Spring	April 1	June 30	October 28	December 31

SCHOOL SERVICES PROGRAM RANDOM MOMENT TIME STUDY

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SECTION 1 – GENERAL TIME STUDY INFORMATION

This chapter describes the random moment time study process for the School Services Program (SSP) direct medical services program.

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

1.1 ADMINISTRATIVE OUTREACH PROGRAM ACTIVITIES

The School Services Program Administrative Outreach Program (AOP) offers reimbursement for the cost of administrative activities that support efforts to identify and enroll potentially eligible persons into Medicaid and that are in support of the state Medicaid plan.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determinations
- Health-related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Transportation and Translation Services

1.2 DIRECT MEDICAL SERVICES

Medicaid covered services that are medically necessary and specified in the beneficiary's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) or other plans in which medical necessity has been established include:

- Occupational Therapy Services
- Orientation and Mobility Services
- Physical Therapy Services
- Assistive Technology Device Services
- Speech, Language and Hearing Services
- Psychological, Behavioral Health, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services

- Physician and Psychiatric Services
- Personal Care Services
- Targeted Case Management Services (Direct Service Claiming [DSC] only)

1.3 Staff Pools and Confidence Levels

The RMTS is carried out utilizing customized claims development software that automates aspects of the school district time study process. The claims development software is comprised of three components: sampling/staff pool lists, training, and cost/claim generation. All ISDs are required to utilize the services of the State's RMTS and Claims Development Contractor (hereafter referred to as the Contractor). The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools Community District (DPSCD) and Michigan School for the Deaf (hereafter referred to as the ISDs).

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

- AOP Only Staff – This staff pool consists of individuals who perform only administrative outreach activities. They do not perform any direct medical activities.
- AOP & Direct Medical Staff – This staff pool consists of individuals who perform both Direct Medical activities and AOP activities.
- Personal Care Services Staff – This direct medical only staff pool consists of individuals who perform direct care Personal Care Services.
- Targeted Case Management Services Staff – This direct medical only staff pool consists of individuals who perform Targeted Case Management (TCM) Services and pertains to the DSC component of the program only.

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

The sample size of each cost pool ensures a quarterly level of precision of +/- 2 percent with at least a 95 percent confidence level and an annual level of precision of +/- 2 percent with at least a 95 percent confidence level.

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

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

SECTION 2 – CENTRALIZED CODING

The Contractor is responsible for coding the time study moments. MDHHS oversees the Contractor and ISDs participating to ensure their compliance with all aspects of program policy and federal regulations.

SECTION 3 – TIME STUDY METHODOLOGY

3.1 RANDOM MOMENT TIME STUDY OVERVIEW

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

The RMTS measures the work effort of each group of approved staff involved in the time study process by sampling and analyzing the work efforts of a randomly selected cross-section of each staff pool. The RMTS methodology employs a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the three-month period comprising each federal quarter of the year, except for the summer quarter (July through September), which uses the RMTS averages of the other three quarters.

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

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

3.1.A. LONG-TERM SUBSTITUTES

Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized:

- A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter.
- The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed.
- The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid School Services Program staff pool.
- If listed on the staff pool list, the substitute staff must complete the time study moment.
- The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.

- All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity.
- All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

3.2 Random Moment Time Study Form Completion

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to the questions. These questions relate to their activities at the time of their randomly selected moment.
- In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the study questions.

The Contractor conducts the statewide time studies each quarter for all ISDs and produces a report detailing the results. This involves importing clinician information from the ISDs to compile the statewide pool of all eligible time study participants for each staff pool list. There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. Currently, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The State and Contractor review compliance every quarter and may adjust sample sizes as necessary for compliance purposes. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.

The Contractor monitors the status of each time study form so that appropriate follow-up emails are made for delinquent moments or missing data. The ISD is responsible for monitoring time study completion. The time study is electronically completed in the Contractor's system. At the end of the sampling period after all data has been collected and tabulated, statistical validity reports will be produced by the Contractor. These reports will verify that a sufficient number of personnel were sampled to ensure time study results that have a confidence level of at least 95% quarterly with a precision level of +/- 2 percent annually.

3.3 Time Study Staff Pools

To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor.

If staff pool lists or financials for the Direct Service, the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the LEA staff pool lists and correlating financials will be

removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

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

3.3.A. AOP Only Staff Pool

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Teacher Consultants
- Direct Medical staff who do not meet the Medicaid qualifications for direct service claiming

3.3.B. AOP & Direct Medical Services Staff Pool

AOP & Direct Medical Services Staff Pool:

- Fully Licensed Speech Language Pathologists
- Audiologists
- Licensed Professional Counselors
- Limited Licensed Professional Counselors under the supervision of a Licensed Professional Counselor
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Board Certified Behavior Analysts
- Board Certified Assistant Behavior Analysts
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Fully Licensed Psychologists (including School Psychologists)

- Limited Licensed Psychologists under the supervision of a Fully Licensed Psychologist
- Temporary Limited Licensed Psychologists under the supervision of a Fully Licensed Psychologist
- Registered Nurses
- Qualified School Nurses as defined by Public Health Act 269 of 1955 as amended
- Licensed Practical Nurses
- Marriage and Family Therapists
- Licensed Master's Social Workers
- Limited Licensed Master's Social Workers under the supervision of a Licensed Master's Social Worker

3.3.C. Personal Care Services Staff Pool

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

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

3.3.D. Targeted Case Management Services Staff Pool – Pupils with an IEP/IFSP only

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

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

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

- Services for infants and toddlers who are eligible under the Individuals with Disabilities Education Act (IDEA) law as appropriate;

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

SECTION 4 – ADMINISTRATIVE OUTREACH AND DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the code categories utilized for the RMTS and indicates whether they are claimable for reimbursement under the AOP only, the AOP & Direct Medical program (including Personal Care Services and Targeted Case Management Services), allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities are those that are purely educational in nature.

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

4.1 ACTIVITY CODES

Staff Activity and Codes – the indicators below, which follow each code, provide the application of the Federal Financial Participation (FFP) rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the code. In order to maintain coding objectivity by time study participants, time study sheets used by employees should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable or unallowable under Medicaid.

Application of FFP Rate	
50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
75 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 75 percent enhanced FFP rate.
Unallowable Activities	
U	Refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether the population served includes Medicaid eligible individuals.
Application of Medicaid Share	
TM	(Total Medicaid) Refers to an activity that is 100 percent allowable as administration under the Medicaid program.
PM	(Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allowable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid eligibility rate [MER] or the IEP Ratio). The Medicaid share is then determined by applying the MER or the IEP Ratio to the appropriate pupil populations.

Reallocated Activities	
R	Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10 - General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved unrestricted indirect cost rate.[1]

4.2 UNIFORM CODES

Staff should document time spent on each of the following coded activities:

Code 1.a.	Non-Medicaid Outreach – U
Code 1.b.	Medicaid Outreach – TM/50 Percent FFP
Code 2.a.	Facilitating Application for Non-Medicaid Programs - U
Code 2.b.	Facilitating Medicaid Eligibility Determination – TM/50 Percent FFP
Code 3.	School Related and Educational Activities – U
Code 4.a.	Direct Medical Services – Not Covered on a Medical Plan of Care (FFS – Non-IEP) - U
Code 4.b.	Direct Medical Services – Covered as IDEA/IEP Services (FFS – IEP) - IEP Ratio
Code 4.c.	Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service – Medical Plan Ratio
Code 5.a.	Transportation for Non-Medicaid Services – U
Code 5.b.	Transportation-Related Activities in Support of Medicaid Covered Services – PM/50 Percent FFP
Code 6.a.	Non-Medicaid Translation – U
Code 6.b.	Translation Related to Medicaid Services – PM/75 Percent FFP
Code 7.a.	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services – U
Code 7.b.	Program Planning, Policy Development and Interagency Coordination Related to Medical/Medicaid Services – PM/50 Percent FFP

❖ [1] Moments from Code 10. General Administration are reallocated to codes 1.b, 2.b, 5.b, 6.b, 7.b, 8.b and 9.b proportionally for the Administrative Outreach Program Claim. Moments from Code 10 are also proportionally reallocated to code 4.b and 4.c for the annual cost report.

Code 8.a.	Non-Medical/Medicaid Training – U
Code 8.b.	Medical/Medicaid Related Training – PM/50 Percent FFP
Code 9.a.	Referral, Coordination, and Monitoring of Non-Medicaid Services – U
Code 9.b.	Referral, Coordination, and Monitoring of Medicaid Services – PM/50 Percent FFP
Code 10.	General Administration – R
Code 11.	Not Scheduled to Work- Not Included in the distribution or invalid

4.2.A. Code 1.a. - Non-Medicaid Outreach – U

This code should be used by all LEA staff when performing activities that inform individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Includes related paperwork, clerical activities and staff travel required to perform these activities.

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate pupils about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage pupils to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of pupils with special medical/dental/mental health needs through various child find activities.
- Outreach activities in support of programs that are 100 percent funded by State general revenue.
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

4.2.B. Code 1.b. - Medicaid Outreach – TM/50 Percent FFP

LEA staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. Activities include bringing potentially eligible individuals into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. LEAs may only conduct outreach for the populations served by their affiliated schools, i.e., pupils and their parents or guardians. Examples include:

- Informing Medicaid eligible and potentially Medicaid eligible pupils and families about the benefits and availability of services provided by Medicaid (including preventive treatment and screening), including services provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. NOTE: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school-developed outreach materials should have prior approval of the Medicaid agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, pupils and their families about health resources available through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

Activities that are not considered Medicaid outreach under any circumstances are: (1) general preventive health education programs or campaigns addressing lifestyle changes, and (2) outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.

4.2.C. CODE 2.A. - FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

LEA staff should use this code when informing an individual or family about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Women, Infants, and Children (WIC), day care, legal aid and other social or educational programs and referring them to the appropriate agency to make application. The following are examples:

- Explaining the eligibility process for non-Medicaid programs, including IDEA.
- Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application.
- Assisting the individual or family in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.

- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

4.2.D. Code 2.b. - Facilitating Medicaid Eligibility Determination - TM/50 Percent FFP

LEA staff should use this code when assisting an individual in becoming eligible for Medicaid. Includes related paperwork, clerical activities and staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility. Examples include:

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families in completing a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third-party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local assistance office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation (does not include determining eligibility).

4.2.E. Code 3. - School Related and Educational Activities – U

This code should be used for any other school related activities that are not health related, such as social services, educational services and teaching services; employment and job training. These activities include the development, coordination and monitoring of a pupil's education plan. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Developing, coordinating, and monitoring the academic portion of the Individualized Education Program (IEP) for a pupil, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the academic portion of the actual IEP meetings with the parents. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan [IFSP].)
- Compiling attendance reports.

- Performing activities that are specific to instructional, curriculum, and pupil-focused areas.
- Reviewing the education record for pupils who are new to the school district.
- Providing general supervision of pupils (e.g., playground, lunchroom).
- Monitoring pupil academic achievement.
- Providing individualized instruction (e.g., math concepts) to a special education pupil.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.
- Carrying out discipline.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the educational aspects of meeting immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new pupils or obtaining registration information.
- Conferring with pupils or parents about discipline, academic matters or other school related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a pupil.

4.2.F. Code 4.a. - Direct Medical Services – Not Covered on a Medical Plan of Care (FFS – Non IEP) - U

This code should be selected when LEA staff members (employees or contracted staff) are providing direct client care services for which medical necessity has not been determined. This code includes pre- and post-activities associated with the actual delivery of the direct client care services, (e.g., paperwork or staff travel required to perform these services).

Examples of activities reported under this code:

- All non-IDEA and/or non-IEP direct client care services as follows:
  - Administering first aid
  - Screening services conducted by non-qualified providers
  - Mental health services conducted by non-qualified providers
  - Nursing services conducted by non-qualified providers.

4.2.G. Code 4.b. - Direct Medical Services – Covered as IDEA/IEP Service (FFS – IEP) – IEP Ratio

This code should be selected when LEA staff members (employees or contracted staff) provide direct client services as covered services delivered by LEAs under the Fee for Service (FFS) Program for pupils with an IEP/IFSP. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the pupil(s). This code includes the provision of all IDEA/IEP medical (i.e., health-related) services. It also includes functions performed pre- and post-actual direct client services (when the pupil may not be present); for example: paperwork, or staff travel directly related to the direct client services.

Examples of activities reported under this code:

4.2.G.1. All IDEA/IEP Direct Client Services With the Pupil/Client Present

Includes:

- Providing health/mental health services as covered in the pupil's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the pupil's IEP.

4.2.G.2. Direct Medical Services Cost Pool

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the pupil's IEP/IFSP).
- Physical Therapy services and evaluations (only if included in the pupil's IEP/IFSP).
- Occupational Therapy services and evaluations (only if included in the pupil's IEP/IFSP).
- Speech/Language Therapy services and evaluations (only if included in the pupil's IEP/IFSP).
- Psychological, Counseling and Social Work services, including therapy services (only if included in the pupil's IEP/IFSP).
- Orientation and Mobility services and evaluations (only if included in the pupil's IEP/IFSP).
- Nursing services and evaluations (only if included in the pupil's IEP/IFSP), including skilled nursing services on the IEP/IFSP and time spent administering/monitoring medication (only if it is included as part of an IEP/IFSP and documented in the IEP/IFSP).
- Physician and Psychiatrist services (only if included in the pupil's IEP/IFSP).
- Assistive Technology Device Services.

4.2.G.3. PERSONAL CARE SERVICES

This code is used for providing a range of human assistance services to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself. The need for services must be documented in the pupil's IEP/IFSP. Services are not covered when provided by a family member or if they are educational in nature.

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

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

4.2.G.4. TARGETED CASE MANAGEMENT SERVICES

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

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

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

This code also includes pre- and post-time directly related to providing direct client care services when the pupil is not present. Examples of pre- and post-time activities when the pupil is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-time activities associated with physical therapy services; for example: time to build a customized standing frame for a pupil or time to modify a pupil's wheelchair desk for improved freedom of movement for the pupil.
- Pre- and post-activities associated with speech language therapy services; for example: preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the IEP.
- Travel to the direct service/therapy.

- Paperwork associated with the delivery of the direct care service, as long as the pupil/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when pupil is not present. (Assessment services are billed for testing time when the pupil is present, for interpretation time when the pupil is not present, and for report writing when the pupil is not present.)

4.2.H. Code 4.c. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service – Medical Plan Ratio

This code should be selected when LEA staff members (employees or contracted staff) provide direct client services as covered services delivered by LEAs under the FFS program when documented on a medical plan other than an IEP/IFSP or for services in which medical necessity has been determined. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the pupil(s). This code includes the provision of medical (i.e., health-related) services outlined on a medical plan other than an IEP/IFSP or for which medical necessity has been determined. It also includes functions performed pre- and post-actual direct client services (when the pupil may not be present); for example: paperwork, or staff travel directly related to the direct client services.

Examples of activities reported under this code:

4.2.H.1. All Medical Plan Direct Client Services With the Pupil/Client Present

Includes:

- Providing health/mental health services as covered in the pupil's medical plan other than an IEP/IFSP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the pupil's medical plan other than an IEP/IFSP.
- Services for which medical necessity has been determined.

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the pupil's medical plan).
- Physical Therapy services and evaluations (only if included in the pupil's medical plan).
- Occupational Therapy services and evaluations (only if included in the pupil's medical plan).
- Speech Language Therapy services and evaluations (only if included in the pupil's medical plan).

- Counseling services, including therapy services (only if included in the pupil's medical plan or when medical necessity has been determined).
- Orientation and Mobility services and evaluations (only if included in the pupil's medical plan).
- Nursing services and evaluations (only if medical necessity has been determined including skilled nursing services on the medical plan, and time spent administering/monitoring medication only if it is included as part of a medical plan of care and documented in the plan of care).
- Nutrition services include the management and counseling for pupils on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status and teaching related to the dietary regimen.
- All EPSDT covered services, such as screenings, immunizations, etc. or services in which medical necessity has been determined.

This code also includes pre- and post-time directly related to providing direct client care services when the pupil/client is not present. Examples of pre- and post-time activities when the pupil/client is not present include: time to complete all paperwork related to the specific direct client care service such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-time activities associated with physical therapy services; for example: time to build a customized standing frame for a pupil or time to modify a pupil's wheelchair desk for improved freedom of movement for the pupil.
- Pre- and post-activities associated with speech language pathology services; for example: preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the medical plan of care.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service as long as the pupil/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when pupil/client is not present. (Assessment services are billed for testing time when the pupil is present, for interpretation time when the pupil is not present, and for report writing when the pupil is not present.)

4.2.I. Code 5.a. - Transportation for Non-Medicaid Services – U

LEA staff should use this code when assisting an individual to obtain transportation to services not covered by Medicaid or accompanying the individual to services not covered by Medicaid. Includes related paperwork, clerical activities and staff travel required to perform this activity:

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

4.2.J. Code 5.b. – Transportation-Related Activities in Support of Medicaid-Covered Services – PM/50 Percent FFP

LEA staff should use this code when assisting an individual to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct cost of the transportation, but rather the administrative activities involved in providing transportation. Includes related paperwork, clerical activities and staff travel required to perform these activities. An example is:

- Scheduling or arranging transportation to Medicaid covered services.

NOTE: Staff that may arrange transportation that may be included in the RMTS include, but are not limited to, Program Administrators, Special Education Support or other staff at the district who are responsible for arranging specialized transportation for pupils to receive medical services; however, job titles of staff that provide these types of services vary by district.

4.2.K. Code 6.a. - Non-Medicaid Translation – U

LEA staff should use this code when providing translation services related to social, vocational or educational programs and activities as an activity separate from the activities referenced in other codes. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.
- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand State education or State-mandated health screenings (e.g., vision, hearing, and scoliosis) and general health education outreach campaigns intended for the pupil population.
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

4.2.L. Code 6.b. - Translation Related to Medicaid Services - PM/75 Percent FFP

Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units or separate employees performing solely translation functions for the LEA and it must facilitate access to Medicaid covered services.

This code should be used by LEA employees who provide translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translation materials that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translated materials, including Braille transcriptions, that assist the individual to access and understand necessary care or treatment covered by Medicaid
- Translation while the school nurse provides covered services to a pupil whose primary language is not English.
- Sign language interpretation during provision of covered services to a deaf pupil.
- Transcribing into Braille the fact sheet that school nurses use to explain/practice steps/proper technique for using an inhaler.
- Translation to help a school psychologist follow up with a pupil's non-English speaking parent on a mental health referral.

4.2.M. Code 7.a. - Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services – U

LEA staff should use this code when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to school age pupils and when performing collaborative activities with other agencies. Non-medical services may include social, educational and vocational services. Only employees whose position descriptions include program planning, policy development and interagency coordination should use this code. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Identifying gaps or duplication of non-medical services (e.g., social, vocational, educational and state-mandated general health care programs) to school age pupils and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.

- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the relationship of each agency's non-medical services to one another.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

4.2.N. CODE 7.B. - PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO MEDICAL/MEDICAID SERVICES - PM/50 PERCENT FFP

This code should be used by LEA staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age pupils, and when performing collaborative activities with other agencies and/or providers. Employees whose position descriptions include program planning, policy development and interagency coordination may use this code. However, it is a state option whether or not the position descriptions need to be explicit with respect to these specific functions. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Identifying gaps or duplication of medical/dental/mental health services to school age pupils and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.

- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to increase provider participation and improve provider relations.
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Defining the relationship of each agency's Medicaid services to one another.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Developing medical referral sources, such as directories of Medicaid providers and managed care plans, which will provide services to targeted population groups, e.g., EPSDT pupils.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

4.2.O. Code 8.a. - Non-Medical/Medicaid Training – U

This code should be used by LEA staff when coordinating, conducting or participating in training events and seminars for school-based services staff regarding the benefit of the programs, other than the Medicaid program, such as educational programs; for example: how to assist families to access the services of the relevant programs and how to more effectively refer pupils for those services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA child find programs.

4.2.P. Code 8.b. - Medical/Medicaid Related Training – PM/50 Percent FFP

This code should be used by LEA staff when coordinating, conducting or participating in training events and seminars for Direct Medical Service and AOP staff regarding the benefits of the Medicaid program, how to assist families in accessing Medicaid services, and how to more effectively refer pupils for services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.

- Participating in or coordinating training that enhances early identification, intervention, and screening of pupils with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)

4.2.Q. Code 9.a. - Referral, Coordination and Monitoring of Non-Medicaid Services –U

LEA staff should use this code when making referrals for coordinating and/or monitoring the delivery of non-medical, such as educational, services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, and scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a pupil's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost. School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.R. Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services – PM/50 Percent FFP

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., pupil follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under codes 4.a. - Direct Medical Services - Not Covered on a Medical Plan of Care (FFS – Non-IEP); 4.b. - Direct Medical Services - Covered as IDEA/IEP Services (FFS – IEP); or 4.c. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service. Examples include:

- Identifying and referring pupils who may be in need of Medicaid family planning services.

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
- Referring pupils for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a pupil's needs for health-related services covered by Medicaid.
- Developing, coordinating, and monitoring the medical portion of the IEP for a pupil which includes the medical portion of the actual IEP meetings with the parents, time spent developing the medical services plan on the IEP, and writing of the medical service goals of the IEP. (If appropriate, this would also refer to the same activities performed in support of an IFSP or other medical plan.)
- Providing follow-up contact to ensure that a pupil has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a pupil with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the pupil to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the pupil's related medical/dental/mental health services and plans.
- Monitoring and evaluating the Medicaid service components of the IEP and/or medical plan as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

NOTE: A "referral" is considered appropriate when made to a provider who can provide the required service, will accept the pupil as a patient, and will accept the pupil's source of payment for services.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost. School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.S. Code 10. - General Administration – R

Time study participants, when performing activities that are not directly assignable to program activities, should use this code. Includes related paperwork, clerical activities and staff travel required to perform these activities. Note that certain functions such as payroll, maintaining inventories, developing budgets, executive direction, etc. are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities but they are not all inclusive.

- Taking lunch, breaks, leave, or other paid time not at work.
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

4.2.T. Code 11. - Not Scheduled to Work – Not Included in the Distribution or Invalid

This code should be used if the random moment occurs at a time when a part-time, temporary or contracted employee is not scheduled to be at work. NOTE: Full-time school staff should not use this code.

SECTION 5 – CONFIDENTIALITY

Aggregate time study data may occasionally be useful for other administrative tasks (i.e., planning) and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy. Aggregate data is defined as data at the state level. That data may be broken down by cost pool as well.

SECTION 6 – TIME STUDY TRAINING

6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies.

The Contractor, along with MDHHS, is responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide and other services that will be provided to the individual ISDs.

6.1.A. LOCAL ISD COORDINATOR TRAINING

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

6.1.B. TIME STUDY PARTICIPANT TRAINING

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

SECTION 7 – SUMMARY OF TIME STUDY STEPS

The Contractor duties are to:

- Import eligible school district staff information to create the RMTS staff pools.
- Randomly select staff/moments to be sampled.
- Generate printed or electronic RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD Coordinators as a local control list.
- Generate mailing labels addressed to randomly selected staff.
- Code the time study responses.
- Calculate activity percentages for each of the activity codes.
- Scan completed and coded time study forms.
- Transfer raw data from scanned forms to the claims development software to calculate activity percentages for each of the activity codes.
- Produce quarterly reports summarizing the results of the RMTS and RMTS compliance reporting. (Both reports are forwarded to the MDHHS Program Policy Division for posting on the MDHHS website. Refer to the Directory Appendix for website information.)
- Produce periodic and special RMTS reports that provide data and information sorted by LEA and ISD that are provided to the CMS, MDHHS, MDE, ISDs and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs.
- Distribute time study forms and collect completed time study forms.
- Code the activity forms received from the ISDs.
- Initiate and complete the ISD claim workbooks by obtaining the financial data from each LEA and compiling data to complete the workbook.

SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

8.1 AOP QUARTERLY CLAIM (OTHER THAN SUMMER QUARTER)

The claim consists of the results of the quarterly RMTS of the approved staff pool for the quarter and the correlating allowable costs applied to the reimbursement methodology.

8.2 AOP SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

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

8.2.A. JULY - SEPTEMBER CLAIM

The summer quarter is comprised of the following elements:

- Staff Pool – those eligible staff in the April through June staff pool define the positions for which costs can be claimed during the summer period.
- Costs – July - September allowable staff pool costs
- A weighted average of the October-December, January-March, April-June, and the summer time study results.

8.3 DIRECT MEDICAL SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

A weighted average of the three time study results for the staff pool periods listed below is applied to the Medicaid Allowable Expenditure Report (MAER) total costs. The MAER costs include the annual costs associated with the direct medical services, personal care services and targeted case management services.

The direct medical services time study application is comprised of the following elements:

- Staff Pools – Those individuals eligible to participate in the following three staff pool periods:
  - October through December
  - January through March
  - April through June
- Cost Pool – The costs from the annual LEA Cost Report (direct medical services, targeted case management and personal care services).
- RMTS – A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

8.4 Financial Reporting Compliance Requirements

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from LEA payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.

SECTION 9 – AUDIT AND QUALITY ASSURANCE

9.1 AUDIT

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

MDHHS audit staff review of selected ISD cost reports includes the following activities:

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

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

9.1.B. STATEMENT ON STANDARDS FOR ATTESTATION ENGAGEMENTS (SSAE) 16 AUDIT REQUIREMENTS

The Contractor is required to have a Statement on Standards for Attestation Engagements (SSAE) 16 Type II audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) were properly applied.

In a SSAE 16 Type II engagement, the service auditor expresses an opinion on whether the description of the service organization's system is fairly presented, whether the controls included in the description are suitably designed, whether the controls were

operating effectively, and provides a description of the service auditor's tests of operating effectiveness and the results of those tests.

The Contractor must undergo a SSAE 16 audit annually. The SSAE 16 audit must be submitted within 90 days after the end of the examination period.

Three (3) copies of the audit should be forwarded to the MDHHS Program Policy Division. (Refer to the Directory Appendix for contact information.)

9.2 Quality Assurance, Oversight and Monitoring

Quality assurance, oversight and monitoring activities include:

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

MDHHS policy staff responsibilities are:

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

9.2.B. MDHHS Office of Inspector General – Post Payment Review and Compliance

MDHHS Office of Inspector General staff responsibilities are:

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

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

9.2.C. MDHHS Rate Review Section – Cost Settlement Review

MDHHS Rate Review Section staff responsibilities are:

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

9.2.D. Contractor Oversight and Quality Assurance

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

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

9.2.E. ISD OVERSIGHT

ISD responsibilities are to:

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